2018

Print

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians** Appl ID: 26

1. **License Number D0082699** Dr. Charlie Browne

2. Individual National Provider Identifier NPI: ☐ I do not have an NPI or I cannot find my NPI
This is the NPI entered in the field for Rendering NPI on a claim (10 digit number)
Search NPI: https://npiregistry.cms.hhs.gov/

3a. OFFICIAL EMAIL ADDRESS: This email address is confidential and will not be shared or disclosed, except in accordance with compulsory process as defined in Section 4-306 of the Health-General Article. The Board will use this email for official correspondence.

3b. ALTERNATE EMAIL ADDRESS: If you have more than one email address, you may enter it here. If you do not have another email, enter the same email address from 3a.

Address Changes (Home and Public):
You must submit a Home address and a Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2018. If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. Home Address: This non-public address is confidential. The Board will use your home address for official correspondence.

Street
Street (2)
Street (3)
City
State
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode
Country: United States

4b. Public Address: This address will be public information and posted on your Practitioner Profile on the Board's Website.

Street: 9730 3rd Ave NE
Street (2)
Street (3)
City: Seattle
State: Washington
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode: 98115
Country: United States

5. CHARACTER AND FITNESS

The following questions pertain to the period since July 1, 2016. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***

* All questions must be answered Yes or No.

Yes No a. Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, denied your application for licensure, reinstatement, or renewal?

Yes No b. Has a state licensing or disciplinary board (including Maryland), a comparable body in the armed services or the Veterans Administration, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation.

Yes No c. Has any licensing or disciplinary board in any jurisdiction (including Maryland), a comparable body in the armed services or the Veterans Administration, filed any complaints or charges against you or investigated you for any reason?

Yes No d. Have you withdrawn your application for a medical license or other health professional license?

Yes No e. Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?

Yes No f. Has a hospital, related health care facility, HMO, or alternative health care system denied your application for privileges, or failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?

Yes No g. Have you pleaded guilty or nolo contendere to any criminal charge, or have you been convicted of a crime or placed on probation before judgment because of a criminal charge?

Yes No h. Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.

Yes No i. Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?

Yes No j. Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

Yes No k. Have any malpractice claims or other claims for money damages been filed against you? Include past claims as well any claim that is now pending, has been dismissed, has been settled, or which has resulted in a damages award against you or your medical practice.

Yes No l. Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?

Yes No m. Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?

Yes No n. Has your employment or contractual relationship with any hospital, HMO, other health care facility, health care provider, or institution, armed services or the Veterans Administration been terminated for disciplinary reasons?

Yes No o. Have you voluntarily resigned or terminated a contract from any hospital, HMO, other health care facility, health care provider, or institution, armed services or the Veterans Administration while under investigation by that institution for disciplinary reasons?

Yes No p. Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services or the Veterans Administration?

Yes No q. Since your last renewal, have you been discharged from any military service of the U.S. Government? If so, submit a copy of your military discharge documentation to the Board that includes type of service, date of discharge, type of discharge. You may fax to 410-358-1298 or email to mdh.mbprenewal@maryland.gov.

6. CONTINUING MEDICAL EDUCATION

○ **a. CME met *.** I have earned at least 50 credit hours of Category I continuing medical education (CME) during the 2-year period preceding the expiration of the license.

◉ **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. See New Physician Orientation Program web site. **The Board will not renew your license unless you have completed the orientation.**

** The Board may impose a fine of up to $100 per CME credit for failure to obtain the required CME credits.*

PERSONAL AND PROFESSIONAL INFORMATION (Questions 7-10)

7. Do you maintain medical professional liability insurance (malpractice)? (This will display on your Practitioner Profile.)

○ Yes ◉ No

8a. Which Self-Designated Practice area would you consider your PRIMARY category?

Primary Self-Designated Area of Practice: Obstetrics & Gynecology

Self-Designated Practice Area

8b. Which area of medicine best describes your current area(s) of concentration/practice?
Please review and make any necessary updates. This will display on the Self-Designated Practice Area section of your Practitioner Profile. *If none, select NONE/Not Applicable.*

8c. Select your PRIMARY specialty category only if certified by a recognized board of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

Primary Specialty: Obstetrics & Gynecology

Specialty Board Certification

8d. Select specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.
Please review and make any necessary updates. This will display on the Specialty Board Certification section of your Practitioner Profile. *If none, select NONE/Not Applicable.*

Other States Licensed

9. Please select all states (excluding Maryland) where you currently hold an active medical license.
Please review and make any necessary updates. This will display on the Other States Licensed section of your Practitioner Profile.

