APPLICATION FOR ENDORSEMENT OF A MEDICAL LICENSE

BY

The State Medical Board, State of Ohio

FORM I.

I hereby make application for a license to practice Medicine and Surgery in the State of Ohio, and submit the following statement regarding my preliminary education.

1. Name William Mudd Martin Haskell
2. Place of birth Birmingham, Alabama
3. Address 2880 Hastings Road
   Birmingham, Alabama 35223
   Date of birth March 2, 1946
4. Intended residence Cincinnati

5. PRELIMINARY EDUCATION.

Name and Location of Institution Attended and Degree Received.	Period and Date of Study.
Ohio Wesleyan Univ BA	1964-1968 4 yrs

Received Ohio Certificate of Preliminary Education No. 48541; issued by Stradley, 4/16/74 (Date) ✓

6. I have made application to the following State Examining and Licensing Boards, and no others. (Give names of States and dates of application—Reciprocity or Examination.)
   Alabama - Recip - 1973

   and received a certificate from each except as follows: ~~Alabama~~ (Give names of States and dates of application — Reciprocity or Examination.)

7. MEDICAL EDUCATION.
   Give the date and source of each medical credential, diploma, license or degree which you hold.
   M.D. Degree, Univ of Alabama, 1972

   Attended 4 years of full courses of medical lectures as follows, to-wit:

   1st Course at Birmingham from Sept. 3, 1968 to June 7, 1969
   2nd Course at Birmingham from Sept 2, 1969 to June 6, 1970
   3rd Course at Birmingham from June 9, 1970 to continued
   4th Course at Birmingham from continued to June 4, 1972

   Was granted a diploma by Univ of Alabama (Name of Medical College.) located at Birmingham State of Alabama on the 9th day of June, 19 72

8. Time of practice Thomasville, Alabama July-Dec 1973 (Give places and dates)
   Birmingham, Alabama Jan, 1974 - present

   Reverse Side

9. Has any license entitling you to practice in any foreign country or in any state or territory of the United States been suspended or revoked? No (Answer Yes or No)

   If so, specify: (State or Country) (Charge) (Date)

   Have you ever been or are you now addicted to narcotic drugs? No (Yes or No)

   Have you ever been charged with addiction? No (Yes or No)

   Specify charge:

   Have you ever found it necessary to surrender your narcotic license? No (Yes or No)

   Have you ever been charged with a violation of a Federal Law, State Law or a municipal ordinance other than a traffic violation? No (Yes or No)

   If so, give full particulars: (Offense) (Place) (Disposition)

   (Date of Disposition) ✓

10. PHYSICAL DESCRIPTION OF APPLICANT

    Color of Hair Brown Color of eyes Blue Complexion Fair

    Height 6' 1" Weight 180 # Build Medium Marks None ✓

FORM II. *AFFIDAVIT.

STATE OF ALABAMA
COUNTY OF JEFFERSON } ss:

On this 22nd day of April 1974, personally appeared before me, Linda W. Collier, within and for the County and State aforesaid, William Mudd Martin Haskell who being duly sworn says that he is the person referred to in the foregoing application for license to practice medicine in the State of Ohio; that the statements therein are strictly true in every respect, and that he has read and understands this Affidavit.

William Mudd Martin Haskell
(Signature of Applicant.)

Signed and sworn to before me, this 22nd day of April, 1974.

(Seal.) Linda W. Collier
(Official designation of officer administering oath.)

* Must be sworn to before an officer authorized to administer oaths, or a Federal officer.

My Commission Expires February 28, 1976

FORM III.
CERTIFIED COPY OF ~~STATE LICENSE OR~~ CERTIFICATE.

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

William Mudd Martin Haskell, 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: J.D. Myers
Chairman of the Board

SEAL

JOHN P. HUBBARD
President of the Board

Philadelphia, Pa.
July 2, 1973

Cert. # 126488

Certificate

I hereby certify that the above is a verbatim copy of ~~license~~ No. 126488, issued to Dr. William Mudd Martin Haskell by the National Board of Medical Examiners on the 2nd day of July, 19 73

(Seal.) Ph.D. ~~M.D.~~

Associate Director,
Division of Psychometrics

FORM IV.
CERTIFICATE AND RECOMMENDATION OF ~~SECRETARY~~

Acting in behalf of the National Board of Medical Examiners
(Name of ~~State~~ Board.)

