STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 Mainstream Drive, Second Floor
Nashville, TN 37243
http://tn.gov/health

Tennessee Board of Medical Examiners
Medical Doctors
1-800-778-4123 or 615-532-4384

September 23, 2019

Christopher Romano DeNapoles MD
341 S GARCON POINT RD Milton
Milton, FL 32583 US

Dear Applicant:

It is my pleasure to inform you that your application for a license to practice as a Medical Doctor in Tennessee has been initially approved by the Board. Your number shall be 59973. This initial approval must be ratified by the Board of Medical Examiners at its next meeting, scheduled for 11/12/19, before a license can be issued to you. **If ratified by the Board of Medical Examiners this number will become your permanent license number and a wall certificate will follow.**

However, this letter serves as your authorization to commence your practice, pending the final action by the Board of Medical Examiners. If the Board of Medical Examiners should not ratify the initial approval of your application, you will be notified in writing at which time this authorization shall cease to be effective.

Within 10 working days after the Board of Medical Examiners meeting, you will be sent either your certificate (indicating final approval by the Board of Medical Examiners) or a letter providing (1) an explanation as to why the Board of Medical Examiners failed to ratify issuance of your certificate and (2) specific instructions as to any action you may take to have the decision reviewed. No further action on your part is necessary at this time.

Our best wishes go with you into a new phase of your career.

Sincerely,

Board Administrator
Tennessee Board of Medical Examiners
INITAPRPTX

Important Information Regarding Professional Privilege Tax

T.C.A. §67-4-1701, et seq., requires the payment of an annual professional privilege (occupation) tax. For more information regarding the professional privilege (occupation) tax please go to:. http://www.tn.gov/revenue/topic/professional-privilege-tax.shtml.

Notice to All Prescribers: All prescribers with DEA numbers who prescribe controlled substances in Tennessee for more that fifteen (15) days per year, **shall** be registered in the controlled substance database. New licensees shall have up to thirty (30) calendar days after notification of licensure to register in the database. For more information, please go to: http://tn.gov/health/article/CSMD-about.shtml.

File Number 54173

CHECK SHEET

Xact Number ______

9-26-19
90- Day Deadline Date

SS# 3545

Christopher Romano DeNapoles MD
341 S Garcon Point Rd
Milton, FL 32583

DOB: 1/2/86 Grad Yr: 2013

✓ 6-25 Online Application 4 - int. sp. 2 - list ed. ! training. ✓ 3 (work hx): (AL CT OK) ✓ Profile Questionnaire ✓

✓ 6-25 Photograph ✓ 6-25 Fee ($410.00) ✓

✓ 6-25 Declaration of Citizenship (as of 10/1/12) ✓ 6-11 Proof of Citizenship/Legal Entitlement

______ Declaration Supporting Documents

✓ 6-25 Letter of Recommendation (letterhead/date) Foster ✓ 7-12 Letter of Recommendation (letterhead/date) ✓ Borgoan

______ Question(s) 8 /____/____/____/____ Explanation ✓ Final Documents ✓

E-mail Address: ______

✓ 6-11 Medical School Transcript: ✓ U.S. ______ Canada ______ Mexico ______ Foreign

✓ 9-12 E.C.F.M.G. (Foreign Medical School Graduates Only) (Notarized copy of ECFMG certificate only)

✓ 6-11 Postgraduate Training: (___) ✓ /____/____/____/____/____/____

✓ 6-11 Exam Scores: ✓ USMLE 14-17 ___ FLEX ___ NBME ___ LMCC ___ STATE EXAM

✓ 7-15 Other Licenses: FL / AL ✓ / CT ✓ / OK ✓ /____/____/____/____

✓ 7-24 Criminal Background Check (as of 6/1/06) ______ SAVE/USCIS Verification (administrator)

✓ 6-24 TSOR Clearance (administrator) ✓ 6-24 FSMB Clearance (administrator)

	____ Approved to send INS Letter*	____ More Information Needed
CONSULTANT REVIEW	✓ Approved for Licensure	____ Interview ____ Deny
	[signature] Consultant Signature	9/21/19 Date

COMMENTS: ______

*INS ("but for") letters will only be sent for those who are not entitled to live or work in the U.S.

Deficiency Letter(s): 1st 6-24 /2nd 8-9 /3rd ____ /4th ____ /5th ____ /6th ____

Email(s): 1st 7-12 /2nd 7-24 /3rd 9-10 /4th 9-18 /5th ____ /6th ____

Phone Call(s): 1st ____ /2nd ____ /3rd ____ /4th ____ /5th ____ /6th ____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)	**No**
Type of intended primary specialty practice in Tennessee:	~~Hospitalist~~ Family Medicine CD 9/12/19
Have you previously applied for a medical license in Tennessee?	**No**

Educational Information

Name of educational institution attended:	**SEE FCVS**
City:	**SEE FCVS**
State:	**Florida**
Degree/certificate earned:	**SEE FCVS**
Program Major:	**SEE FCVS**
Start date of education program:	**11/11/1111 (mm/dd/yyyy)**
Completion date of education program:	**11/11/1111 (mm/dd/yyyy)**
Graduation date of education program:	**11/11/1111 (mm/dd/yyyy)**

Postgraduate Training History

Educational Institution where you completed your postgraduate training:	**SEE FCVS**
City where the postgraduate training was completed:	**SEE FCVS**
State or Country were the postgraduate training was completed:	**Florida**
Date Started:	**11/11/1111 (mm/dd/yyyy)**
Date Ended:	**11/11/1111 (mm/dd/yyyy)**
Specify the total number of years you have spent in postgraduate medical training:	**1111**

Employment Information

Have you ever been employed in healthcare in any position?	**Yes**

EDUCATIONAL AND EXAMINATION INFORMATION

PRE-MEDICAL EDUCATION

From: 08/04 To: 06/08 — Stanford Arizona State University — Tempe, AZ
MM/YY MM/YY — Educational Institution — Location

From: _____ To: _____ — _____ — _____
MM/YY MM/YY — Educational Institution — Location

From: _____ To: _____ — _____ — _____
MM/YY MM/YY — Educational Institution — Location

MEDICAL EDUCATION

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

From: 09/09 To: 06/13 — Trinity School of Medicine — St. Vincent
MM/YY MM/YY — Educational Institution — Location

From: _____ To: _____ — _____ — _____
MM/YY MM/YY — Educational Institution — Location

POSTGRADUATE TRAINING

I have spent 3 years in medical training in the medical educational institutions below:

From: 06/14 To: 06/17 — Stamford Hospital / Columbia University — Stamford, CT
MM/YY MM/YY — Educational Institution — Location

From: _____ To: _____ — _____ — _____
MM/YY MM/YY — Educational Institution — Location

From: _____ To: _____ — _____ — _____
MM/YY MM/YY — Educational Institution — Location

I have taken the following medical licensure examinations: (Check all applicable)

1. ___ National Boards (NBME) Certificate Number
2. ___ FLEX examination administered by the State of _____ on _____ (Date(s))
3. ___ Licensure by the Medical Council of Canada (LMCC)
4. ✓ USMLE
5. ___ State Board administered by _____ (State) prior to 1972.