If none, select NONE Reported.

ID	Other States Licensed
NV	Nevada
WA	Washington
AR	Arkansas

10a. **What best describes your physician employment status for the majority of the time? Please select the best choice from the list below.**

Independent contractor

If *Physician Employee of the Federal Government* was selected from the list above, please select the state where you work:

Select State

Other

10b. **What best describes the work you do as a physician for the majority of the time? Definitions of these categories are listed below.**

a. Patient Care Related Activities includes seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

b. Research includes clinical, laboratory, and analytical research (does not include patient care).

c. Teaching includes the teaching of medical undergraduate & graduate students and other graduate students.

d. Administration Administration includes practice management & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs).

e. Other Retired, semi-retired, military, not practicing, charitable. Anything else not listed above.

Please check only one box.

a. Patient Care Related Activities
b. Research
c. Teaching
d. Administration
e. Other

PRACTICE INFORMATION (Questions 11-16)

---

11. Please indicate below the number of practice/office locations at which you routinely deliver patient care.

a. Number of locations in Maryland (if none, enter 0)

b. Number of locations outside of Maryland (if none, enter 0)

---

12. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0)

b. Number of hospitals outside of Maryland (if none, enter 0)

Maryland Hospital Privilege Information

c. Hospitals are no longer required to report privileges to the Board. Physicians **must** maintain their own hospital privileges within their Profile, if they maintain privileges. Please add/delete your hospital privileges below and make any necessary updates.

This will display on the Maryland Hospital Privileges section of your Practitioner Profile. *If none, select NONE.*

---

13. Primary Practice Address / Administrative Office Location: This address is the physical location of your office and/or practice.

Please answer all Primary Practice questions

a. Organization Name

	All Women's Care
Organization Name2	
b. Street Address	9730 3rd Ave NE
c. Street2	Suite 200
	Enter suite or room number here. (Ex. Suite 101 or Room 101)
d. City	Seattle
e. State	Washington
f. Zip Code	98115
g. County	Non-Maryland

14. Secondary Practice / Office Location

If you have a secondary practice/office location and you have checked the box above, you will see a series of questions that must be completed.

a. Organization Name	PPGWNI
Organization Name2	
b. Street Address	1117 Tieton Dr
c. Street2	
	Enter suite or room number (Ex. Suite 101 or Room 101)
d. City	Yakima
e. State	Washington
f. Zip Code	98902
g. County	Non-Maryland

15. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a.	Do you participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc.	Yes No
b.	Do you participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization)	Yes No
	b1. If **Yes**, are you accepting new Maryland Medical Assistance patients?	Yes No
c.	Do you participate in the MEDICARE program (in either the traditional program or a Medicare Advantage Plan)?	Yes No
	c1. If **Yes**, are you accepting new Medicare patients?	Yes No

16. Workers' Compensation Coverage

Workers' Compensation Coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

Not Applicable (Do not complete below)

I do not practice in Maryland.

I do not employ anyone in my practice in Maryland.

I employ one or more persons in my Maryland practice and have the following Workers' Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date Enter as MM/DD/YYYY

PHYSICIAN'S EMERGENCY CONTACT INFORMATION

17. As part of Maryland's emergency preparedness efforts, the Department of Health has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime *

Nighttime*

18. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

☑ a. I affirm that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge, information, and belief. I understand that providing any false, misleading, or incomplete information may result in disciplinary action by the Maryland Board of Physicians (the Board).

☑ b. I agree that any person, entity, or agency may release information to the Board that is necessary to my renewal application.

☑ c. I agree to inform the Board within 30 days of the change in any answer that was originally given in this application.

☑ d. I affirm that I completed a Criminal History Records Check, in accordance with Health Occ. §14-308.1. I understand that my failure to submit to a criminal history records check is a violation of §14-404(a)(42) and may result in disciplinary action against me.

