Part I

APPLICATION FOR A CERTIFICATE
UNDER INTERSTATE RECIPROCITY AGREEMENT Date May 10, 1984

On the basis of License No. _____ issued by the State of _____
or Certificate No. 279736 issued by the National Board of Medical Examiners on the 7th
day of ~~April~~ March, 19 84.

I hereby make application for a License Certificate to practice Medicine and Surgery in Tennessee and submit the following statement of facts and proof in support of same:

1. Name in full Susan Price Dodd Date of birth 08/09/55
2. Place of birth Sevierville, Tennessee U.S. Citizen: Yes ☑ No ☐
3. Present address 5635 Waterman, Apt #34, St. Louis, MO 63112
4. Telephone Number 314-776-8100 Social Security No. _____
   (During Regular Business Hours) or 314-622-5341
5. Intended practice address in Tennessee Univ. of Tenn. Memorial Hosp., Knoxville, TN
6. Type of intended practice in Tennessee Resident in Obstetrics & Gynecology
7. Has your application for examination or license been rejected by any Board of Medical Examiners?
   No
   If yes, by what Board and for what reason? _____
8. Have you failed an examination before any Board of Medical Examiners? No
   If yes, name the Board and give date of examination _____
9. Give names of States in which you are now licensed or have ever been licensed and give dates.
   None except temporary licence in Missouri July 1, 1983-June 30, 19
10. Has any State Medical Board taken any disciplinary action against a license certificate issued to you? No
    If yes, name the Board and state why such action was taken _____
11. Have you been rejected by a Medical Society? No If so, why, and by what Society? _____
12. Have you ever been addicted to narcotics or intoxicants, charged with, or convicted of violation of any State or Federal Narcotic or Dangerous Drug laws or of any State or Federal Statute? No
    If so, give particulars in a separate letter.
13. Have you ever been charged with or convicted of a felony? No
    If so, give particulars in a separate letter.

PRELIMINARY AND PRE-MEDICAL EDUCATION

	Name of School or College	Date Attended	Certificate or Degree
1.	Berea College	1973-77	B.A.
2.	Univ. of Tennessee, Knoxville	1977-79	None
3.			

MEDICAL EDUCATION

I have spent 4 years in the study of medicine in the institutions below:

	Day, Month, Year		Day, Month, Year	Name of School	Location
From	4-9-79	to	20-6-80	Univ. of Tennessee	Memphis
From	2-9-80	to	13-3-81	Univ. of Tenn. Coll. of Med.,	Memphis
From	6-7-81	to	30-6-82 (6-11-83)	Univ. of Tenn. Coll. of Med.,	Memphis
From	6-7-82	to	28-2-83	Univ. of Tenn. Coll. of Med.,	Memphis

MAY 23 1984

NOTE: Any false or misleading information in, or in connection with, this application may be cause for automatic denial of licensure.

AFFIDAVIT OF APPLICANT

State of Missouri

County of St Louis

Susan P. Dodd, M.D., of St Louis University Hospital

being duly sworn says that he/she is the person referred to in this application for a License Certificate to practice Medicine and Surgery in the State of Tennessee and that each of the statements herein contained is true in every respect.

Susan P. Dodd, M.D.
(Signature of Applicant)

SEAL

Sworn to before me, this 11th day of May, 19 84

My commission expires August 27, 1985

Notary Public

PART II CERTIFICATE OF MEDICAL EDUCATION

It is hereby certified that Susan Lynn Price Dodd of St. Louis, Missouri matriculated in Univ. of Tenn. Coll. of Med. at Memphis, Tennessee. Date 8/30/79 attending Four courses of lectures Nine months each, and received a diploma from Univ. of Tenn. Coll. of Med., Memphis conferring the degree of Doctor of Medicine June 11, 1983 (Date)

Registrar (Assistant Secretary of Board)

SEAL

Date May 22, 1984

PART III CERTIFICATE OF SECRE[illegible] [illegible]IGINAL LICENSE
(If licensure is based on Nationa[illegible] [illegible]te this section.)

I, [illegible] tary of the [illegible]

Board of Medical Examiners, certify that [illegible]

of [illegible] was grante[illegible] [illegible] to practice

Medicine in the State of [illegible] [illegible], 19[illegible]

based on a written examination before t[illegible] [illegible] and prior graduation

from [illegible], 19[illegible]

and that said license certificate has never been revoked. Enclosed photograph is a true likeness of [illegible] I further certify that the aforesaid in his written examination before this Board obtained a general average of [illegible] per cent or FLEX weighted average of [illegible] per cent in the following subjects.

Subject	Percent	Subject	Percent

Day I Average [illegible]

Day II Average [illegible]

Day III Average [illegible]

City of St. Louis

DEPARTMENT OF HEALTH AND HOSPITALS

HOSPITAL DIVISION

CHOEMEHL, JR.
AYOR

SECTIONS
ST. LOUIS CITY HOSPITAL
(MAX C STARKLOFF MEMO
1515 LAFAYETTE 63104
HGP AMBULATORY CARE (
2601 N WHITTIER 63113
HARRY S TRUMAN
RESTORATIVE CENTER
5700 ARSENAL STREET
ST LOUIS MO 63139
ROBERT KOCH HOSPITAL
4101 KOCH ROAD
KOCH, MISSOURI
SNODGRAS LABORATORY
1605 GRATTAN 63104
HOMER G PHILLIPS LABOF
2601 N WHITTIER 63113

May 10, 1984

Tennessee Board of Medical Examiners
R.S. Gass State Office Building
Ben Allen Road
Nashville, TN 37216

RE: Susan Dodd, M.D.