Are you ABMS Board certified? Y Ø N O

If yes, identify board of specialty/subspecialty: ABFM

I intend to perform Level II Office Based Surgery which is integral to a planned treatment regimen and not performed on an urgent or emergent basis. Y O N Ø

If you intend to perform Level III Office Based Surgery, you must apply for and obtain a permit prior to engaging in such practice. You may access the application by visiting: https://tn.gov/assets/entities/health/attachments/PH-3963.pdf

PRACTICE AND LICENSURE INFORMATION

	YES	NO
Are you or have you ever been licensed to practice medicine in another state?		
Are you or have you ever been licensed in any other profession in Tennessee or another state?		

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
OK	MD	34685	12-April-19	Current
FL	MD	132255	11-1-15	Current
AL	MD	38134	4-4-19	Current
CT	~~55624~~ MD	55624	8-15-16	Non-Renewal

Do you have a DEA Registration? Y ☒ N ○

If yes, please provide: FD6985646

Intended practice location in Tennessee:

Name: _____

Address: _____

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES	LOCATION	POSITION AND DUTIES
From: Pending MM/YY To: ____ MM/YY	____ (City) TN (State)	Locums Hospitalist / Arnold Air Force Base
From: 09/17 MM/YY To: curent MM/YY	Pensacola (City) FL (State)	Physician - West Florida Hospital
From: 10/18 MM/YY To: Curent MM/YY	Pensacola (City) FL (State)	Physician / Medical Director Nursing Home
From: ____ MM/YY To: ____ MM/YY	____ (City) ____ (State)	

PRACTICE AND LICENSURE INFORMATION

	YES	NO
Are you or have you ever been licensed to practice medicine in another state?	✓	
Are you or have you ever been licensed in any other profession in Tennessee or another state?		✓

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
FL	Physician	13 2255	11/01/2018	Active
AL	Physician	38134	04/04/2019	Active
OK	Physician	34683	04/12/2019	Active
CT	Physician	55624	01/26/2017	Inactive

Do you have a DEA Registration? Y ◉ N ○

If yes, please provide FO6985646

Intended practice location in Tennessee

Name: Locums Hospitalist, Parkridge East Hospital

Address 941 Spring Creek RD, Chattanooga TN 37412

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES	LOCATION	POSITION AND DUTIES
From: 09/2017 (MM/YY) To: Current (MM/YY)	Pensacola (City) FL (State)	Physician Hospitalist
From: 06/2019 (MM/YY) To: Current (MM/YY)	Mobile (City) AL (State)	Physician Hospitalist
From: 06/14 (MM/YY) To: 06/17 (MM/YY)	Stamford (City) CT (State)	Physician Resident in training
From: 06/14 (MM/YY) To: Current (MM/YY)	Various military Bases (City) (State)	Flight Surgeon USAF occupational health

To whom it May Concern,

On 2/25/2006 I was arrested and charged for damage of a native Arizona plant. At that time I was attending Arizona State University and I was living in a house bordering the university campus. That day my two roommates and myself attempted to remove a saguaro cactus from the front yard of the house we were living in. The cactus was very large and often times dangerous and obstructive especially when having guests over.

While attempting to take down the cactus, patrolling campus police stopped us and arrested us on the spot. With myself being from Connecticut and the two others being from Michigan and Illinois, we were shocked to find out that this particular cactus we were taking down happened to be a saguaro cactus and the state plant of Arizona.

Since this offence is taken extremely serious by the state it was escalated from university police to the Maricopa County Court. The disposition of the case was a Class 1 Misdemeanor.

I was placed on unsupervised probation for 9 months, had to pay restitution for the damages and complete 24 hours of community service. The probationary period was terminated after 5 months due to completion of probationary requirements.

The cactus survived.

If you have an questions or need further clarification, please feel free to contact me by phone or e-mail.

Thank you,

Christopher DeNapoles M.D.

7/1/19

D

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
UNSUPERVISED PROBATION CONDITIONS

State of Arizona, Maricopa County

Christopher Derapoks

SID#: AZ

CR 2006-119513-001SE
Other CR

A.R.S. §13-901.01 ☐ 1st ☐ 2nd ☐ Ineligible

OFFENSE(S) Criminal Damage, 1 Misdemeanor

It is ordered suspending imposition of sentence and placing defendant on **Unsupervised Probation** to be monitored by the Adult Probation Department (APD) for a period of 9 ☐ year(s) ☑ month(s) from this date 8/15/06 under the following conditions:

FILED
AUG 17 2006 9:04 am
MICHAEL K. JEANES, Clerk
By J. Jasmina
Deputy

THE DEFENDANT SHALL: (Conditions Checked Also Apply)

1. Obey all laws.

4. Notify APD within 10 days of any address change.

☐ 6. Not possess or control any firearms, ammunition, or prohibited weapons as defined by A.R.S. §13-3101.

☐ 10. Complete a minimum of _____ hours of drug education and provide verification to APD within _____ days of sentencing.

☐ 14. Provide a sample for DNA testing if required by law.

16. Abide by the Judgment and Orders of Restitution, Fines, and Fees in this cause.

☑ 19. Complete a total of 24 hours of community service work beginning 8/15/06 at a minimum of 10 hours each month. Provide proof of completion to APD within 180 days of sentencing.

☐ 21. Be incarcerated in the County Jail for _____ ☐ day(s) ☐ month(s), beginning ____/____/____ with credit for _____ days served. Upon screening and acceptance, abide by all conditional release program rules. Contact APD within 72 hours of release from incarceration.

☐ 24. Complete the additional following programs of assistance:

- ☐ Substance Abuse and/or Alcohol Counseling
- ☐ Anger Management/Domestic Violence Program
- ☐ MADD Victim Impact Panel Program

☐ 26. Other:

Immediately after Court, report to one of the following locations:

☐ **Adult Probation Department**
111 S. 3rd Ave., 5th Floor
Phoenix, AZ 85003

☐ **Adult Probation Department**
222 E. Javelina, Suite #1500
Mesa, AZ 85201

Unsupervised Probation Hotline # 602/506-5169

RECEIPT AND ACKNOWLEDGEMENT: I hereby acknowledge receipt of the conditions of probation and any attached addenda to these conditions. I understand that a violation of any of the conditions could result in the revocation of my probation and the Court may impose sentence upon me in accordance with the law. As a further condition, I waive extradition for any probation revocation proceedings in this matter.