I do hereby certify that Dr. William Mudd Martin Haskell was on the 2nd day of July, 19 73, granted a ~~license to practice Medicine and Surgery in the State of~~ Certificate # 126488 on the basis of written examination
(State board examination or medical diploma of graduation.)

in the following subjects Anatomy 82; Physiology 86; Biochemistry 78; Pathology 77; Microbiology 72; Pharmacology 71; Medicine (81)470; Surgery (80)465; Obstetrics (77)395; Public Health & Prev. Med. (86)575; Pediatrics (75)345; Psychiatry (73)315; Practical, Clinical, (Part III) (78,1)390

on which he received an average of 77.7 per cent, ~~and from evidence on file in this office, I do hereby certify~~

With reference to memorandum to all State Medical Examining Boards from Frederick T. Merchant, M.D. dated December 1, 1970, please note: "The National Board of Medical Examiners is to be regarded as an examining agency with no function in determining the moral character of its Diplomates or their fitness to practice other than that related to the completion of educational requirements and successful completion of its examinations in accordance with the rules and regulations established by the National Board of Medical Examiners."
John P. Hubbard, M.D., President, National Board of Medical Examiners

(Seal.) Ph.D. ~~M.D.~~

Associate Director,
Division of Psychometrics

May 29, 1974
(Date)

FORM V.

AFFIDAVIT OF PHYSICIANS.

STATE OF ALABAMA
JEFFERSON COUNTY } ss:

Before me, personally appeared PAUL ANTHONY PALMISANO M. D.
known to me as a reputable practicing physician and surgeon, of good moral character, and on being sworn says that he has known William Mudd Martin Haskell M. D., well for five years and knows him to be of good moral and professional character, that he is a graduate of University of Alabama School of Medicine College in the year 1972, that he has been in the practice of Medicine for the last twelve months at Thomasville & Birmingham, Alabama and recommended him as worthy of professional recognition and that the foregoing physical description is correct.

Address 1601 6th Ave., South Paul A. Palmisano, M. D. ✓
Birmingham, Alabama 35233 Graduate of Univ. Cincinnati, Ohio Certificate No. 21346

Subscribed and sworn to this 19th day of April, 1974.

(Seal.) Linda H. Collier
Notary Public.

STATE OF ALABAMA
JEFFERSON COUNTY } ss:

Before me, personally appeared RUSSELL D. CUNNINGHAM M. D.
known to me as a reputable practicing physician and surgeon, of good moral character, and on being sworn says that he has known William Mudd Martin Haskell M. D., well for 4 years and knows him to be of good moral and professional character, that he is a graduate of University of Alabama School of Medicine College in the year 1972, that he has been in the practice of Medicine for the last twelve months at Thomasville & Birmingham, Alabama, and recommended him as worthy of professional recognition and that the foregoing physical description is correct.

Address P.O. Box 67, NBSB Russell Cunningham, M. D. ✓
Birmingham, Alabama 35294 Graduate of Vanderbilt University, Certificate No. 3367

Subscribed and sworn to this 22nd day of April, 1974.

(Seal.) Linda H. Collier
Notary Public.

FORM VI.

CERTIFICATE OF ETHICAL AND MORAL CHARACTER FROM PRESIDENT OR SECRETARY OF COUNTY, DISTRICT OR STATE MEDICAL SOCIETY:

P. O. Address ..... Date ....., 19.....

I certify that Dr. ..... of .....

is a member in good standing of the ..... and that he is an ethical practitioner of good moral character.

not a member

..... M. D.
President or Secretary

(If you are not and have never been a member of a medical society, give a brief explanation of the reason.) ✓

SECTION 4731.29, REVISED CODE

When a physician or surgeon licensed by the licensing department of another state, a territory, or the District of Columbia, or a diplomate of the national board of medical examiners or the national board of examiners for osteopathic physicians and surgeons wishes to remove to this state to practice his profession, the state medical board may, in its discretion, issue to him a certificate to practice medicine or surgery or osteopathic medicine and surgery without requiring the applicant to submit to examination, provided he meets the requirements for entrance as set forth in section 4731.09 of the Revised Code. . .

FOR USE OF SECRETARY ONLY

State Certificate No. 37358

Issued 7/29/74

APPLICATION FOR
ENDORSEMENT OF A
MEDICAL LICENSE
BY STATE MEDICAL BOARD,
STATE OF OHIO

309-A 7-3-74 150.00 MO

HASKELL, W.M. MARTIN, M. D.

150-

Filed ..., 19 74

A.M.A.-ok

Paid date 7/10/74

Bd approved

'74 JUL -2

OHIO STATE
MEDICAL BOARD

QUALIFICATION

A certificate of registration showing that an examination has been made by the proper board of any state in which an average grade of not less than 75 per cent was awarded, the holder thereof having been at the time of said examination the legal possessor of a diploma from a medical college in good standing in the state where reciprocal registration is sought, may be accepted, in lieu of examination, as evidence of qualification. Provided, that in case the scope of the said examination was less than that prescribed by the state in which registration is sought, the applicant may be required to submit to a supplemental examination by the board thereof in such subjects as have not yet been covered.