Dear Sirs:

This is written as a reference for Dr. Dodd, whom I have known as a resident for the past year. She has the highest moral and ethical qualifications, and I have no hesitation in recommending her for licensure in the State of Tennessee.

If you have further questions, please do not hesitate to contact me.

Sincerely,

Tamara Ostapowicz

Tamara Ostapowicz, M.D.
Physician-Instructor
Department of Obstetrics
and Gynecology

MAY 14 19

St. Louis University
Medical Center

School of Medicine
1325 S. Grand Blvd., St. Louis, Mo. 63104
314/771/7600, Sta. 3286

Department of Obstetrics
and Gynecology

Charles H. Dahm, Jr., M.D.

May 10, 1984

Tennessee Board of Medical Examiners
R.S. Gass State Office Building
Ben Allen Road
Nashville, TN 37216

RE: Susan Dodd, M.D.

Dear Sirs:

This is written as a reference for Dr. Dodd, whom I have known as a resident for the past year. She has the highest moral and ethical qualifications, and I have no hesitation in recommending her for licensure in the State of Tennessee.

If you have further questions, please do not hesitate to contact me.

Sincerely yours,

Charles H. Dahm, Jr., M.D.

MAY 14

ol Medicine • School of Nursing • School of Allied Health Professions • Graduate Program in Orthodontics • Center for Health
ces Education and Research • Center for Health Care Ethics • University Health Center • Institute for Molecular Virology
rsity Hospitals Beaudry Memorial Pavilion Farmer Desloge David P. Wohl Memorial Mental Health Institute

ATIONAL BOARD OF MEDICAL EXAMINERS • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Susan P. Dodd, 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 C. WILLIAM DAESCHNER, JR., M.D.
Chairman of the Board

SEAL EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa
07/02/84 Certificate # 279736

t is certified that the above is a facsimile of the Diplomate Certificate which has been or will be awarded to the hysician named above, who graduated from U TENNESSEE COLL MEDICINE
n JUNE ,1983 and whose birth date is 08/09/1955 This physician has successfully completed ll examinations required for certification by the National Board of Medical Examiners. The scores obtained by his physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
ART I passed 06/81		
natomy, incl. histology and embryology	520	82
hysiology	460	79
iochemistry	655	91
athology	490	80
icrobiology, incl. immunology	555	84
harmacology and Materia Medica	385	73
ehavioral Sciences	540	83
OTAL TEST (Minimum Passing Score 380/75)	525	82
art II passed 09/82		
nternal medicine and the medical specialties	410	78
urgery and the surgical specialties	325	75
bstetrics and Gynecology	590	87
ublic Health and Preventive Medicine	540	84
ediatrics	510	83
sychiatry	550	85
OTAL TEST (Minimum Passing Score 290/75)	475	81
ART III passed 03/84		
General Test of Clinical Competence		
OTAL TEST (Minimum Passing Score 290/75)	490	81.7
ENERAL AVERAGE (Parts, I, II, and III Scale Score)	81.6	

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

Ann K. Heverling
Secretary for Certification

SEAL

05/24/84
Date

A 175.0 PNI
BI:8 4 0 /:?/84 17

BOARD OF MEDICAL EXAMINERS

NAME: Susan P. Dodd, M.D.

DATE: 5-23-84

_____ EXAM APPLICATION - $200.00

_____ RETAKE EXAM APPLICATION - $200.00

_____ FLEX RETAKE EXAM FEE - DAY I _____ $50.00 DAY II _____ $50.00 Day III _____ $10(

✓ RECIPROCITY APPLICATION - $175.00

_____ ENDORSEMENT - $10.00

_____ LICENSURE EXEMPTION - No. of exemptions: _____
Total $_____

_____ MISCELLANEOUS REVENUE _____

Explanation: _____

Managing Abortion Emergencies

The National Abortion Federation (NAF) certifies that:

Susan Dodd

(Name of physician)

has participated in the educational activity titled "Managing Abortion Emergencies" on August 30, 2018 and is awarded 3 *AMA PRA Category 1 Credits.* ™

NAF is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

NAF designates this live activity for a maximum of 3 *AMA PRA Category 1 Credits.* ™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Vicki Saporta	Matthew Reeves, MD MPH FACOG	Reesa Roberts, PA-C MS
President and CEO	Medical Director	Quality Assurance Clinician

1090 Vermont Avenue NW, Suite 1000 • Washington, DC 20005 • p: 202.667.5881 • f: 202.667.5890
www.prochoice.org

CERTIFICATE OF PHYSICIAN ATTENDANCE

NAF's 41st Annual Meeting: Joining Together for Justice

April 24-25, 2017 — Montreal, Quebec, Canada

The National Abortion Federation is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The National Abortion Federation designates this live activity for a maximum of 12.0 *AMA PRA Category 1 Credits.™* Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NAF certifies that

Susan Dodd, MD

(Name of physician)

has participated in the educational activity titled "NAF's 41st Annual Meeting: Joining Together for Justice" on April 24-25, 2017, and is awarded 10.5 *AMA PRA Category 1 Credits.™*

The American College of Obstetricians and Gynecologists has assigned up to 12 cognate credits to this program. This Live activity, NAF's 41st Annual Meeting, with a beginning date of 04/24/2017, has been reviewed and is acceptable for up to 11.75 Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Vicki Saporta
President and CEO