Defendant — Date: 8-15-06

126 Big Oak RD
Address

Stamford CT 06903 (203)667-4773
City/State Zip Telephone

Judge of the Superior Court — Date: 8/15/06

1100-058 (R 03-04)

White (Original): Court File Yellow: APD File Pink: Defendant

IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
JUDGMENT AND ORDERS OF RESTITUTION, FINES AND FEES

State of Arizona

VS. Christopher Denapoles

PID#:

COUNTY/DIVISION: _____

CASE / CR / COUNT: CR2006-119513-001SE

☐ Reinstatement Commencing: [ ] Today's date This Date: _____

Pursuant to Uniform Condition 16 the defendant shall abide by the following judgment and order of restitution, fines and fees:

Financial Sanctions	Total Amount	Payment	Begin Date
☐ a. Total Restitution Ordered*			
☐ b. Probation Service Fee (PSF)			
☐ c. Base Fine: _____ Drug: _____ Non-drug:		25.00	
☐ d. Surcharges _____ + _____			
Total Fine & Surcharges (add c and d) =			
☐ e. Warrant Charge $45 (Maricopa County A.O. 2004-199)			
☐ f. Reimbursement			
☐ g. A.R.S. 28-1382 DUI Abatement Fund $250			
☐ h. Delinquent Probation Service Fees			
☐ i. A.R.S. 12-114.01 (Probation Surcharge-$5 per fine/assessment)	5.00		
☐ j. A.R.S. 28-1444 (DUI Incarceration Cost)			
☐ k. A.R.S. 41-1651 (Prison Construction & Operations Fund)			
☐ l. A.R.S. 28-1383 (State General Fund)			
☐ m. Other: _____			
TOTAL PAYMENT MONTHLY =			
☐ n. Interstate Compact Application Fee **			10/1/06
Mandatory Assessments (paid in conjunction with monthly payment)		25.00	
☐ o. A.R.S. 12-116 (Time Payment Fee) ☐ $20 or ☐ $12			
☐ p. Other: _____			
Total Mandatory Assessments (add o and p)			

☐ q. It is ordered credit be given for any monies paid to date, during incarceration and, if necessary, balances be adjusted accordingly. All modified orders are to be considered new orders for billing purposes.

☐ r. Condition(s) # _____ of previous order dated _____ is/are deleted.

☐ s. Condition(s) # _____ is/are suspended until further ordered.

☐ t. Defendants probation is automatically extended for _____ years _____ months from _____, pursuant to A.R.S. 13-902 C.

☐ u. Restitution has been paid in full through JSI. payments. It is ordered that any delinquent or unpaid balance be exonerated.

The Court further orders:

All previous orders and conditions of the Court remain in effect, unless otherwise stipulated above.

* Probation will automatically be extended pursuant to A.R.S. 13-902 C.

** Interstate Compact Process and Application Fee: Only one fee per defendant with entire fee due at time of application.

RECEIPT AND ACKNOWLEDGMENT: I hereby acknowledge receipt of the Judgment and Orders of Restitution, Fines and Fees and understand my financial obligation to the Court and other related parties, and agree to comply with all directives contained therein. See the reverse side of this form for payment instructions.

Defendant — 8-15-06 Date

Judge of the Superior Court — 8/15/06 Date

Form 1100-044 (R9/2005)

White (original): Court File Yellow: APD File Pink: Defendant

VD

IN THE SUPERIOR COURT
OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF MARICOPA

8.16.06 FILED 5:00 pm
MICHAEL K. JEANES, Clerk
By B Miller
Deputy

STATE OF ARIZONA
vs.

Christopher Denapoles,
Defendant

SUPERIOR COURT CASE # CR 2006-119513-001 SE

WAIVER OF PRELIMINARY HEARING
WITH PLEA AGREEMENT

DECLARATION by defendant as follows:

Defendant is represented by his/her attorney Bruce Feller (print name)

(CD) I hereby voluntarily waive my right to a preliminary hearing understanding that I will be held to answer and an information will be filed charging me with having committed: **Count 1: Criminal Damage, a Class 6 Felony committed on 2-25-2006**
This is a NON dangerous, NON repetitive offense under the criminal code.

(CD) I understand and acknowledge that:

A. I have a right to a preliminary hearing
B. I am represented by an attorney now. Further, I know that I have a right to an attorney for all further proceedings in this case. If I cannot afford one, then one will be appointed to represent me at this preliminary hearing as well as in the Superior Court for all purposes including trial, free of charge.
C. I am giving up the right to confront and cross-examine witnesses.
D. I am giving up the right to present evidence in my behalf and that I am giving up the right to have the magistrate determine if there is sufficient evidence against me to establish probable cause to hold me to answer in the Superior Court on the above stated charges, as well as the right to a dismissal of charges against me if the evidence is insufficient.

(CD) 1. The State of Arizona and the defendant hereby agree to the following disposition of this case: VD

Plea: The defendant agrees to waive the preliminary hearing and plead guilty to: **Count (1), Criminal Damage, a Class 1 Misdemeanor, in violation of ARS §§ 13-1601, 13-1602, 13-707, and 13-802 committed on 2-25-2006.** #5 amended

This is a NON-dangerous, NON-repetitive offense under the criminal code.

TERMS: On the following understandings, terms and conditions:

1. The crime carries a maximum sentence of **SIX MONTHS JAIL**. Probation is available. Restitution of economic loss to the victim and waiver of extradition for probation revocation procedures will be required. The maximum fine that can be imposed is **$2,500 plus 80% surcharge and $5 probation fee**. Special conditions regarding sentence, parole, or commutation imposed by statute (if any) are:

(CP) 2. The parties stipulate to the following additional terms: **The Defendant shall be placed on probation. The Defendant shall complete 24 hours of community service. The Defendant shall pay restitution for all damages arising under Arizona State University PD DR #060544 in an amount not to exceed $1000.**

(CD) 3. The following charges are dismissed, or if not yet filed, shall not be brought against the defendant: **N/A**

[redacted]

SUPERIOR COURT OF THE STATE OF ARIZONA
MARICOPA COUNTY

MICHAEL K. JEANES, CLERK
BY K Dickson DEP
FILED
2007 JAN 25 AM 8:5

Division RCCSE
Pros Atty: DCA
APO Margaret A. Johnston, DTJC

THE STATE OF ARIZONA
vs.
CHRISTOPHER DENAPOLES
DOB: 01/02/1986

Case Number: **CR2006-119513-001-SE**

PETITION FOR EARLY TERMINATION OF PROBATION OR UNSUPERVISED PROBATION

The defendant was formally judged guilty of the crime of **COUNT I: CRIMINAL DAMAGE, A CLASS 1 MISDEMEANOR.**

Probation Start Date: 08/15/2006 Prob. Length: 9 month(s) Unsupervised

It is respectfully recommended that the defendant's probation be terminated for the following reasons:

The defendant completed five months of a nine-month probation grant. he completed twenty-four hours of community restitution and has paid all Court fees in full. Based on his compliance on probation, and early termination is requested.

Victim Status: victim has not opted-in for post-conviction notice of probation matters.