19. Please provide your electronic signature (type your name) below:

Name: Charlie Browne

Today's Date: 9/17/2018

20. Select the Credit Card Payment Option here to complete your application.

Your renewal fee is:

◉ **Credit Card**

RECEIPT OF PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started	9/17/2018
Date Application Submitted	9/17/2018
Confirmation Number	
Payment Method	Credit Card
Amount Paid	$512.00
Credit Card Approval:	Payment Approved
Credit Card Trans ID	

2020

Maryland Board of Physicians
2020 License Renewal Application

License No: D0082699
Name: Dr.Charlie Browne

Part 1 - NPI, Contact Information and Address Changes (Q1-3)

1. Individual National Provider Identifier (NPI)
2a. Official Email Address:
2b. Personal Email Address (This should not be your work email address):

Addresses
You must submit a Home address and a Public address. If either address has changed, please correct here. Your address(es) on the online renewal application is current as of **July 1, 2020**. If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

3a. Home Address
This should not be your office address. This is where you live. This non-public address is confidential. The Board will use your home address for official correspondence. Do not use your practice address.

3b. Public Address
I do not have a Public Address.

Part 2 - Character and Fitness Questions (Q4)

The following questions pertain to the period **since July 1, 2018.** If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.*** All questions must be answered Yes or No.

1. Has a state licensing or disciplinary board, a comparable body in the armed services or the Veterans Administration, ever denied your application for licensure, reinstatement, or renewal?

2. Has a state licensing or disciplinary board, a comparable body in the armed services or the Veterans Administration, ever taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment or reprimand, suspension, probation or revocation.

3. Has any licensing or disciplinary board in any jurisdiction, a comparable body in the armed services or the Veterans Administration, ever filed any complaints or charges against you or investigated you for any reason?

4. Have you ever withdrawn your application for a medical license or other health professional license?

5. Has a hospital, related health care institution, HMO, or alternative health care system ever investigated you or brought charges against you?

6. Has a hospital, related health care facility, HMO, or alternative health care system ever denied your application for privileges, or failed to renew your privileges, including your privileges as a resident; or limited, restricted, suspended, or revoked your privileges in any way?

7. Have you ever pleaded guilty or nolo contendere to any criminal charge, or have you been convicted of a crime or placed on probation before judgment because of a criminal charge?

8. Have you ever committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgment? Such offenses include, but are not limited to, driving while under the influence of alcohol or controlled dangerous substances.

9. Are there any charges pending against you in any court of law, are you currently under arrest, released pending trial with or without bond, or is there an outstanding warrant for your arrest?

10. Do you currently have any condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or a physical, mental, emotional, or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

11. Have any malpractice claims or other claims for money damages been filed against you? Include past claims as well any claim that is now pending, has been dismissed, has been settled, or which has resulted in a damages award against you or your medical practice.

12. Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?

13. Have you ever failed to make arrangements to satisfy State or Federal loans that financed your medical education?

Veterans Administration ever been terminated for disciplinary reasons?

15. Have you ever voluntarily resigned or terminated a contract from any hospital, HMO, other health care facility, health care provider, or institution, armed services or the Veterans Administration while under investigation by that institution for disciplinary reasons?

16. Have you ever surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction, any entity of the armed services or the Veterans Administration?

17. Since your last renewal, have you been discharged from any military service of the U.S. Government? If so, submit a copy of your military discharge documentation to the Board that includes type of service, date of discharge, type of discharge. You may fax to 410-358-1298 or email to mdh.mbprenewal@maryland.gov.

Part 3 - Continuing Medical Education (Q5)

◉ **a. CME met.**
I have earned at least 50 credit hours of Category I continuing medical education (CME) during the 2-year period preceding the expiration of the license.

○ **b. First Renewal & NPO.**
I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. See New Physician Orientation Program web site. **The Board will not renew your license unless you have completed the orientation.**

⚠ The Board may impose a fine of up to $100 per CME credit for failure to obtain the required CME credits.

Part 4 - Personal and Professional Information (Q6-9)

6. Do you maintain medical professional liability insurance (malpractice)? (This will display on your Practitioner Profile.) Yes

7a. Which Self-Designated Practice area would you consider your PRIMARY category?
Obstetrics & Gynecology

Self-Designated Practice Area
7b. Which area of medicine best describes your current area(s) of concentration/practice? Please review and make any necessary updates. This will display on the Self-Designated Practice Area section of your Practitioner Profile. If none, select NONE/Not Applicable.

Licensee has not reported Self-Designated Practice Areas.

7c. Select your PRIMARY specialty category only if certified by a recognized board of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.
Obstetrics & Gynecology

Specialty Board Certification
7d. Select specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada.

Licensee has not reported Specialty Board Certification.

Other States Licensed
8. Please select all states (excluding Maryland) where you currently hold an active medical license. Please review and make any necessary updates. This will display on the Other States Licensed section of your Practitioner Profile. If none, select None Reported.