Having failed the Ohio Examination (FLEX licensure method), the applicant cannot endorse from another state unless the endorsement is based on an examination equivalent to or superior to our own (i.e., FLEX or National Boards). "Ohio Examination" means FLEX examination in Ohio or in any other state.

INSTRUCTIONS

1. The State Medical Board of Ohio holds regular meetings on the first Tuesday in January, April, July, and October at Columbus.
2. Fill out Form I and make the necessary affidavit to Form II. Then obtain the affidavit required by Form V. This must be signed by two reputable physicians residing in the applicant's home state or Ohio; then obtain certification of Form VI.
3. Forward to the Administrator of the Medical Board of the State in which the applicant is licensed, or the National Board of Medical Examiners, if a Diplomate. They will fill out Forms III and IV, if justified in doing so, and return the blank to the applicant.
4. The application should then be forwarded to the Administrator of the State Medical Board.
5. Address all communications to the Administrator of the State Medical Board, Wyandotte Building, 21 West Broad Street, Columbus, Ohio 43215.

1 Martin Haskell
Signature of Applicant

2 Martin Haskell
Signature of Applicant

I hereby certify that the photograph on the reverse side to which this slip is pasted is a genuine likeness of

William Mudd Martin Haskell

who was recommended by me to the State Medical Board for a license to practice in Ohio.

April 19 1974
Date

Paul A. Palmisano M.D.
Signature of First Endorser.

4/19/74
Date

Russell Cummins
Signature of Second Endorser.

HASKELL, W.M. MARTIN

37358

ISSUED 7-29-74

ENDORSEMENT

17. GAILIUNAS, JR., Peter
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GRADUATED: Loyola University Stritch School of Medicine, 6/10/72
LICENSED: National Board, 7/2/73
A.M.A. Okay
1973-Present, Internship, New England Deaconess Hospital, Boston, Massachusetts

18. GERBER, Arthur N.
BORN: New York, New York, 2/2/37
GRADUATED: Cornell University Medical College, 6/3/69
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PETER LANCIONE, M.D.

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LICENSED: National Board, 7/1/74
A.M.A. Okay
1973-Present, Internship, Kettering Memorial Hospital, Dayton, Ohio

25. HASKELL, William Mudd Martin
BORN: Birmingham, Alabama, 3/2/46
GRADUATED: University of Alabama College of Medicine, 6/4/72
LICENSED: National Board, 7/2/73
A.M.A. Okay
1972-1973, Internship, University of Alabama Hospitals, Birmingham
1973-1974, General Practitioner, Fulton, Alabama
1974-Present, Resident, Cincinnati General Hospital

W. M. MARTIN HASKELL, M. D.
APARTMENT 4-D
1600-9TH AVENUE SOUTH
BIRMINGHAM, ALABAMA 35205

June 28, 1974

Medical Board
State of Ohio
Columbus, Ohio

Gentlemen:

This letter is to supplement my application for a permanent license to practice medicine in the State of Ohio.

I was graduated from the School of Medicine, University of Alabama in Birmingham in June, 1972.

Beginning July, 1972, I served a Rotating 8 (specialty - anesthesia) also at the University of Alabama. This lasted one year until July, 1973.

At that time began work for Dr. Joseph Dozier, Fulton, Alabama, as

a General Practitioner until January, 1974.

In January of 1974, I moved back to Birmingham to work for the Steen Clinic — Industrial Medicine & Surgery. I remained there until moving to Cincinnati this month.

I am starting a residency — General Surgery at Cincinnati General Hospital and plan to do a small amount of work as an emergency room physician — area hospitals also.

While interning, my medical society dues were paid by the hospital. However, due to the transient nature of my private practice, and high cost of dues for that interim, I did not continue my membership — the county medical society. Hence the reason for their lack of endorsement.

If you need further information, please contact me c/o Dept of Surgery, Cincinnati General Hospital.

Sincerely, [illegible]

MD

HASKELL, W. M. MARTIN

STATE OF OHIO
THE STATE MEDICAL BOARD

Official Board

JOHN D. BRUMBAUGH, M.D.
President, Akron

HENRY G. CRAMBLETT, M.D.
Vice-President, Columbus

ANTHONY RUPPERSBERG, JR., M.D.
Secretary, Columbus

HENRY A. CRAWFORD, M.D.
Cleveland

PETER LANCIONE, M.D.
Bellaire

SANFORD PRESS, M.D.
Steubenville

RALPH K. RAMSAYER, M.D.
Canton

WILLIAM J. TIMMINS, JR., D.O.
Warren

✓AMA REQ 3/28/74 EF
✓APP. SENT 3/28/74

WILLIAM J. LEE
Administrator
21 West Broad Street
Columbus, Ohio 43215

3/15/74

Dear Doctor, W. M. MARTIN HASKELL,

Physicians may be licensed in Ohio by endorsement of a full license granted on the basisof a written examination in any other state or U.S. Territory, or by endorsement of the examination of the National Board of Medical Examiners or the National Board of Osteopathic Examiners.