Dated this 18th day of January, 2006 Margaret A Johnston for APO Sherry Johnston
MAJ:amp:/01/17/2007
Probation Officer Margaret A. Johnston Phone 602 506-1225

☑ **IT IS ORDERED that the foregoing petition for early termination will be granted by this court 30 days from this date unless written objection thereto is filed not less than 72 hours before said date. A copy of this petition is herewith transmitted to the prosecuting attorney.**

☐ **IT IS ORDERED denying the petition for early termination. It is further ordered that the defendant be placed on unsupervised probation. If the defendant obeys all laws it is ordered that unsupervised probation be automatically terminated on _____.**

☐ **IT IS ORDERED** _____

Dated this 24th day of January, 2007

Judge of the Superior Court

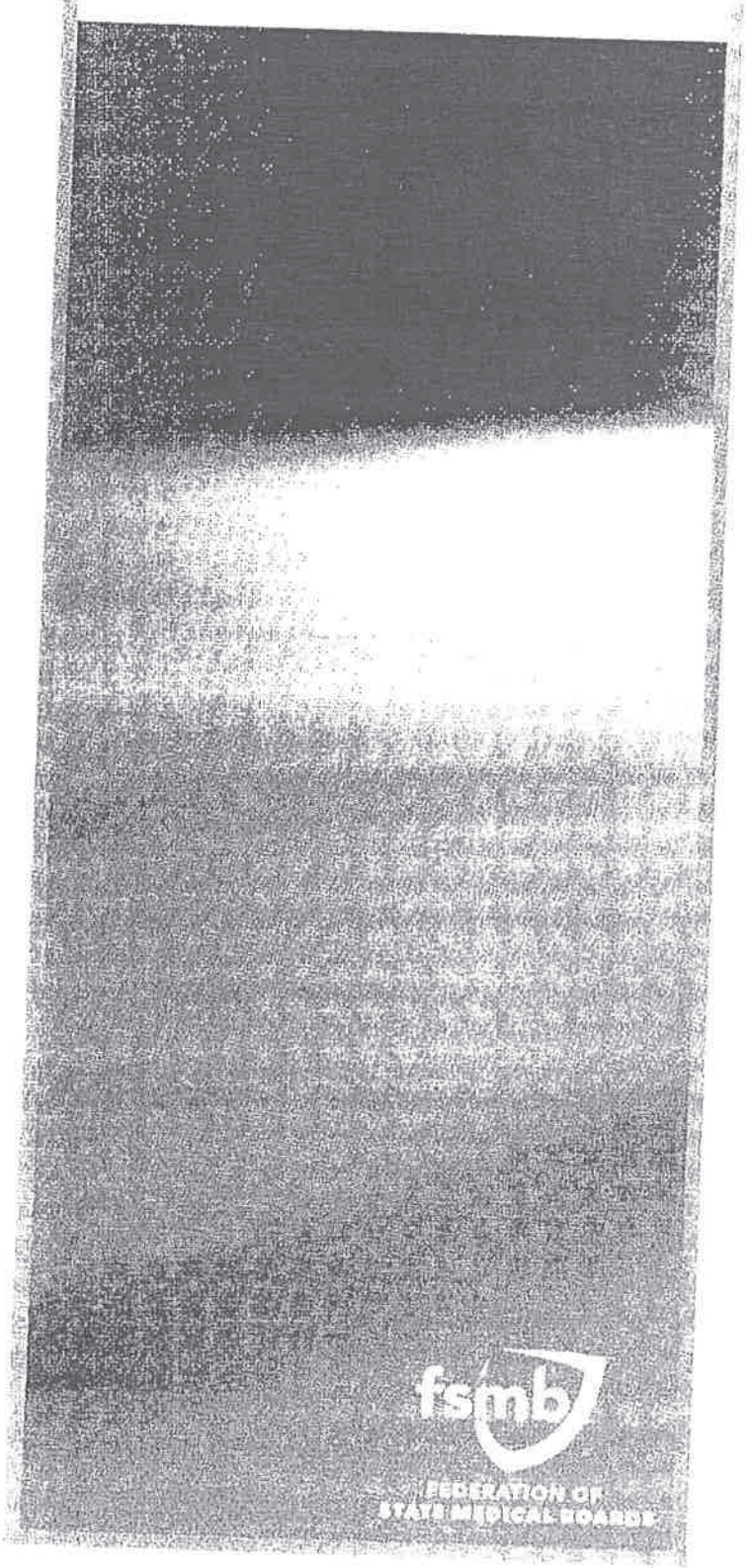
PETITION FOR EARLY TERMINATION OF PROBATION OR UNSUPERVISED PROBATION

CC: APD File Court (Original) Pros Atty.

APD Macros

Rev. 12/13/2006

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE



Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Denapoles, Christopher Romano**
Social Security Number:	
Date of Birth:	**January 02, 1986**
FID#:	**217679034**
Recipient:	**TN - Tennessee Board of Medical Examiners**
Delivery Date:	**06/11/2019**

ABOUT THIS PROFILE

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

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

This FCVS Medical Professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

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

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

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

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

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

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

DeNapoles
Applicant's Printed Last Name

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

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

TONI JOSETTE WRIGHT
ELECTRONIC NOTARY PUBLIC
REG # 7635128
EXPIRES 6/30/2020
COMMONWEALTH OF VIRGINIA

State of Virginia, County of James City

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

Notary Public Signature: Toni Josette Wright

My Notary Commission Expires: 06/30/2020

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

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

© 2014 Federation of State Medical Boards

Docid: 58ca35ef742cf48c8714a419

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

fsmb

Biographic Information

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

Date of Birth: January 02, 1986

Place of Birth: Stamford, CT, UNITED STATES

Contact Information

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

Mobile Phone: (203) 667-4773

Email: crdenapoles@gmail.com

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

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

FCVS ID Number: 217679034

Notary – Please complete the section below:

State of Virginia County of James City

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

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

Notary Public Signature: Toni Josette Wright

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

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

Notary Stamp Here

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

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

DocId: 58cc35cf742cf48e6714a419


SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE
PASSPORT
PASSEPORT
PASAPORTE
UNITED STATES OF AMERICA
P
506171009
DENAPOLES
CHRISTOPHER ROMANO
UNITED STATES OF AMERICA
02 Jan 1986
CONNECTICUT U.S.A.
M
United States
Department of State
P<USADENAPOLES<<CHRISTOPHER<ROMANO<<<<<<<<<<
5061710099USA8601023M2503251268800331<949960

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

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

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

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **Trinity School of Medicine**

Location: Kingstown, 04

SAINT VINCENT AND THE GRENADINES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

ECFMG® EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

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

VERIFICATION OF MEDICAL EDUCATION

INSTRUCTIONS TO THE DEAN

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

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

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

SECTION 1: MEDICAL SCHOOL TRANSCRIPT

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

SECTION 2A: CERTIFICATION

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

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

Signature:

Printed Name: Leslie Keith Hollers

Title: VP of Operations and Student Finance

Date of Signature: 23 May 2013

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

Email: khollers@trinityschoolofmedicine.org

SECTION 2B: DEGREE CERTIFICATION

This individual:

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

– Or –

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

SEAL
VERIFIED

SECTION 3A: PRE-MEDICAL EDUCATION

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

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

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

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

_____

SECTION 3B: MEDICAL EDUCATION

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

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

SECTION 4: UNUSUAL CIRCUMSTANCES

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

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

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

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

Please Specify: _____

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

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

_____

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

Please specify reason: _____

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

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

_____
_____

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

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

_____
_____

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

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

_____
_____

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Denapoles, Christopher R

Trinity School of Medicine

Unusual Circumstances

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

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

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

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TRINITY
SCHOOL OF MEDICINE

TRANSCRIPT

Student Name: Denapoles, Christopher, R.
Student ID: 099-573-006
Degree Program: Doctor of Medicine
Date: Wednesday, May 22, 2013