Current Medical Licenses

Nevada

Washington

Arkansas

9a. What best describes your physician employment status for the majority of the time?
Independent contractor

9b. What best describes the work you do as a physician for the majority of the time? Definitions of these categories are listed below.

a. **Patient Care Related Activities** includes seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

b. **Research** includes clinical, laboratory, and analytical research (does not include patient care).

c. **Teaching** includes the teaching of medical undergraduate & graduate students and other graduate students.

d. **Administration** includes practice management & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs).

e. **Other** Retired, semi-retired, military, not practicing, charitable. Anything else not listed above.

Please check one selection:

a. Patient Care Related Activities
b. Research
c. Teaching
d. Administration
e. Other

9c. Email Alerts and Recruitment

1. Do you want to receive emails and alerts from the Maryland Department of Health (MDH)? **No**

1a. If yes, enter email address.

2. The Maryland Board of Physicians (the Board) is recruiting providers for its peer/expert review process. Are you interested in conducting future reviews for the Board? **Yes**

*If you Select **YES**, an email notification will be sent to the Board, noting your interest in conducting future peer reviews.*

9d. Are you retired?

Part 5 - Practice Information (Q10-15)

10. Please indicate below the number of practice/office locations at which you routinely deliver patient care.
a. Number of locations in Maryland:
b. Number of locations outside of Maryland:

c. Do you practice in Maryland?

d. Do you practice in Washington, DC?

e. Do you practice in Virginia?

11. Please indicate below the number of hospitals at which you currently have privileges.
a. Number of hospitals in Maryland:
b. Number of hospitals outside of Maryland:

c. Maryland Hospital Privilege Information
Hospitals are no longer required to report privileges to the Board. Physicians must maintain their own hospital privileges within their Profile, if they maintain privileges. Please add/delete your hospital privileges below and make any necessary updates. This will display on the Maryland Hospital Privileges section of your Practitioner Profile. If none, select NONE.

Licensee has not reported Maryland Hospital Privilege information for the profile site.

12. Primary Practice Address / Administrative Office Location
This address is the physical location of your office and/or practice.

All Women's Care
9730 3rd Ave NE
Suite 200
Seattle WA 98115
County: Non-Maryland

13. Secondary Practice Address / Administrative Office Location
If you have a secondary practice/office location as indicated by your response to having at least 2 practice/office locations (Part 5 Question 10), you will see a series of questions that must be completed.

A-Z Women's Center
1670 E. Flamingo Rd
Suite C
Las Vegas NV 89119
County: Non-Maryland

14. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Do you participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc.

b. Do you participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization)

If Yes, are you accepting new Maryland Medical Assistance patients?

c. Do you participate in the MEDICARE program (in either the traditional program or a Medicare Advantage Plan)?

If Yes, are you accepting new Medicare patients?

15. Workers' Compensation Coverage
Workers' Compensation Coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

Workers' Compensation Coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

Not Applicable (Do not complete below)

I do not practice in Maryland.

I do not employ anyone in my practice in Maryland.

I employ one or more persons in my Maryland practice and have the following Workers' Compensation coverage (Please complete the information below.).

a. Insurance Company

b. Policy Number

c. Expiration Date

Part 6 - Physician Emergency Contact Information (Q16)

As part of Maryland's emergency preparedness efforts, the Department of Health has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health.) Please provide the phone number that should be used in the event of an actual emergency.
Daytime:
Nighttime:

Certification and Authorization of License Application

17. Please check the first 3 boxes to certify and affirm your renewal application.

☑ a. I affirm that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge, information, and belief. I understand that providing any false, misleading, or incomplete information may result in disciplinary action by the Maryland Board of Physicians (the Board).

☑ b. I agree that any person, entity, or agency may release information to the Board that is necessary to my renewal application.

☑ c. I agree to inform the Board within 30 days of the change in any answer that was originally given in this application.

18. Please provide your electronic signature (type your name) below:
Name: Charlie Browne
Date: 9/24/2020
Last 4 digits of Social Security No.: XXXX
19. Your renewal fee is: $486.00

ⓘ Payment is made by Credit Card Only. Upon affirmation of your application you will be directed to a secure payment page. Please note MBP does not collect any of your credit card account information.

Certificate of Completion and Payment Receipt

Date: 9/24/2020
Board Confirmation
New License Expiration Date: 9/30/2022
Payment Method: CREDIT CARD

Amount Due: $486.00
Amount Paid: $486.00
Credit Card Approval: Payment Approved