Applicants for the endorsement licensure must be either full citizans of the United States either by birth or by Naturalization, or have a Declaration of Intention, an Alien Registration Receipt Card, or have a current approval of a petition for a Permanent Immigrant Status. If you are not a citizen of the United States, it will be necessary for you to submit evidence of your status as defined earlier in the paragraph.

If you are licensed in another state or by National Boards you must have received a minimum average of 75% or better on the examination for licensure.

In order that we may send you an application for endorsement licensure, please supply us with the following information:

a. *Your place and date of birth:* Birmingham, Alabama March 2, 1946

b. *Your medical school of graduation, its location, and date you received your degree:* University of Alabama, Birmingham, Alabama June 4, 1972

c. *The state in which you are licensed by written examination and the year you were licensed, if applicable:* ~~None~~ Alabama, 1973 based on reciprocity with the National Board of Med. Examiners

d. *The year in which you were certified by the National Board of Medical Examiners or the National Board of Osteopathic Examiners (please note which Board) and the year of certification, if applicable:* 1973

You may answer the questions on this sheet. If you choose to do so, please print the following:

NAME: W. M. MARTIN HASKELL, M.D.

ADDRESS: 1600-9TH AVE. S. APT. 4D
BIRMINGHAM, ALABAMA 35205

Very truly yours,
MRS. MARGI PAGE

STATE OF OHIO STATE MEDICAL BOARD

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE ~~OHIO STATE MEDICAL ASSN~~ AMERICAN ACADEMY OF FAMILY PHYSICIANS AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL

William Haskell MD 10/25/84
(SIGNATURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A
DOCTOR OF MEDICINE

IDENTIFICATION NUMBER
[redacted]-7358

RECEIVED
OCT [illegible]

WILLIAM MUDD MARTIN HASKELL
P.O. BOX 43222
CINCINNATI OH 45243

OP-0345-F

MD & DO SPECIALTY CODES	AMOUNT DUE	DATE DUE
SPECIALTY CODES CURRENTLY ON RECORD → 21-25	$100.00	11/15/84
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS → (SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)	TREASURER, STATE OF OHIO	

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME | FIRST NAME | INITIAL

STREET ADDRESS

CITY | STATE | ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY DUE DATE.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS — IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME | FIRST NAME | INITIAL

STREET ADDRESS

CITY | STATE | ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER _____

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN CONVICTED OF OR PLEAD NOLO CONTENDERE TO:

YES	NO	
☐	☐	a.) a felony,
☐	☐	b.) a misdemeanor committed in the course of your practice, or
☐	☐	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO		YES	NO	
☐	☐	1). Been addicted to or dependent upon alcohol or any chemical substance?	☐	☐	3). Surrendered or consented to limitation of your license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☐	2). Had any disciplinary action taken or initiated against you by a state licensing agency?	☐	☐	4). Had any hospital privileges suspended or revoked?

0345-B

STATE MEDICAL BOARD OF OHIO

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Haskell 10/30/86

(SIGNATURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A
DOCTOR OF MEDICINE

IDENTIFICATION NUMBER
35-03-7358

WILLIAM MUDD MARTIN HASKELL
P.O. BOX 43222
CINCINNATI OH 45243

MD & DO SPECIALTY CODES
ENTER ALL SPECIALTY CODES → 15 21
(SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00

DATE DUE 11/15/86

EDM-14948

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO:

TREASURER, STATE OF OHIO
BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 15

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS – IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

HASKELL WILLIAM MARTIN
LAST NAME FIRST NAME INITIAL

173 E. McMillan
STREET ADDRESS

CINCINNATI, OH 45243
CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER Redacted

EDM-14946-B

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☒	a.) a felony.
☐	☒	b.) a misdemeanor committed in the course of your practice, or
☐	☒	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO		YES	NO	
☐	☒	1.) Been addicted to or dependent upon alcohol or any chemical substance?	☐	☒	3.) Surrendered or consented to limitation upon a license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☒	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?	☐	☒	4.) Had any hospital privileges suspended or revoked?