Ann Schutt-Ainé, MD
Chair, Board of Directors

CERTIFICATE OF PHYSICIAN ATTENDANCE

Post-Graduate Seminar: Improving Emergency Preparedness in Abortion Care

April 23, 2017 — Montreal, Quebec, Canada

The National Abortion Federation is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The National Abortion Federation designates this live activity for a maximum of 6.5 *AMA PRA Category 1 Credits.™* Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NAF certifies that

Susan Dodd, MD

(Name of physician)

has participated in the educational activity titled "Post-Graduate Seminar: Improving Emergency Preparedness in Abortion Care" on April 23, 2017, and is awarded 6.5 *AMA PRA Category 1 Credits.™*

The American College of Obstetricians and Gynecologists has assigned up to 7 cognate credits to this program. This Live activity, Post-Graduate Seminar: Improving Emergency Preparedness in Abortion Care, with a beginning date of 04/23/2017, has been reviewed and is acceptable for up to 6.00 Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Vicki Saporta
President and CEO

Ann Schutt-Ainé, MD
Chair, Board of Directors

Maintenance of Certification
American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 721-7510
Fax: (214) 871-1943

November 16, 2018

Susan Price Dodd, M.D.
3904 Legends Way
Maryville, TN 37801

Dear Doctor Dodd,

Congratulations! We are pleased to inform you that you have satisfactorily completed your 2018 Maintenance of Certification (MOC) assignments.

As of the date of this letter, you have earned 38 AMA Category 1 CME credits for completing the 2018 Part II and Part IV MOC requirements. Your CMEs will be awarded by the American College of Obstetricians and Gynecologists. You should have already received your 2018 MOC label insert. If you have not, please contact the MOC Division at MOC@abog.org.

Your certification in Obstetrics and Gynecology is valid through 12/31/2019. The ABOG MOC program is a continuous process, and to maintain your certification, you must apply and participate each year. The application for next year's program will be available through your ABOG Member Login page beginning in January 2019.

Please use this letter to provide documentation of your current 2018 ABOG certification for your hospital(s). Thank you for your continued participation in MOC.

Sincerely,

Susan M. Ramin MD

Susan M. Ramin, M.D.
Associate Executive Director

SMR

ABOG ID: 872722

A710063

July 06, 2017

Maintenance of Certification
American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 721-7510
Fax: (214) 871-1943

Susan Price Dodd, M.D.
3904 Legends Way
Maryville, TN 37801

Dear Doctor Dodd,

Congratulations! We are pleased to inform you that you have satisfactorily completed your 2017 Maintenance of Certification (MOC) assignments.

As of the date of this letter, you have earned 38 AMA Category 1 CME credits for completing the 2017 Part II and Part IV MOC requirements. Your CMEs will be awarded by the American College of Obstetricians and Gynecologists. In addition, you have completed the Patient Safety Course as part of the Part II requirement, which includes the following chapters:

1. Patient Safety - An Imperative
2. A Just Culture
3. Enhancing Patient Safety Through Teamwork
4. Disclosure of Adverse Events
5. Patient Safety in the Surgical Environment
6. Medication Safety
7. Communication and Patient Safety
8. Cultural Awareness and Sensitivity for the Obstetrician-Gynecologist

You should have already received your 2017 MOC label insert. If you have not, please contact the MOC Division at MOC@abog.org.

Your certification in Obstetrics and Gynecology is valid through 12/31/2018. The ABOG MOC program is a continuous process, and to maintain your certification, you must apply and participate each year. The application for next year's program will be available through your ABOG Member Login page beginning in January 2018.

Please use this letter to provide documentation of your current 2017 ABOG certification for your hospital(s). Thank you for your continued participation in MOC.

Sincerely,

Susan M. Ramin MD

Susan M. Ramin, M.D.
Associate Executive Director

SMR

ABOG ID: 872722

A065904

INFORMED

certifies that

Susan Dodd, M.D

Has participated in the enduring material titled

Tennessee Guidelines for Treatment of Chronic Pain

and is awarded 2 *AMA PRA Category 1 Credits™*

Date Completed: November 13, 2016

William J. Ratliff,
Director, Program Administration

THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER

Created July 5, 2019

Certificate of Participation

at a Continuing Medical Education activity

COLLEGE *of* MEDICINE
Office of Continuing Medical Education
960 East Third Street, suite 104
Chattanooga, TN 37403
Tel: (423) 778-6884 Fax: (423) 778-3673

Susan Price Dodd MD
3904 Legends Way
Maryville TN 37801

Activity Details:	Hours of CME/AMA Instruction received at this activity:
1852: Responding to the Opioid Crisis: Law, Policy, Practice October 3, 2018 Live activity - Johnson City, TN Joint Provider: SVMIC	2.00

The University of Tennessee College of Medicine certifies that the medical professional indicated above participated in this educational activity.

Accreditation: This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint providership of The University of Tennessee College of Medicine (UTCOM) and SVMIC. The UTCOM is accredited by the ACCME to provide continuing medical education for physicians.

AMA Credit Designation: The UTCOM designates this live activity for a maximum of *2.0 AMA PRA Category 1 Credits™*.

The University of Tennessee College of Medicine certifies that the medical professional indicated above attended sessions that meet the Tennessee Board of Medical Examiners requirement for two hours in controlled substance prescribing, which includes instruction in the Department Chronic Pain Guidelines on opioids, benzodiazepines, barbiturates and carisoprodol and may include topics such as medicine addiction, risk management tools and other topics approved by the Board.

The Kentucky Board of Medical Licensure has approved this course for 2 hours of HS 1 Approved CME ID#: 0218-H2.0-SVM1a.