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

Course Number	Course Name	Grade	Credit Hours	Hours Earned	Quality Points
Fall Semester 2009					
CLM 110	Intro to Clinical Med. I	B	3	3	9
ANAT 113	Gross Anatomy I	B	3	3	9
BIOC 111	Biochem and Genetics I	C+	4	4	10
PHYS 112	Physiology I	B	3	3	9
Term Totals				13	37
Term Grade Point Average					2.85
Cumulative Totals				13	37
Cumulative Grade Point Average					2.85
Spring Semester 2010					
CLM 120	Intro to Clinical Med. II	B	2	2	6
ANAT 123	Gross Anatomy II with Embryology	B	3	3	9
ANAT 124	Histology	B+	2	2	7
BIOC 122	Biochem and Genetics II	B	3	3	9
PHYS 122	Physiology II	B+	3	3	10.5
NEUR 125	Neuroscience	C	3	3	6
PHM 132	Introduction to Pharmacology	C	1	1	2
IBS 110	Integrated Basic Science I	P	1	1	4
Term Totals				18	53.5
Term Grade Point Average					2.97
Cumulative Totals				31	90.5
Cumulative Grade Point Average					2.92
Summer Semester 2010					
CLM 211	Intro to Clinical Med. III	P	1	1	4
PATH 230	Pathology I	B+	6	6	21
EPID 301	Epidemiology/Biostatistics	A	1	1	4
BEH 230	Behavioral Sci/Pastr. & Phys.	A(h)	2	2	8
MICR 231	Microbiology and Immunology I	B	3	3	9
PHM 234	Pharmacology I	B	3	3	9
IBS 210	Integrated Basic Science II	P	1	1	4
Term Totals				17	59
Term Grade Point Average					3.47
Cumulative Totals				48	149.5
Cumulative Grade Point Average					3.11
Fall Semester 2010					
CLM 350	Intro to Clinical Med. IV	P	1	1	4
PATH 240	Pathology II	B	8	8	24
MICR 241	Microbiology II	B	3	3	9
PHM 244	Pharmacology II	B	3	3	9
IBS 310	Integrated Basic Science III	P	1	1	4
Term Totals				16	50
Term Grade Point Average					3.13
Cumulative Totals				64	199.5
Cumulative Grade Point Average					3.12
Spring Semester 2011					
CLM 250	Advanced Intro to Clinical Med. V	P	1	1	4
MED 510	Basic of Diseases	A	12	12	48
MED 520	Clinical Therapeutics	B	3	3	9
IBS 410	Integrated Basic Science IV	P	2	2	8
Term Totals				18	69
Term Grade Point Average					3.83
Cumulative Totals				82	268.5
Cumulative Grade Point Average					3.27

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

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

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

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

SEAL VERIFIED

5/22/2013 6:48 PM

Affixed by medical school on: 23 May 2013

OFFICIAL DOCUMENT

Trinity School of Medicine

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

CAMPUS AND OFFICE OF THE DEANERY
Ratho Mill
POB 885, Kingstown
St. Vincent, West Indies
Phone: 784-456-9751 Fax: (784)456-9715

ACCREDITATION

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

TERM

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

RELEASE OF INFORMATION

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

INTERPRETATION

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

PREMEDICAL GRADING SCALES

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

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

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

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

MEDICAL PROGRAM GRADING SCALE

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

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

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

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

TRANSCRIPT

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

COURSEWORK ON TRANSCRIPT

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

TRANSFER CREDIT

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

TRANSCRIPTS ISSUED TO STUDENTS

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

Trinity School of Medicine

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

Christopher Romano DeNapoles

the degree of

Doctor of Medicine

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

TRINITY SCHOOL OF MEDICINE

Affixed by medical school on:
23 May 2013

April 30, 2013

W. Douglas Skelton, M.D.
Dean

Steve R. Wilson
Chancellor

SEAL
VERIFIED

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EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

3624 Market Street
Philadelphia, PA 19104-2685 USA
215-386-5900 | 215-386-9767 FAX
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Issue Date: 11 Jun 2019

To: TENNESSEE STATE BOARD OF MEDICAL EXAMINERS
ADMINISTRATOR
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

State Board Code:
043
Please include this number on all requests.

ECFMG® CERTIFICATION STATUS REPORT

USMLE®/ECFMG Identification Number: 0-824-016-0
Applicant's Name: Christopher R. Denapoles
Applicant's Date of Birth: 02 Jan 1986
ECFMG Certified: Yes
Certificate Issue Date: 11 Jun 2013
English Test Valid Through: Valid Indefinitely
Clinical Skills Assessment Valid Through: Valid Indefinitely

Passing Performance on Medical Science Examinations:

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

Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
USMLE Step 2 CS	14 Aug 2012

Name of Medical School and Country: Trinity School of Medicine, Kingstown, SAINT VINCENT AND THE GRENADINES

Degree Year: 2013

Medical Education Credentials Status†: Complete

How to Verify the Authenticity of this Report:

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

Report Verification Code: BFC6PKQXUS

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

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

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

Important Note:

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: 1200811078

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

Location: Stamford, CT
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified.

DocuSign Envelope ID: 507601F9-0D46-42A6-9B19-C59291C18D03

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Verification of Postgraduate Medical Education

Accreditation Code: 1200811078

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

Affiliated University:

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

Verification For: Christopher Romano Denapoles **Date of Birth:** 01/02/1986

Program Participation:

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

FID: 217679034

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

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

Unusual Circumstances

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

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

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

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

FID: 217679034

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

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

Unusual Circumstances

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

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

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

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Stamford Hospital

Columbia University College of Physicians & Surgeons

This certifies that

Christopher Romano DeNapoles, M.D.

has faithfully served on the Resident Staff of this Hospital

as

Chief Resident in Family Medicine

July 1, 2016 - June 30, 2017

Program Director

Joseph Connelly, M.D.