STATE MEDICAL BOARD OF OHIO

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

(SIGNAURE OF APPLICANT) (DATE)

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED
3. MAKE CHECK OR MONEY ORDER PAYABLE TO TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK
5. UPDATE SPECIALTY IF NEEDED
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438, COLUMBUS, OHIO 43216

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A: DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-03-7358

QT-00223-OF

1 WILLIAM MUDD MARTIN HASKELL
P.O. BOX 43222
CINCINNATI OH 45243

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD 13 21

IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS (SEE LIFE ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00 DATE DUE 11/01/88

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 1.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

HASKELL W. MARTIN
LAST NAME FIRST NAME INITIAL

173 E. McMILLAN
STREET ADDRESS

CINCINNATI, OH 45243
CITY STATE ZIP CODE

HAMILTON

SOCIAL SECURITY NUMBER Redacted

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☒	a.) a felony
☐	☒	b.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATION HAVE YOU:

YES	NO	
☐	☒	1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer no to this question if you have successfully completed treatment at a program approved by this Board and have subsequently adhered to all statutory requirements as contained in Section 4731.224, O.R.C., and related provisions; or are currently enrolled in a Board approved program.
☐	☒	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☒	3.) Surrendered or consented to limitation upon a license to practice medicine or state or federal privileges to prescribe controlled substances?
☐	☒	4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

QT-00224-03

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE ~~OHIO STATE MEDICAL ASSOCIATION~~ AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 10/5/90
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35-03-7358	$160.00	11/01/90

WILLIAM MUDD MARTIN HASKELL, M.D.
P.O. BOX 43222
CINCINNATI OH 45243

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

15 FAMILY PRACTICE
21 GYNECOLOGY
→ AMERICAN ACADEMY OF FAMILY PRACTICE

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS: CODE1 CODE2 CODE3

CHANGE OF ADDRESS

P O BOX 43168
STREET
STREET
CINCINNATI OH 45243
CITY STATE ZIP CODE
HAMILTON
COUNTY

:96969696 2: 0935037358 "00000 16000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

HAVE YOU BEEN FOUND GUILTY OF, OR PLEAD GUILTY OR NO CONTEST TO :

	YES	NO
A.) A felony		☒
B.) A federal or state law regulating the possession, distribution or use of any drug?		☒

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

	YES	NO
1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.		☒
2.) Had any disciplinary action taken or initiated against you by any state licensing board?		☒
3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?		☒
4.) Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?		☒

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X William Haskell 6/3/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-7358	$160.00	07/01/92

WILLIAM MUDD MARTIN HASKELL,M.D.
PO BOX 43100
CINCINNATI OH 45243

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

15 FAMILY PRACTICE
21 GYNECOLOGY

[X] SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:969696962: 0935037358" "00000160000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

MAX BATCH P DATE SEQ# MC#

HAVE YOU BEEN FOUND GUILTY OF, OR PLED GUILTY OR NO CONTEST TO :

A.) A felony or misdemeanor. YES [ ] NO [X]

B.) A federal or state law regulating the possession, distribution or use of any drug? YES [ ] NO [X]

160.00 AMOUNT

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

1.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES [ ] NO [X]

935037358 ACCOUNT #

2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES [ ] NO [X]

3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES [ ] NO [X]

4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings? YES [ ] NO [X]

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-7358	$250.00	05/01/94

WILLIAM MUDD MARTIN HASKELL,M.D.
PO BOX 43100
CINCINNATI OH 45243

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

FP FAMILY PRACTICE
GYN GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY. PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

1:96969696 21: 0935037358 " "00000250000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

123 E Mitchell Ave
Street

Street

Cincinnati OH 45219
City State Zip Code

Hamilton
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO
☐ ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES NO
☐ ☑ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES NO
☐ ☑ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO
☐ ☑ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO
☐ ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO
☐ ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO
☐ ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO
☐ ☑ 8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** *AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.*

X _____ 5/1/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-7358	$250.00	05/01/96

WILLIAM MUDD MARTIN HASKELL,M.D.
PO BOX 43100
CINCINNATI OH 45243

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

FP FAMILY PRACTICE
GYN GYNECOLOGY

PLEASE ☒ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:969696962: 935037358 00000250000

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street 11 Erkenbrecher Road
City Cincinnati State OH Zip Code 45229
County Hamilton

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

	YES	NO
1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.		☒
2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?		☒
3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.		☒
4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?	☒	
5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?		☒
6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?		☒
7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?		☒
8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?		☒

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

PLEASE CHANGE THEIR WORDSMITHING TO CAITLIN AND REFUSED TO REMOVE MANY PHYSICIANS. I HAD NO PAID CLAIMS WITH THEM!