RECEIVED
JUL - 9 2019
By Compliance Unit

[redacted]

Bill Reynolds, MBA
Director of Continuing Medical Education

Continuing Education Units for Non-Physicians: Non-physicians can obtain continuing education credits for attending activities that award continuing medical education credits to physicians. The University of Tennessee designates CEU's using the national standard that 1 hour of educational instruction is awarded .1 CEU.

JUNE 2019 CE AUDIT

July 01, 2019

HEALTH RELATED BOARD COMPLIANCE UNIT TRACKING FORM

YOUR DOCUMENTS MUST BE MAILED OR FAXED WITH THIS FORM.

1606 15635
SUSAN P DODD MD
3904 LEGENDS WAY SUITE 100
Maryville, TN 37801 US

Profession Code: 1606 **Profession: Medical Doctors** All medical doctors licensed in the state of Tennessee must earn 40 hours of qualifying continuing medical education credits in the two calendar years preceding the year they are required to renew their medical license. For example, if you are required to renew your Tennessee medical license by December 31, 2019, you must earn all required continuing education between January 1, 2017 – December 31, 2018. **Unless you are statutorily exempted, your 40 hours earned should include at least two hours in a course or courses designed specifically to address controlled substance prescribing which includes instruction in the "Tennessee Chronic Pain Guidelines".** Only licensees holding an ABMS, AOA or ABPS certification in one of the following specialties are statutorily exempted from the requirement to complete the required prescribing course: pain management; anesthesiology; physical medicine and rehabilitation; neurology; and rheumatology.

Are you ABMS, AOA or ABPS board certified in one of the aforementioned specialties? ☐ Yes ☒ No
If yes, please list certifying board(s): _____

What constitutes qualifying continuing medical education?

- ☐ AMA Category 1 credits awarded by ACCME accredited organizations;
- ☐ AAFP credits awarded by ACCME accredited organizations; and
- ☐ If requested by the Department, a licensee's written report summarizing conclusions regarding disciplinary case review.

What is considered satisfactory proof of completion?

- ☐ Original certificates or photocopies of original certificates verifying licensee's attendance and completion of hours;
- ☐ Letter(s) from course providers verifying the licensee's attendance and completion of hours; and
- ☐ For AAFP members, the AAFP log indicating hours earned.

If you are meeting the requirements for MOC of an ABMS board, you may choose to have your satisfactory participation serve as proof of completion of the CME requirements of your profession by returning this completed form along with proof of completion of the two hours of Tennessee specific controlled substance prescribing medical education.
Are you participating in MOC? ☒ Yes ☐ No

Certifying board(s): ABOG

Please return satisfactory proof of compliance with these requirements to the Audit Compliance Unit. Please remember to include this tracking form along with any documents submitted. NOTE: Only CME earned between January 1, 2017 – December 31, 2018 will be accepted.

Facsimile: (615) 401-7683

Postal mail: Audit/CE Compliance Unit
James Hill
665 Mainstream Drive
Nashville, TN 37243

Frequently asked questions concerning the CME requirements of your profession, including penalties for noncompliance and the Board's enforcement process, are available at: **https://www.tn.gov/content/dam/tn/health/documents/MDcmefaqs.pdf**

FOR OFFICE USE ONLY

☐ Non-compliant _____ Hours ☐ Compliant 40+ Hours

Administrator Signature Angela Laurence Date 7/16/19

Department of
Health

July 17, 2019

1606 15635
Susan P. Dodd MD
3904 Legends Way Suite 100
Maryville, TN 37801 US

JUNE 2019 CE AUDIT

Re: Notice of Compliance Letter;

This letter serves as confirmation of compliance with the continuing education requirements.

Thank you for participating in the recent audit conducted by the TN Department of Health, Division of Health Related Boards.

If you have any questions, please contact me at 1-800-778-4123 ext. 532-2520.

Sincerely,

James Hill, Administrator
james.a.hill@tn.gov
Division of Health Related Boards
Continuing Education Audit Unit

AUDTCOMPLY

MEDICAL DOCTORS

RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM

DO NOT SEPARATE ANY PART OF THIS FORM

Lic./Cert. No: MD0000015635 Lic./Cert. Status: ACTIVE

Expiration Date: 08/31/2001

File ID: 00016835

NPI/UPIN#:

Transaction No: 000077365

SUSAN P DODD MD
3215 JOHN SEVIER HIGHWAY
KNOXVILLE TN 37920-5540

Social Sec. No:

Birth Date: 08/09/1955

Name and/or Mailing Address Change

Home Phone: (865) 540-4469

(865) 984-8237

Work Phone: (865) 546-1642

E-mail:

Activity Status: FULL TIME

Specialty:

OB/GYN

☐ 1 Full Time ☐ 3 Not Working

☐ 2 Part Time

Work Address:

Work Address Change

KNOXVILLE TN 37920

STATE REGULATORY FEE $ 10.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competency requirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotated and the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

Susan Dodd, MD 7/9/01

Circle YES if the following applies to you:

I have been convicted of a crime and I have not previously notified the Board in writing of that action.	YES
My license has been disciplined in another state and I have not previously notified the Board in writing of that action.	YES
I am currently in poor physical and / or mental health.	YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states. _____

INSTRUCTIONS

Read all instructions before completing this renewal application.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided.
2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.
3. Sign and Date the application and return it in the enclosed self-addressed envelope. DO NOT SEPARATE any part of this form.