Department Chair

President and CEO

Chair, Medical Staff

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Licensure / Examinations

fsmb

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Date: 06/11/2019

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 466427

Examinee: Denapoles, Christopher Romano
Alt Name(s):

Examinee ID: 0-824-016-0
Date of Birth: 01/02/1986

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
09/21/2011	Pass	213	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
10/02/2012	Pass	216	(196)	
07/30/2012	Fail	191	(196)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
08/14/2012	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/01/2013	Pass	230	(190)	

End of Exam History

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Examinee: Denapoles, Christopher Romano

Examinee ID: 0-824-016-0
Date of Birth: 01/02/1986

INTERPRETATION OF RESULTS
USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)
Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"
Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"
Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"
The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: FCVS

As of Date:6/11/2019

PRACTITIONER INFORMATION

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

BOARD ACTIONS

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

LICENSE HISTORY

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

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PDC PHYSICIAN DATA CENTER

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PRACTITIONER PROFILE

Prepared for: FCVS

Practitioner Name: Denapoles, Christopher Romano

As of Date:6/11/2019

ABMS® CERTIFICATION HISTORY

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

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

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AOA® CERTIFICATION HISTORY

No AOA Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

NPDB Report

fsmb

DENAPOLES, CHRISTOPHER ROMANO

DCN: 5500000148040673

FOR AUTHORIZED USE BY: Tennessee Board of Medical Examiners

Process Date: 6/11/2019

The following is a render of data received by National Practitioner Data Bank (NPDB) as interpreted by FSMB

DENAPOLES, CHRISTOPHER ROMANO

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name:	DENAPOLES, CHRISTOPHER ROMANO
Date of Birth:	1/2/1986
Gender:	MALE
Work Address:	126 BIG OAK RD STAMFORD, CT 06903
Home Address:	341 S GARCON POINT RD MILTON, FL 32583
National Provider Identifiers (NPI):	1578973715
License(s):	Physician (MD), 00038134, AL Physician (MD), 34683, OK Physician (MD), ME132255, FL
Professional School(s):	TRINITY SCHOOL OF MEDICINE (2013)

B. QUERY INFORMATION

Statutes Queried:	Title IV, Section 1921, Section 1128E
Query Type:	This is a One-Time query response. Your organization will only receive future reports on this practitioner if another query is submitted.
Entity Name:	Tennessee Board of Medical Examiners
Authorized Agent:	Federation of State Medical Boards, (817) 868 - 4000
Customer Use:	217679034

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 6/11/2019

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

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State of Alabama

Medical Licensure Commission

James H. Walburn, M.D., Chairman/Executive Officer
Karen Silas, Executive Assistant

07/08/2019

Tennessee Medical Board
665 Mainstream Drive Suite 300
Nashville, TN 37243

VERIFICATION OF ALABAMA MEDICAL LICENSURE

Name of Licensee (as it appears in our Records)
Christopher Romano DeNapoles

Date of Birth:	**01/02/1986**
License Number:	**MD.38134**
Current Status:	**Active**
Date Issued:	**04/04/2019**
Basis of License:	**USMLE/CT**
Expiration Date:	**12/31/2019**
Medical School:	**Trinity School of Medicine**
Location:	**Kingstown West Indies**
Date From/To:	**09/09-04/13**

Disciplinary Actions:

[X] No

[ ] Yes, visit Public Actions at www.albme.org for documents.

Signature: James H Walburn, MD

James H. Walburn, M.D. Chairman
Medical Licensure Commission of Alabama

To expedite the verification process, the above is the standard format used by the Medical Licensure Commission of Alabama. Verification information can also be obtained by accessing our website at http://www.albme.org.

Courtney Lewis

From: Medical Health
Sent: Thursday, July 11, 2019 9:54 AM
To: Courtney Lewis
Subject: FW: Verification Mail
Attachments: verification.pdf

From: verification@albme.org [mailto:verification@albme.org]
Sent: Monday, July 8, 2019 7:49 AM
To: Medical Health; support@tnhlr.zendesk.com
Subject: Verification Mail

please check the verification print

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

July 8, 2019

TENNESSEE BOARD OF MEDICINE
665 MAINSTREAM DR
NASHVILLE, TN 37228

LICENSURE VERIFICATION

This is to certify that the records of the Connecticut Department of Public Health indicate that:

CHRISTOPHER DENAPOLES

Was issued a Connecticut:	Physician/Surgeon
Date Issued:	August 15, 2016
License Number:	55624
Basis for Licensure:	Exam-FT
Expiration Date:	January 31, 2018
Status of License:	INACTIVE
Public Disciplinary History	No
Subject of a Pending Investigation	No

Please note that this is the only verification provided by this office. The Connecticut Department of Public Health does not affix a raised seal to this document. Please note that the information containined in this letter can be verified online at https://www.elicense.ct.gov.

Sincerely,

Stephen B. Carragher

Stephen B. Carragher
Public Health Services Manager
Practitioner Licensing and Investigations Section

Courtney Lewis

From: support@veridoc.org
Sent: Thursday, July 4, 2019 11:31 AM
To: Courtney Lewis
Subject: [EXTERNAL] License Verification Statement - DENAPOLES, CHRISTOPHER (M.D.)
Attachments: v696934AA.pdf; v696934BA.pdf

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Verification of Licensure Status

The attached verification reports have been sent to you by the VeriDoc.org website. This email can be verified as coming from this site by clicking on the link below.

Validate Verifications

Physician: DENAPOLES, CHRISTOPHER

Transaction ID: 696934

Confirmation Number: 15717860582541322551

This email contains 2 PDF attachments. If any are missing please contact support@veridoc.org

Information from the attached verifications can be refreshed for up to 6 months. To view an updated copy, click on a link below.
Florida Board of Medicine
Oklahoma Board of Medical Licensure & Supervision

July 04, 2019

Tennessee Board of Medical Examiners
Heritage Place MetroCenter
227 French Landing, Suite 300
Nashville, TN 37243

RE: License Certification for Christopher Denapoles

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:	Medical Doctor
LICENSE NUMBER:	ME132255
ORIGINAL CERTIFICATION:	04/26/2017
EXPIRATION DATE:	01/31/2021
CURRENT STATUS OF LICENSE:	CLEAR, ACTIVE
AGENCY ACTION:	None

This license information was last updated on: 07/04/2019

To expedite the verification process, the above format is the standard format for all healthcare practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595.

Board of Medical Licensure & Supervision
State of Oklahoma

101 N.E. 51st Street
Oklahoma City, OK 73105

P.O. Box 18256
Oklahoma City, OK 73154-0256

Letter of Verification
July 04, 2019

This is to certify that the records of this Board indicate on the date of this letter the following information regarding:

Name:	CHRISTOPHER ROMANO DENAPOLES
Address Date:	March 11, 2019
Address 1:	WEST FLORIDA HOSPITAL
Address 2:	2360 S HWY 29
Address 3:	
City, State, ZIP:	CANTONMENT, FL 32533

Profession:	MEDICAL DOCTOR
Profession Type:	MD
License Number:	34683
License Date:	04/12/2019
Status:	Active
Status Class:	
Expiration Date:	04/01/2020
Endorsed By:	USMLE
Restricted To:	

Previous Licenses:

Type	Issued	Expired

Disciplinary Actions:

Date	Description

No Disciplinary Actions Taken

Details of Disciplinary Action, if applicable, will be made available by photocopy from the public file upon written request only.

To expedite the verification of licensure/certification process, the above is the standard format for all professions regulated by this board

The Oklahoma State Board of Medical Licensure and Supervision certifies that the verification data displayed here is accurate according to the information stored in our database as of 07/04/2019.