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER **AMOUNT DUE** **DATE DUE**
35-03-7358-H $275.00 05/01/98

WILLIAM MUDD MARTIN HASKELL,M.D.
PO BOX 43100
CINCINNATI OH ~~45429~~
45243

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

FP FAMILY PRACTICE
GYN GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE 45243
COUNTY

:96969696 2: 0935037358 :00000 27500:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES ☐ NO ☒

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES ☐ NO ☒

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES ☐ NO ☒

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES ☐ NO ☒

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES ☐ NO ☒

6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES ☐ NO ☒

7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES ☐ NO ☒

8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement? YES ☐ NO ☒

SOCIAL SECURITY NUMBER
(Optional for purposes of identification.)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 4/10/2000
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-7358-H	$305.00	07/01/2000

WILLIAM MUDD MARTIN HASKELL,M.D.
PO BOX 43100
CINCINNATI OH 45243

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
FP FAMILY PRACTICE
GYN GYNECOLOGY

☒ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL
6650 GIVEN ROAD
STREET
~~CT~~
STREET
CINCINNATI CITY OH STATE 45243 ZIP CODE
HAMILTON COUNTY

:96969696 2: 035037358 :0000030500:

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
3319 TECUMSEH Street
Street
CINCINNATI City OH State 45243 Zip Code
HAMILTON County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES ☐ NO ☒ 1.) *Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor?*

YES ☐ NO ☒ 2.) *Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?*

YES ☐ NO ☒ 3.) *Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.*

YES ☐ NO ☒ 4.) *Had malpractice insurance cancelled or limited for other than failure to pay premiums?*

YES ☒ NO ☐ 5.) *Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?* OHIO

YES ☐ NO ☒ 6.) *Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances?*

YES ☐ NO ☒ 7.) *Had any clinical privileges or other authority to practice suspended,restricted or revoked for reasons other than failure to maintain records or attend staff meetings?*

REQUIRED: Redacted
SOCIAL SECURITY NUMBER

INSURER TO #5 IS NCC [illegible]

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2000 - 2002 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 4/23/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-03-7358-H	$305.00	07/01/02	10/01/02

WILLIAM MUDD MARTIN HASKELL,M.D.
6650 GIVEN RD
CINCINNATI OH 45243

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
FP FAMILY PRACTICE
GYN GYNECOLOGY

☒ **SPECIALTY CODE(S) CORRECT AS LISTED**

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.
6650 GIVEN ROAD
STREET
STREET
CINCINNATI OH 45243
CITY STATE ZIP CODE
HAMILTON
COUNTY

0935037358 30500

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony? YES ☐ NO ☒

2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices. YES ☐ NO ☒

3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio? YES ☐ NO ☒

4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you? YES ☐ NO ☒

5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board. YES ☐ NO ☒

6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?** YES ☐ NO ☒

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
☐ Check this Box if you have NO principal Practice address.
1401 E STRAIGHT ROAD
Street
Street
CINCINNATI OH 45263
City State Zip Code
HAMILTON
County

REQUIRED:
[redacted]
SOCIAL SECURITY NUMBER

Redacted

0935037358 SE 0000030500

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE 2002 - 2004 CME PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION IN COMPLIANCE WITH O.R.C. 4731.281 AND O.A.C. 4731-10, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 6/4/04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 037358	305.00	7/1/2004	10/1/2004

Dr. WILLIAM MUDD MARTI HASKELL
6650 GIVEN RD
CINCINNATI OH 45243

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

FP

GYN

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

6650 GIVEN ROAD
STREET
STREET
CINCINNATI OH 45243
CITY STATE ZIP CODE
HAMILTON
COUNTY

SELECT ONE ADDRESS FOR MAILINGS FROM THE BOARD.
☒ RESIDENCE ☐ PRINICIPAL PRACTICE ADDRESS

0003679210 30500 35ZZ 037358

APPLICATION FOR LICENSURE / RENEW IN OHIO :

1.) Have you been fou guilty of, or pled guilty or contest to, or receiv treatment or intervention lieu of conviction of, a felc or misdemeanor? YES ☐ NO ☒

2.) Have you been addicted or dependent upon alcohol any chemical substance; been treated for, or be diagnosed as suffering fro drug or alcohol depender or abuse? **You may answ "NO" to this question if y** have successfully complet treatment at, or are currentl enrolled in, a program approv by this Board and have adhered to all statutory requireme during and subsequent to treatment. You must answer "YE if you have ever relapsed. Any questions concerning progra approval or concerning this question can be directed to t board offices.' YES ☐ NO ☒

3.) Have any malpractice awards or settlemer been paid by you or on your behalf for ac occurring in any state other than Ohio? YES ☐ NO ☒

4.) Has any board, bureau, department, agency, other body, including those in Ohio, **other th this board**, filed any charges, allegations complaints against you? YES ☐ NO ☒

5.) Have you surrendered, or consented limitation of, or to suspension, reprimand probation concerning, a license to practice a healthcare profession or state or feder privileges to prescribe controlled substances any jurisdiction? You may answer "NO" to th question if the only such surrender or conse was given to this board. YES ☐ NO ☒

6.) Have you had any clinical privileges or oth similar institutional authority suspended, restricte or revoked for reasons **other than failure maintain records on a timely basis or to atte staff meetings?** YES ☐ NO ☒

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principal Practice address.