   If you do not sign and date the application, it WILL be returned to you. Failure to sign and date this application will cause a delay in issuing your renewal certificate.
4. Make your check or money order payable to the Department Of Health. DO NOT SEND CASH.
5. To insure processing by the expiration date, complete the application and submit with check or money order upon receipt of this application.
6. Pursuant to T.C.A. Section 63-1-108, it is the licensee's responsibility to keep the Board apprised of any change of address within thirty days of the change. For the purpose of

MEDICAL DOCTORS

RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM

Online Renewal Now Available At www.tennesseeanytime.org/hlrs

DO NOT SEPARATE ANY PART OF THIS FORM

Lic./Cert. No: MD0000015635 Lic./Cert. Status: ACTIVE

Expiration Date: 08/31/2003

Transaction No: 000099036

File ID: 00016835

NPI/UPIN#:

SUSAN P DODD MD
3215 JOHN SEVIER HIGHWAY
KNOXVILLE TN 37920-5540

Social Sec. No:

Birth Date: 08/09/1955

Name and/or Mailing Address Change

Home Phone: (865) 940-8237

Work Phone: (865) 546-1642

E-mail:

Specialty:

Activity Status: FULL TIME

☐ 1 Full Time ☐ 3 Not Working

☐ 2 Part Time

Work Address:

KNOXVILLE TN 37920

Work Address Change

STATE REGULATORY FEE $ 10.00

RENEWAL 225.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competency requirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotated and the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

Susan Dodd
SIGNATURE

7/11/03
DATE

Circle YES if the following applies to you:

I have been convicted of a crime and I have not previously notified the Board in writing of that action. ..... YES

My license has been disciplined in another state and I have not previously notified the Board in writing of that action. ..... YES

I am currently in poor physical and / or mental health. ..... YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states. _____

Emergency Phone: 8655461642

Emergency Fax: 8655446713

INSTRUCTIONS

Read all instructions before completing this renewal application.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided.
2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.
3. Sign and Date the application and return it in the enclosed self-addressed envelope. DO NOT SEPARATE any part of this form.

   If you do not sign and date the application, it WILL be returned to you. Failure to sign and date this application will cause a delay in issuing your renewal certificate.
4. Make your check or money order payable to the Department Of Health. DO NOT SEND CASH.
5. To insure processing by the expiration date, complete the application and submit with check or money order upon receipt of this application.
6. Pursuant to T.C.A. Section 63-1-108, it is the licensee's responsibility to keep the Board apprised of any change of address within thirty days of the change.

MEDICAL DOCTORS

RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM

Online Renewal Now Available At www.tennessee.gov/health

DO NOT SEPARATE ANY PART OF THIS FORM

Lic./Cert. No: MD0000015635 Lic./Cert. Status: ACTIVE

Expiration Date: 08/31/2005

Transaction No: 000121354

File ID: 00016835

NPI/UPIN#:

Social Sec. No: [redacted]

SUSAN P DODD MD
1932 ALCOA HWY #150
KNOXVILLE TN 37920-1532

Birth Date: 08/09/1955

Name and/or Mailing Address Change

Home Phone: (865) 546-1642

Work Phone: (865) 546-1642

E-mail:

Specialty:

Activity Status: FULL TIME

- [ ] 1 Full Time
- [ ] 2 Part Time
- [ ] 3 Not Working

Work Address:

KNOXVILLE TN 37920

Work Address Change

STATE REG FEE $ 10.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competency requirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotated and the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

Susan Dodd, MD 7/6/05

Circle YES if the following applies to you:

I have been convicted of a crime and I have not previously notified the Board in writing of that action. ..... YES

My license has been disciplined in another state and I have not previously notified the Board in writing of that action. ..... YES

My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry)..... YES

I am currently in poor physical and / or mental health. ..... YES

Have you ever been denied a license to practice your profession in another jurisdiction. ..... YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states. _____

Emergency Phone: 8655461642

Emergency Fax: 8655446713

INSTRUCTIONS

Read all instructions before completing this renewal application.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided.
2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.
3. Sign and Date the application and return it in the enclosed self-addressed envelope. DO NOT SEPARATE any part of this form.

   If you do not sign and date the application, it WILL be returned to you. Failure to sign and date this application will cause a delay in issuing your renewal certificate.
4. Make your check or money order payable to the Department Of Health. DO NOT SEND CASH.
5. To insure processing by the expiration date, complete the application and submit with check or money order upon receipt of this application.
6. Pursuant to T.C.A. Section 63-1-108, it is the licensee's responsibility to keep the Board

MEDICAL DOCTORS

RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM

Online Renewal Now Available At www.tennessee.gov/health

DO NOT SEPARATE ANY PART OF THIS FORM

Lic./Cert. No: MD0000015635 Lic./Cert. Status: ACTIVE

Expiration Date: 08/31/2007

Transaction No: 000144332

File ID: 00016835

NPI/UPIN#:

SUSAN P DODD MD
1932 ALCOA HWY #150
KNOXVILLE TN 37920-1532

Birth Date: 08/09/1955

Name and/or Mailing Address Change

Home Phone: (865) 546-1642

Work Phone: (865) 546-1642

E-mail:

Activity Status: FULL TIME

Specialty:

☐ 1 Full Time ☐ 3 Not Working

☐ 2 Part Time

Work Address:
1932 ALCOA HIGHWAY
SUITE #150
KNOXVILLE TN 37920

Work Address Change

STATE REG FEE $ 10.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competency requirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotated and the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

Susan Dodd, MD 7-5-07

Circle YES if the following applies to you:

I have been convicted of a crime and I have not previously notified the Board in writing of that action. ..... YES

My license has been disciplined in another state and I have not previously notified the Board in writing of that action. ..... YES

My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry)..... YES

I am currently in poor physical and / or mental health. ..... YES

Have you ever been denied a license to practice your profession in another jurisdiction. ..... YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states. _____

Emergency Phone: 8655461642

Emergency Fax: 8655446713

INSTRUCTIONS

Read all instructions before completing this renewal application.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided.
2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.
3. Sign and Date the application and return it in the enclosed self-addressed envelope. DO NOT SEPARATE any part of this form.