Teresa Mitchell
Director of Licensing
(405) 962-1400 ext 113

TENNESSEE BUREAU OF INVESTIGATION

Tennessee Sexual Offender Registry Search Data Not Found

Return to Search

No data found for your search.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Tennessee State Board of Medical Examiners

As of Date:6/26/2019

PRACTITIONER INFORMATION

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

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ALABAMA	00038134	04/04/2019	12/31/2019	06/25/2019
CONNECTICUT	055624	08/15/2016	01/31/2018	06/25/2019
FLORIDA	ME132255	04/26/2017	01/31/2021	06/17/2019
OHIO	APP-000272079			06/21/2019
OKLAHOMA	34683	04/12/2019	04/01/2020	06/24/2019

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PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Tennessee State Board of Medical Examiners

As of Date:6/26/2019

Practitioner Name: Denapoles, Christopher Romano

ABMS® CERTIFICATION HISTORY

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

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

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AOA® CERTIFICATION HISTORY

No AOA Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or licensing agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or republished in whole or in part without the prior written consent of the Federation of State Medical Boards.

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TENNESSEE BOARD OF MEDICAL EXAMINERS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
www.tennessee.gov/health

Today's Date: 6-26-19

Christopher Romano DeNapoles MD
341 S Garcon Point Rd
Milton, FL 32583

DEFICIENCY LETTER

This letter is prepared to notify you of deficiencies remaining in order to complete your application for licensure as a medical doctor in the state of Tennessee. Pursuant to Board rule, applications not complete within ninety days of the initial deficiency letter will be closed. An applicant seeking licensure after the closure of his or her application file will be required to submit a new application and fee. *Please let our office know if additional documents are uploaded to the online system at: Medical.Health@tn.gov.*

Date of your initial deficiency letter: 6-26-19 **Date your application will be closed:** 9-26-19

Review of your application on the above date revealed the items checked below are required to complete your file:

✓ We are in receipt of your application; however, page(s) 1, 2, 3 is incomplete and/or incorrect.
#1 list intended specialty, education & training, work history and AL, CT, OK licen

____ $____ is required to complete payment of licensure fees. **Please remit this amount now.**

____ A recent passport-type photograph, passport-type.

____ Official graduate transcript, indicating courses taken, grades, and M.D. (or equivalent) degree. **Transcripts must be submitted directly from the University to our office.** International graduates must also submit an official English translation of the transcript and curriculum if original is not in English.

____ If you are an international medical school graduate, please provide proof that your medical school's admission standards meet or exceed those of the Liaison Committee on Medical Education (LCME). Please consult the Board's rules and policy for further clarification on this matter: Tenn. Comp. R. & Regs. 0880-02-.04(3)
https://www.tn.gov/content/dam/tn/health/documents/Foreign_Medical_School_Policy.pdf

✓ A notarized copy of your E.C.F.M.G. certificate.

____ Verification of successful completion of qualifying postgraduate medical education (Attachment 2) must be completed by program director, notarized, and sent directly from the training program to this office. ALL TRAINING completed in the US (including Internships, Residencies, and Fellowships) must be verified for every applicant. Any training listed below has not been received:

_____ / _____ / _____

____ NBME, FLEX, LMCC, USMLE or State Board exam scores. This information must come to this office directly from the testing agency.

✓ Verification of licensure directly from each state, country or province in which you hold or have ever held a license. Clearance form has not been received from.

✓ Two (2) individual letters of professional recommendation from licensed physicians on professional letterhead. Please make sure the letters have been dated and written within the last six (6) months. One (1) letter has been received from Faahul; Bargavan need's a date

✓ Applicants for initial licensure in Tennessee must obtain a criminal background check. Please follow the directions that are enclosed. (However if you have already submitted your Criminal Background Check to the appropriate reporting agency please feel free to contact the office at (615) 532-4384).

___ Your first set of fingerprints was rejected by TBI/FBI. Please submit new prints.

___ Your second set of fingerprints was rejected by TBI/FBI. You will be required to travel to Tennessee to have your prints taken electronically.

___ The criminal background check that we received was dated _____ by TBI/FBI. This office can only accept criminal background checks that completed within the last six (6) months. Please resubmit an updated criminal background check.

___ Notarized copy of legal entitlement to live or work in the United States (for U.S. Citizens, birth certificate or current passport only). For non-U.S. citizens, if your current visa is expired please notify us in writing and submit proof of waiver, H1B visa, or other pending visa application request.

___ Declaration of Citizenship must accompany all applications for initial licensure or reinstatement of licensure. The "SAVE ACT" requires the Tennessee Department of health (including all Boards, Commissions, and contractors) along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out of 8 U.S.C. 1621.

☐ Answer question # 5 on page 1 ☐ Remove license number

☐ Complete mailing address on line 2 ☐ TN license number

✓ Completed Mandatory Practitioner Profile Questionnaire (this is a separate document from the application). You may complete the online profile at: https://lars.tn.gov/datamart/mainMenu.do or download it from the website and fax the completed form (6 pages) to 615-253-4484, or mail it to this office.

☐ We received your profile; however, the following pages are incomplete or incorrect: _____

___ Notarized copy of your specialty certificate.

___ Application indicates pending legal action, malpractice judgment, or settlement. **Please have a copy of the complaint, answer, and/or final action sent to this office concerning your response to question #_____.**

✓ Please submit a written explanation for an affirmative answer to Question(s) #8 on the application.

✓ Affirmative responses require final documents or orders from the issuing states, courts and/or agencies. Please submit these for affirmative response to question(s) #8.

___ Please submit documentation showing proof of _____ hours of continuing education.

___ Please submit court documents in regards to the arrest date(s) _____

___ Other: _____

_____

_____

It can take up to fourteen (14) days for documents sent by U.S. Mail to reach this office. U.S. mail is delivered to our State Post Office, then distributed. *Overnight and special courier mail* may reduce your mailing time; however, you must use the Zip Code 37228 for all *overnight or special courier mail*.

TENNESSEE BOARD OF MEDICAL EXAMINERS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
www.tennessee.gov/health

Today's Date: 6-26-19

Christopher Romano DeNapoles MD
341 S Garcon Point Rd
Milton, FL 32583

JUL 12 2019

DEFICIENCY LETTER

This letter is prepared to notify you of deficiencies remaining in order to complete your application for licensure as a medical doctor in the state of Tennessee. Pursuant to Board rule, applications not complete within ninety days of the initial deficiency letter will be closed. An applicant seeking licensure after the closure of his or her application file will be required to submit a new application and fee. *Please let our office know if additional documents are uploaded to the online system at: Medical.Health@tn.gov.*

Date of your initial deficiency letter: 6-26-19 **Date your application will be closed:** 9-26-19

Review of your application on the above date revealed the items checked below are required to complete your file:

X We are in receipt of your application; however, page(s) 1, 2, 3 is incomplete and/or incorrect.
#1 list invalid specialty, education & training, work history and AL, CT, OK licenses

_____ $_____ is required to complete payment of licensure fees. **Please remit this amount now.**

_____ A recent passport-type photograph, passport-type.

_____ Official graduate transcript, indicating courses taken, grades, and M.D. (or equivalent) degree. **Transcripts must be submitted directly from the University to our office.** International graduates must also submit an official English translation of the transcript and curriculum if original is not in English.

_____ If you are an international medical school graduate, please provide proof that your medical school's admission standards meet or exceed those of the Liaison Committee on Medical Education (LCME). Please consult the Board's rules and policy for further clarification on this matter: Tenn. Comp. R. & Regs. 0880-02-.04(3)
https://www.tn.gov/content/dam/tn/health/documents/Foreign_Medical_School_Policy.pdf

✓ A notarized copy of your E.C.F.M.G. certificate.