1401 E Stroop Road
Street
Street
DAYTON OH 45429
City State Zip Code
Montgomery
County

REQUIRED: [redacted]
SOCIAL SECURITY NUMBER

Date Posted: 6/24/2006 5:36:49 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.037358
License Name	WILLIAM HASKELL
Email Address	

Fees

Relicensure Fee	$305.00
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   ..... GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... FAMILY PRACTICE
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   ..... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... NO
2. Have you surrendered, consented to limitation of, or to suspension,

reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . YES

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . Gwen Aviah-Gyebi -- in Indiana re: Indiana License

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 6/29/2008 10:47:15 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS	1401 E STROOP RD Dayton, OH 45429 Montgomery County 937 293 3917
CREDENTIAL MAIL ADDRESS	6700 GIVEN RD CINCINNATI, OH 45243 Hamilton County 516 272 0002 martyh@fortemgt.com
MAIN	6700 GIVEN RD CINCINNATI, OH 45243 Hamilton County 513 272 0002

License Information

License Number	35.037358
License Name	WILLIAM HASKELL
Email Address	martyh@fortemgt.com

Fees

Relicensure Fee	$305.00
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below

. . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 6/17/2010 1:37:34 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS	11250 Lebanon Road Cincinnati, OH 45243 Hamilton County United States of America 513 751 6000
CREDENTIAL MAIL ADDRESS	6700 GIVEN RD CINCINNATI, OH 45243 Hamilton County 513 272 0002 martyh@fortemgt.com

License Information

License Number	35.037358
License Name	William Haskell

Fees

Relicensure Fee	$305.00
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   ..... GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... FAMILY PRACTICE
3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 4/30/2012 4:55:45 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

CREDENTIAL MAIL ADDRESS

6700 GIVEN RD
CINCINNATI, OH 45243
Hamilton County
513 272 0002
martyh@fortemgt.com

License Information

License Number	35.037358
License Name	William Haskell

Fees

Relicensure Fee	$305.00
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . FAMILY MEDICINE

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 10-14

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 5-9

4. "Education" - preceptor, mentor, etc.

. 0

5. "Volunteering" - providing medical and medical-related services at no cost

. 0

6. "Other" - medical professional activities not included in above categories

. 0

Clinical - Practice setting

1. Enter the number of hours per week spent in

"Office/Clinic/Ambulatory care" (out-patient care).

. 10-14

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 45242

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 11250 Lebanon Rd, Cincinnati, OH 45242; 1401 E Stroop Rd, Dayton, OH 45429

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 7/14/2014 6:03:42 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.037358
License Name	William Haskell

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 15-19

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 5-9

4. "Education" - preceptor, mentor, etc.

. 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

. 0

6. "Other" - medical professional activities not included in above categories

. 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 15-19

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 45241

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45429

4. Enter the second county:

. . . . . Montgomery

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 11250 Lebanon Rd, Cincinnati, OH 45241; 1401 E Stroop Rd, Dayton, OH 45429

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1215088018

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . AH6305064

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 5/3/2016 3:51:02 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.037358
License Name	William Haskell

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 10-14

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 5-9

4. "Education" - preceptor, mentor, etc.

. 0

5. "Volunteering" - providing medical and medical-related services at no cost

. 0

6. "Other" - medical professional activities not included in above categories

. 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 10-14

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 45243

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. 45429

4. Enter the second county:

. . . . . Montgomery

5. Enter the third zip code:

. . . . . *{not Answered}*

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. . . . . *{not Answered}*

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. . . . . YES

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1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

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. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1215088018

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . AH6305064

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . YES

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . YES

I understand that submitting a false, fraudulent, or forged statement or

document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Submission Date and Time: 8/28/2018 5:01 PM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Title
Dr.
First Name
William
Middle Name
Mudd Martin
Last Name
Haskell
Maiden Name
No Response
Social Security Number
REDACTED
Date of Birth
3/2/1946
Email Address
martyh@fortemgt.com
Phone Number
5132720002
Other Phone Number
(937) 293-3917

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
No Response
What is your gender?
Male
What is your ethnicity?
White
In which country were you born?
United States
In which state were you born (if United States)?
Alabama
In which city were you born?

BIRMINGHAM

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

6700 Given Rd
Cincinnati
OH
45243-2844
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

PO Box 43100
Cincinnati
OH
45243-0100
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
Has your spouse served in the military?
No
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue.