   If you do not sign and date the application, it WILL be returned to you. Failure to sign and date this application will cause a delay in issuing your renewal certificate.
4. Make your check or money order payable to the Department Of Health. DO NOT SEND CASH.
5. To insure processing by the expiration date, complete the application and submit with check or money order upon receipt of this application.
6. Pursuant to T.C.A. Section 63-1-108, it is the licensee's responsibility to keep the Board

MEDICAL DOCTORS

RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM

Online Renewal Now Available At www.tennessee.gov/health

DO NOT SEPARATE ANY PART OF THIS FORM

PLEASE ALLOW 10-14 BUSINESS DAYS FOR YOUR LICENSE TO BE RENEWED

Lic./Cert. No: MD0000015635 Lic./Cert. Status: ACTIVE

Expiration Date: 08/31/2009

File ID: 00016835

NPI/UPIN#: [redacted]

Transaction No: 000168987

SUSAN P DODD MD
1932 ALCOA HWY #150
KNOXVILLE TN 37920-1532

Birth Date: 08/09/1955

Name and/or Mailing Address Change

Home Phone: (865) 546-1642

Work Phone: (865) 546-1642

E-mail:

Specialty:

Activity Status: FULL TIME

☐ 1 Full Time ☐ 3 Not Working

☐ 2 Part Time

Work Address:
1932 ALCOA HIGHWAY
SUITE #150
KNOXVILLE TN 37920

Work Address Change

STATE REG FEE $ 10.00

RENEWAL

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competency requirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotated and the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

Susan P Dodd MD 2/7/09

Circle YES if the following applies to you:

I have been convicted of a crime and I have not previously notified the Board in writing of that action. ..... YES

My license has been disciplined in another state and I have not previously notified the Board in writing of that action. ..... YES

My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry). ..... YES

I am currently in poor physical and / or mental health. ..... YES

Have you ever been denied a license to practice your profession in another jurisdiction. ..... YES

I currently do Level II Office Based Surgery Which is integral to a planned treatement regimen and not performed on an urgent or emergent basis. ..... YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states. _____

Emergency Phone: 8655461642

Emergency Fax: 8655446713

INSTRUCTIONS

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at http://health.state.tn.us/Boards/index.htm. Please check this website periodically for updates.

Read all instructions before completing this renewal application. You can also renew your license online at https://www.tennesseeanytime.org/hlrs/begin.jsp up to 120 days prior to your expiration date.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided. Name changes require a copy of the relevant official document (i.e. marriage certificate, divorce decree, etc.) be attached to this application. Some professions also require an additional fee for name changes. Failure to submit the required document and additional fee, if required, will result in the renewal certificate being issued in the previous name. Name changes cannot be submitted online.

2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.

3. Sign and date the application and return it to the Board office at the address on the front of the form. If you do not sign and date the application, it WILL be returned to you. DO NOT SEPARATE any part of this form. Failure to sign and date the application or separating the form will delay your renewal being processed and can result in your license falling into a failed to renew status.

MEDICAL DOCTORS

RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM

Online Renewal Now Available At https://apps.tn.gov/hlrs/

DO NOT SEPARATE ANY PART OF THIS FORM

PLEASE ALLOW 10-14 BUSINESS DAYS FOR YOUR LICENSE TO BE RENEWED

Lic./Cert. No: MD0000015635 Lic./Cert. Status: ACTIVE

Expiration Date: 08/31/2011

File ID: 00016835

NPI/UPIN#:

Transaction No: 000193796

SUSAN P DODD MD
1932 ALCOA HWY #150
KNOXVILLE TN 37920-1532

Birth Date: 08/09/1955 error

~~865 984 8237~~

Home Phone: (865) 546-1642

865 984 8237

Work Phone: (865) 546-1642

Name and/or Mailing Address Change

E-mail:

Specialty:

OB/GYN

Activity Status: FULL TIME

- [x] 1 Full Time
- [ ] 2 Part Time
- [ ] 3 Not Working

Work Address:
1932 ALCOA HIGHWAY
SUITE #150
KNOXVILLE TN 37920

Work Address Change

STATE REG FEE $ 10.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competencyrequirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotatedand the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

RENEWAL

Circle YES if the following applies to you:

I have been convicted of a crime and I have not previously notified the Board in writing of that action. ..... YES

My license has been disciplined in another state and I have not previously notified the Board in writing of that action. ..... YES

My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry). ..... YES

I am currently in poor physical and / or mental health. ..... YES

Have you ever been denied a license to practice your profession in another jurisdiction. ..... YES

I currently do Level II Office Based Surgery Which is integral to a planned treatement regimen and not performed on an urgent or emergent basis. ..... YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states. _____

Emergency Phone: 8655461642

Emergency Fax: 8655446713

INSTRUCTIONS

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at http://health.state.tn.us/Boards/index.htm. Please check this website periodically for updates.

Read all instructions before completing this renewal application. You can also renew your license online at https://www.tennesseeanytime.org/hlrs/begin.isp up to 120 days prior to your expiration date.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided. Name changes require a copy of the relevant official document (i.e. marriage certificate, divorce decree, etc.) be attached to this application. Some professions also require an additional fee for name changes. Failure to submit the required document and additional fee, if required, will result in the renewal certificate being issued in the previous name. Name changes cannot be submitted online.

