NAME: CAMERA: ROLL: DATE:

DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICAL EXAMINERS OF FLORIDA

RECEIVED
APR 4 12 36 PM '83
DEPARTMENT OF PROFESSIONAL REGULATION

ENDORSEMENT APPLICATION

Fee of ~~$175~~ $250.00 must accompany application. NO FEE REFUNDED.

Answer all questions. If the answer to any question is YES, give details in a notarized affidavit attached to the application.

RECEIVED APR 5 1983

On the basis of certification by the National Board of Medical Examiners ✓ Federation Licensure Examination (FLEX) ____ I hereby, apply for licensure to practice medicine and surgery in Florida, and in support of this submit the following information.

Name in full STRICKER COLES MAYS II (Type or print. Use no initials.)

List all other names you have used. —

Have you ever legally changed you name? — If so, enclose certified copy of legal document giving change.

Residence address (at time of filing application) 5910 HILLTOP RD, PENSACOLA, FLA 32504

Office address —

Permanent address (if different from above) —

Intended residence 5910 HILLTOP RD PENSACOLA FLA 32504 (Print street and number, city, state, zip code)

Place of birth MONTGOMERY, ALA Date of birth JAN 29, 1954

Are you a citizen of the United States? YES (If foreign born attach proof of citizenship or declaration of intention.)

Did you attend a college or university? HUNTINGDON COLLEGE, MONTGOMERY ALA '72-'76 (Give name/location and dates)

Do you have any degree other than M.D.? BA, '76, HUNTINGDON COLLEGE (Degree, date, school)

MEDICAL EDUCATION: Be specific. Account for each year.

UNIV. ALABAMA, BIRMINGHAM (Name of medical school, location) from JULY 1978 to MAY 1982

________ (Name of medical school, location) from ______ 19__ to ______ 19__

________ (Name of medical school, location) from ______ 19__ to ______ 19__

________ (Name of medical school, location) from ______ 19__ to ______ 19__

Degree of Doctor of Medicine was obtained from UNIV ALABAMA – BIRMINGHAM (Name of medical school, location) BIRMINGHAM, ALA on MAY 15 1982

CERTIFICATE OF MEDICAL EDUCATION (Applicant must submit certified copy of medical diploma. Documents written in language other than English must be accompanied by a notarized translation.)

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NAME:
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ACCOUNT FOR ALL TIME FROM DATE OF GRADUATION TO PRESENT

Training. List chronologically residency or other post-graduate training. Give name and address of hospitals, exact dates, and specify type of training. If currently in training give name of department chief.

SACRED HEART – PENSACOLA SEPTEMBER - DECEMBER '82
BAPTIST – " JULY – AUGUST '82
UNIVERSITY – " JANUARY – MARCH '83
DEPT. CHIEF – B.L. STALNAKER MD / D.Z. KITAY MD

List chronologically locations practiced and/or employed. Give addresses, dates, specify type of practice and/or employment.

0

List hospitals where you have staff privileges (Give addresses, dates of service, chief of staff.)

0

Have you ever been denied staff privileges in any hospital? No

MILITARY SERVICE: (Attach copy of separation report.)

0
(Branch of service, rank, dates)

FOREIGN GRADUATES: ECFMG Standard Certificate No. — issued — after passing examination. (Attach notarized copy of certificate.)

In what states are you licensed? List states giving license number and date of issuance.

0

Have you ever studied to become, or do you hold a license in any state as a chiropractor, naturopath or osteopath? No

Have you ever failed a state board, FLEX or National Board examination? No

Have you ever been denied an application for a license to practice medicine by any state board or other governmental agency of any state or country? No

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

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

NAME: ROLL:
CAMERA: DATE:

Are you certified by an American Specialty Board? No If yes, give name of Board. ______ (Enclose copy of Board certificate or letter verifying eligibility.)

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

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

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

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

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

Have you ever been treated but not hospitalized? [redacted]

If any of these questions are answered yes, give details including dates, names of and addresses of hospitals and treating physicians on sworn affidavit.

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

LIST MEDICAL SOCIETY AFFILIATIONS: State, county, national including dates and complete address (street, city, state).

AMA, 535 N DEARBORN ST, CHICAGO ILL. 60610
ACOG, 600 MARYLAND AVE, S.W, WASHINGTON D.C 20024-2588

Has any application for medical society membership been rejected? No

Have you ever been notified to appear before a medical society in regard to charges or complaints filed against you? No

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

0

FLEX Certification: (Applicant must have weighted average of 75% or above on one complete writing of the examination to be eligible for consideration.)
Applicant is responsible for contacting FLEX and having a certified transcript of FLEX grades sent to the Florida Board. The address is: FLEX c/o The Federation of State Medical Boards, 1612 Summit Avenue, Suite 308, Fort Worth, Texas 76102.

CERTIFICATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: Applicant is responsible for contacting the National Boards and having a certified copy of grades and certificate number sent to the Florida Board. The address is: National Board of Medical Examiners, 3930 Chestnut Street, Philadelphia, Pa. 19104.

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PLEASE NOTE: ALL certificates accompanying the application MUST be certified OR notarized as a True and Correct Copy. This application WILL NOT be considered complete unless this requirement is met by the applicant.

****

NAME:
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RECOMMENDATIONS: Give the names and complete addresses of two physicians in each city where you have practiced. If in training or employed give names and addresses of physicians with whom you have worked.

DAVID TURNER MD, 627 CONNELL DR 32503 PENSACOLA FLA

~~GORDON GARDNER MD, 361 SHERIDAN, PACE, FLA 32570~~

DENNIS FAULKNER, 5830 ADELYN RD, PENSACOLA, FLA 32504

AFFIDAVIT OF APPLICANT

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

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida State Board of Medical Examiners any information, files or records requested by the Board in connection with the processing of this application I further authorize the Florida State Board of Medical Examiners to release to the organizations, individuals and groups listed above any information which is material to my application.

I have carefully read the questions in the foregoing application and have answered them completely, witho[ut re]servations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are tr[ue and c]orrect. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause f[or] [illegible] suspension or revocation of my license to practice medicine and surgery in the State of Florida

COUNTY OF Escambia

STATE OF Florida

Stricker C. [illegible]
(Signat[ure of Applic]ant)

Subscribed and sworn to before me this 30th day of March, 1983.

Debbie L. Sellers
(Notary Public)

My Commission Expir[es] Notary Public, State Of Florida At Large
My Commission Expires May 13, 1985
Bonded By South Carolina Insurance Co.
(NOTARY SEAL)

TO BE COMPLETED BY APPLICANT

Date 3/28/83

Age 29

Height 6'2" Weight 170

Color of Eyes BLUE

Color of Hair BROWN

Other means of identification

FOR USE OF SECRETARY ONLY

Oral Examination: Yes ______ No. ______

Date ______

Approved ______ Disapproved ______

License Number 42462

Date Issued 7-6-83

Stricker Coles Mays II
Name as it appears on license.