Question - At any time since signing your last application for renewal of your certificate have you ever been denied a license to prescribe, dispense, administer, supply, or sell a controlled substance by the drug enforcement administration or appropriate issuing body of any state or jurisdiction, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever had a restriction of a license issued by the drug enforcement administration or a state licensing administration in any jurisdiction, under which you could prescribe, dispense, administer, supply or sell a controlled substance, that was restricted, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying, or selling a controlled substance or other dangerous drug?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you ever been subject to disciplinary action by any licensing entity that was based, in whole or in part, on inappropriate prescribing, dispensing, diverting, administering, supplying or selling a controlled substance or other dangerous drug?
Answer -
Question - Have you completed at least two hours of continuing medical education, annually for the past two years, that were certified by the Ohio State Medical Association or the Ohio Osteopathic Association, that assist physicians in diagnosing qualifying medical conditions and treating these conditions with medical marijuana including the characteristics of medical marijuana and possible drug interaction.
Answer -
Question - At any time since signing your last application for renewal of your certificate do you have an ownership or investment interest in or compensation agreement with any medical marijuana entity or applicant?
Answer -
Question - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - At any time since signing your last application for renewal of your certificate has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
Answer - No

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - No

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

Question - Primary NPI Number
Answer - 1215088018

Question - Primary DEA Number
Answer - AH6305064

Question - What is your current employment status?
Answer - Actively working in a position that requires the license I am renewing

Question - Do you currently possess an active license other than that for which you are renewing?

Answer - No

Question - On average, how many hours per week do you work under the license for which you are currently applying or renewing?
Answer - 20

Question - How many locations are you currently working in that require the license you are renewing?
Answer - 1

Question - Please provide the following information for up to 3 locations in which you use the license you are renewing, beginning with the locations you spend the most time: Facility Name, Address, City, State, Zip Code, Health Care Facility Type
Answer - Women's Med Dayton, 1401 E Stroop Rd, Dayton OH 45429 ASF

Question - Do you have hospital privileges?
Answer - No

Question - Which of the following best describes your five-year employment plan?
Answer - Retire

Question - Please select a language, other than English that you personally use to communicate with patients. Do not include a language that you use with the help of an interpreter or language software.
Answer - Not Applicable

Question - What is your U.S. residency status related to your employment?
Answer - U.S. Citizen

Question - Do you consider yourself Hispanic, Latino/a or of Spanish origin?
Answer - No

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - Yes

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

Attestation
I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license. Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 8/28/2018 5:01 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
William Haskell
Submit your Application -After clicking the ‘Submit’ button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.

Submission Date and Time: 9/30/2020 2:55 PM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title
Dr.
First Name
William
Middle Name
Mudd Martin
Last Name
Haskell
Maiden Name
No Response
Social Security Number
REDACTED
Date of Birth
3/2/1946
Email Address
martyh@fortemgt.com
Phone Number
(513) 272-0755
Other Phone Number
(937) 293-3917
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if N/A enter all zeroes
1215088018
Enter home US zip-code. Enter NA if unavailable
45243

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
No
What is your gender?
Male
In which country were you born?
United States
In which state were you born (if United States)?
Alabama
In which city were you born?
BIRMINGHAM

Employment Status

Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Retire
Are you currently employed outside of USA?
No

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

6700 Given Rd
Cincinnati
OH
45243-2844
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

PO Box 43100
Cincinnati
OH
45243-0100
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position that requires this license (e.g. student or recent graduate) employment location information is optional.

Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - Women's Med Group Professional Corporation
Practice Settings - Office/Clinic - Single Specialty Group
Street Address - 1401 E Stroop Rd
City - Cincinnati
State - OH
Zip Code - 45429
Major Area of Focus or Specialty - Obstetrics & Gynecologic Surgery
Total Hours Worked at this practice site, per Week - 2

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 0
Teaching/Academic - 0
Research - 0
Professional Services - 0
Administrative Activities - 100
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - No
Current Employment Arrangement - Self-Employed
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - Yes

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue. For any question that is answered in the affirmative you will later be required to upload a detailed explanation and supporting documents.

Question - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, disciplined, or have had any charges, allegations or complaints filed against you, by any board, bureau, department, agency, or any other body, including those in Ohio?
Answer - No

Question - At any time since submission of your last application for renewal have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer NO to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer YES if you have ever relapsed.
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you had admissions monitored, had clinical privileges or other similar institutional authority limited, restricted, suspended, revoked, terminated, or placed on probation for any reason, or have resigned privileges at any institution?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
Answer - No

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - No

Question - Do you currently supervise one or more Physician Assistants?
Answer - No

Question - Do you prescribe controlled substances?
Answer - Yes

Question - Primary DEA Number
Answer - AH6305064

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, terminated, or disciplined by any employer, hospital, group practice, nursing home, clinic, health maintenance organization, or other similar institution, for any reason?
Answer - No

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?

Answer - Yes

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - Yes

Question - At any time since signing your last application for renewal of your certificate, have you engaged in conduct prohibited by the Medical Board's rules regarding sexual misconduct and impropriety (chapter 4731-26 of the Administrative Code)?
Answer - No

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). Attachments related to affirmative answers must include a detailed explanation and supporting documentation. If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

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