2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.

3. Sign and date the application and return it to the Board office at the address on the front of the form. If you do not sign and date the application, it WILL be returned to you. DO NOT SEPARATE any part of this form. Failure to sign and date the application or separating the form will delay your renewal being processed and

RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM

Online Renewal Now Available At https://apps.tn.gov/hlrs/

DO NOT SEPARATE ANY PART OF THIS FORM

PLEASE ALLOW 10-14 BUSINESS DAYS FOR YOUR LICENSE TO BE RENEWED

Lic./Cert. No: MD0000015635 Lic./Cert. Status: LICENSED

Expiration Date: 08/31/2013

File ID: 00016835 NPI/UPIN#:

Transaction No: 000219809

SUSAN P DODD MD
1932 ALCOA HWY #150
KNOXVILLE TN 37920-1532

JUL 25 2013

Birth Date: 08/09/1955

JUL 25 2013

Name and/or Mailing Address Change
Susan P. Dodd MD
9314 Parkwest Blvd Ste 100
Knoxville TN 37923

Home Phone: (865) 984-8237

Work Phone: (865) 546-1642

865-690-7677

E-mail:
sdoddmd@charter.net

Activity Status: FULL TIME

Specialty:
Gynecology

☐ 1 Full Time ☐ 3 Not Working
☐ 2 Part Time

Work Address:
1932 ALCOA HIGHWAY
SUITE #150
KNOXVILLE TN 37920

Work Address Change
9314 Parkwest Blvd, Ste 100
Knoxville, TN 37923

STATE REGULATORY FEE $ 10.00

RENEWAL 225.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competencyrequirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotatedand the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

Susan P Dodd, MD 7/15/13
SIGNATURE DATE

I have been convicted of a crime and I have not previously notified the Board in writing of that action. ..... YES

My license has been disciplined in another state and I have not previously notified the Board in writing of that action. ..... YES

My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry). ..... YES

I am currently in poor physical and / or mental health. ..... YES

Have you ever been denied a license to practice your profession in another jurisdiction. ..... YES

I currently do Level II Office Based Surgery Which is integral to a planned treatement regimen and not performed on an urgent or emergent basis. ..... YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states. _____

Emergency Phone: ~~8665481642~~ Emergency Fax: ~~8655446713~~

INSTRUCTIONS

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at http://health.state.tn.us/Boards/index.htm. Please check this website periodically for updates.

Read all instructions before completing this renewal application. You can also renew your license online at https://www.tennesseeanytime.org/hlrs/begin.jsp up to 120 days prior to your expiration date.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided. Name changes require a copy of the relevant official document (i.e. marriage certificate, divorce decree, etc.) be attached to this application. Some professions also require an additional fee for name changes. Failure to submit the required document and additional fee, if required, will result in the renewal certificate being issued in the previous name. Name changes cannot be submitted online.

2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.

3. Sign and date the application and return it to the Board office at the address on the front of the form. If you do not sign and date the application, it WILL be returned to you. DO NOT SEPARATE any part of this form. Failure to sign and date the application or separating the form will delay your renewal being processed and can result in your license falling into a failed to renew status.

Susan Dodd, M.D. PLLC
9314 Parkwest Blvd
Suite 100
Knoxville, TN 37923

July 22, 2013

Explanation to Question answered "Yes":

I currently perform in office surgical procedures.

Susan Dodd, MD

BOARD OF MEDICAL EXAMINERS
MEDICAL DOCTORS

RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM

Online Renewal Now Available At https://apps.tn.gov/hlrs/

DO NOT SEPARATE ANY PART OF THIS FORM

PLEASE ALLOW 10-14 BUSINESS DAYS FOR YOUR LICENSE TO BE RENEWED

Lic./Cert. No: MD0000015635 Lic./Cert. Status: LICENSED

Expiration Date: 08/31/2015

Transaction No: 000247475

File ID: 00016835

NPI/UPIN#: [redacted]

DODD, SUSAN P
9314 PARKWEST BLVD
SUITE 100
KNOXVILLE TN 37923

Birth Date: 08/09/1955

Name and/or Mailing Address Change

Home Phone: (865) 984-8237

Work Phone: (865) 690-7677

E-mail: SDODDMD@CHARTER.NET

Specialty:

Activity Status: FULL TIME

- [x] 1 Full Time
- [ ] 2 Part Time
- [ ] 3 Not Working

Work Address:
9314 PARKWEST BLVD
SUITE 100
KNOXVILLE TN 37923

Work Address Change

STATE REG FEE	$	10.00
RENEWAL FEE		225.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competencyrequirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotatedand the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

Susan Dodd, MD 07/09/2015

TENNESSEE DEPARTMENT OF HEALTH
BOARD OF MEDICAL EXAMINERS
MEDICAL DOCTORS
RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM

Online Renewal Now Available At https://apps.tn.gov/hlrs/

DO NOT SEPARATE ANY PART OF THIS FORM

PLEASE ALLOW 10-14 BUSINESS DAYS FOR YOUR LICENSE TO BE RENEWED

Lic./Cert. No: MD0000015635 Lic./Cert. Status: LICENSED

Expiration Date: 08/31/2017

File ID: 00016835

NPI/UPIN#:

Transaction No: 000276069

DODD, SUSAN P
~~9314 PARKWEST BLVD~~
~~SUITE 100~~
~~KNOXVILLE TN 37923~~

Birth Date: 08/09/1955

Name and/or Mailing Address Change
3904 Legends Way
Maryville, TN 37801

Home Phone: (865) 984-8237

Received By:
JUL 21 2017
BME Unit

E-mail: SDODDMD@CHARTER.NET

Work Phone: ~~(865) 690-7677~~

NONE

Specialty:

JUL 19 2017

GYNECOLOGY

Activity Status: FULL TIME

☐ 1 Full Time
☒ 2 Part Time
☐ 3 Not Working

Work Address:
~~9314 PARKWEST BLVD~~
~~SUITE 100~~
~~KNOXVILLE TN 37923~~

Work Address Change
3904 Legends Way
Maryville, TN 37801

STATE REG FEE	$	10.00
RENEWAL FEE		225.00
TOTAL	$	235.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competencyrequirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotatedand the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

Susan Dodd
SIGNATURE

7/14/17
DATE

DCF 109 17174

CAREFULLY READ ALL QUESTIONS

Circle YES if the following applies to you:

I have been convicted of a crime and I have not previously notified the Board in writing of that action. ..... YES

My license has been disciplined in another state and I have not previously notified the Board in writing of that action. ..... YES

My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry). ..... YES

I am currently in poor physical and / or mental health. ..... YES

Have you ever been denied a license to practice your profession in another jurisdiction. ..... YES

I currently do Level II Office Based Surgery Which is integral to a planned treatement regimen and not performed on an urgent or emergent basis. ..... YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states. _____

Emergency Phone: ~~8655461642~~ 865 207 5452

Emergency Fax: ~~8655446713~~ None

INSTRUCTIONS

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at http://tn.gov/health. Please check this website periodically for updates.

Read all instructions before completing this renewal application. You can also renew your license online at https://apps.tn.gov/hlrs/ up to 70 days prior to your expiration date.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided. Name changes require a copy of the relevant official document (i.e. marriage certificate, divorce decree, etc.) be attached to this application. Some professions also require an additional fee for name changes. Failure to submit the required document and additional fee, if required, will result in the renewal certificate being issued in the previous name. Name changes cannot be submitted online.

2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.

3. Sign and date the application and return it to the Board office at the address on the front of the form. If you do not sign and date the application, it WILL be returned to you. DO NOT SEPARATE any part of this form. Failure to sign and date the application or separating the form will delay your renewal being processed and can result in your license falling into a failed to renew status.

4. Make your check or money order payable to the Department of Health. DO NOT SEND CASH.

TENNESSEE DEPARTMENT OF HEALTH

BOARD OF MEDICAL EXAMINERS
MEDICAL DOCTORS

RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM
Online Renewal Now Available At https://lars.tn.gov/
DO NOT SEPARATE ANY PART OF THIS FORM
PLEASE ALLOW 10-14 BUSINESS DAYS FOR YOUR LICENSE TO BE RENEWED

Lic./Cert. No: MD 0000015635 Lic./Cert. Status: LICENSED

Expiration Date: 08/31/2019
Transaction No: 000311998

RECEIVED BY
JUN 25 2019
BME Unit

File ID: 00016835 NPI/UPIN#: [redacted]

DODD, SUSAN P
3904 LEGENDS WAY
~~SUITE 100~~
MARYVILLE TN 37801

Birth Date: 08/09/1955

Name and/or Mailing Address Change

Home Phone: (865) 984-8237

Work Phone: ( )

E-mail: SDODDMD@CHARTER.NET

Specialty:

OB-GYN

Activity Status: FULL TIME

- [ ] 1 Full Time
- [ ] 3 Not Working
- [x] 2 Part Time

Work Address:
3904 LEENDS WAY
SUITE 100
MARYVILLE TN 37801

Work Address Change

STATE REG FEE	$	10.00
RENEWAL FEE		225.00
TOTAL	$	235.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competencyrequirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotatedand the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

Susan Dodd, MD
SIGNATURE

6/3/19
DATE

DCF109 19144

CAREFULLY READ ALL QUESTIONS

Circle YES if the following applies to you:

1. I have been convicted of a crime and have not previously notified the Board of the conviction. ..... YES
2. My license has been disciplined in another state and I have not previously notified the Board in writing of the action. ..... YES
3. I am currently in poor physical and / or mental health. ..... YES
4. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry). ..... YES
5. I have been denied a license to practice my profession in another jurisdiction and have not previously notified the Board of the denial. YES
6. I currently do Level II Office Based Surgery Which is integral to a planned treatement regimen and not performed on an urgent or emergent basis. ..... YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states **in the past two years**, list those states. _____

Emergency Phone: 8652075452 Emergency Fax: 9999999999

INSTRUCTIONS

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at http://www.tn.gov/health. Please check this website periodically for updates.

Read all instructions before completing this renewal application. You can also renew your license online at https://lars.tn.gov/ up to 70 days prior to your expiration date.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided. Name changes require a copy of the relevant official document (i.e. marriage certificate, divorce decree, etc.) be attached to this application. Some professions also require an additional fee for name changes. Failure to submit the required document and additional fee, if required, will result in the renewal certificate being issued in the previous name. Name changes cannot be submitted online.

2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.

3. Sign and date the application and return it to the Board office at the address on the front of the form. If you do not sign and date the application, it WILL be returned to you. DO NOT SEPARATE any part of this form. Failure to sign and date the application or separating the form will delay your renewal being processed and can result in your license falling into a failed to renew status.

4. Make your check or money order payable to the Department of Health. DO NOT SEND CASH.