_____ Verification of successful completion of qualifying postgraduate medical education (Attachment 2) must be completed by program director, notarized, and sent directly from the training program to this office. **ALL TRAINING** completed in the US (including Internships, Residencies, and Fellowships) **must be verified** for every applicant. Any training listed below has **not** been received:

_____ / _____ / _____

_____ NBME, FLEX, LMCC, USMLE or State Board exam scores. This information must come to this office **directly from the** testing agency.
pending verification

4 Verification of licensure directly from each state, country or province in which you hold or have ever held a license. Clearance form has not been received from:
sent

FL / AL / CT /

X Two (2) individual letters of professional recommendation from licensed physicians on professional letterhead. Please make sure the letters have been dated and written within the last six (6) months. One (1) letter has been received from

Faduli; Bangura received date _____

✓ Applicants for initial licensure in Tennessee must obtain a criminal background check. Please follow the directions that are enclosed. (However if you have already submitted your Criminal Background Check to the appropriate reporting agency please feel free to contact the office at (615) 532-4384).

_____ Your first set of fingerprints was rejected by TBI/FBI. Please submit new prints.

_____ Your second set of fingerprints was rejected by TBI/FBI. You will be required to travel to Tennessee to have your prints taken electronically.

_____ The criminal background check that we received was dated _____ by TBI/FBI. This office can only accept criminal background checks that completed within the last six (6) months. Please resubmit an updated criminal background check.

_____ Notarized copy of legal entitlement to live or work in the United States (for U.S. Citizens, birth certificate or current passport only). For non-U.S. citizens, if your current visa is expired please notify us in writing and submit proof of waiver, H1B visa, or other pending visa application request.

_____ Declaration of Citizenship must accompany all applications for initial licensure or reinstatement of licensure. The "SAVE ACT" requires the Tennessee Department of health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out of 8 U.S.C. 1621.

☐ Answer question # 5 on page 1 ☐ Remove license number

☐ Complete mailing address on line 2 ☐ TN license number

X Completed Mandatory Practitioner Profile Questionnaire (this is a separate document from the application). You may complete the online profile at: https://lars.tn.gov/datamart/mainMenu.do or download it from the website and fax the completed form (6 pages) to 615-253-4484, or mail it to this office.

☐ We received your profile; however, the following pages are incomplete or incorrect: _____

_____ Notarized copy of your specialty certificate.

_____ Application indicates pending legal action, malpractice judgment, or settlement. **Please have a copy of the complaint, answer, and/or final action sent to this office concerning your response to question #_____.**

X Please submit a written explanation for an affirmative answer to Question(s) # 8 on the application.

X Affirmative responses require final documents or orders from the issuing states, courts and/or agencies. Please submit these for affirmative response to question(s) # 8.

_____ Please submit documentation showing proof of _____ hours of continuing education.

_____ Please submit court documents in regards to the arrest date(s) _____

_____ Other: _____

_____

_____

It can take up to fourteen (14) days for documents sent by U.S. Mail to reach this office. U.S. mail is delivered to our State Post Office, then distributed. *Overnight and special courier mail* may reduce your mailing time; however, you must use the Zip Code 37228 for all *overnight or special courier mail*.

#66758 Customer Inquiry

Submitted	Received via	Requester
July 4, 2019, 11:12	Mail	Crdenapoles <crdenapoles@gmail.com>

Status	Type	Priority	Group	Assignee
Open	Question	Normal	BME Admins	Courtney Lewis

BME Profession
Medical Doctor

Crdenapoles Jul 4, 11:12

Hello,
I received a deficiency letter and I will send in what's missing. There was one section which I'm confused about and that's the notarized copy of my ECFMG certificate. There should be a copy included with my FCVS application. Please advise on how I should satisfy this requirement.
Thank you,
Dr. DeNapoles

Angela M. Lawrence Jul 9, 16:33

We apologize for the delay in response. Typically the ECFMG certificate is included in the FCVS packet and accepted. By copy on this email the board administrator will need to provide more information concerning this deficiency.

TN Health

Medical Health Administration
665 Mainstream Drive
Nashville, TN 37243
615-532-4384
tn.gov/health
Connect with TDH on Facebook or Twitter @TNDeptofHealth!

Our Mission - To protect, promote and improve the health and prosperity of people in Tennessee.

CONFIDENTIALITY NOTE: The information transmitted, including attachments, is intended only for the person(s) or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited. If you received this in error, please contact the sender and destroy any copies of this information.

Support Software by **Zendesk**

ECFMG®
EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

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

Issue Date: 16 Jul 2019

To: TENNESSEE STATE BOARD OF MEDICAL EXAMINERS
ADMINISTRATOR
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

State Board Code:
043
Please include this number on all requests.

ECFMG® CERTIFICATION STATUS REPORT

Received By:
JUL 22 [illegible]
BME Unit

USMLE®/ECFMG Identification Number: 0-824-016-0
Applicant's Name: Christopher R. Denapoles
Applicant's Date of Birth: 02 Jan 1986
ECFMG Certified: Yes
Certificate Issue Date: 11 Jun 2013
English Test Valid Through: Valid Indefinitely
Clinical Skills Assessment Valid Through: Valid Indefinitely

Passing Performance on Medical Science Examinations:

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

Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
USMLE Step 2 CS	14 Aug 2012

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

How to Verify the Authenticity of this Report:

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

Report Verification Code: S4V2P537AG

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

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

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

Important Note:

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

Lifespan

Rhode Island Hospital

7/26/27

To Whom It May Concern,

This letter is to endorse Christopher DeNapoles M.D. I have had the opportunity to work with Dr. DeNapoles for several years. I also had the opportunity to work with him during his training at Stamford Hospital.

He is an outstanding physician who takes pride in maintaining his academic and clinical knowledge. He is a true patient advocate and delivers terrific care while managing his patients. He is a team player and will be an asset to whatever health care system is fortunate enough to have him. I endorse him without reservation.

Sincerely,

Dr. Theo Borgovan
Physician, Hematology/Oncology
Brown University
716 640 2817
TB2182@columbia.edu

#79081 Customer Inquiry

Submitted	Received via	Requester
July 25, 2019, 14:53	Mail	Crdenapoles <crdenapoles@gmail.com>

Status	Type	Priority	Group	Assignee
Solved	Question	Normal	BME Directors	Angela M. Lawrence

BME Profession
Medical Doctor

Crdenapoles Jul 25, 14:53

Hello,
I want to follow-up to find out what my application is missing. I see that there are pending required documents but I believe I've submitted everything. Please advise.
Thank you,
Dr. DeNapoles

Angela M. Lawrence Jul 26, 13:38

According to the system last updated by the administrator on July 23, 2019, the following are required to complete the file.
1. Correction to application (provided intended specialty, list medical education and post graduate training information, list work history and license information for AL, CT and OK) correction can be made on the attached pages from the paper.
2. Notarized ECFMG certificate (not certificate status report)
3. I letter of recommendation (rec'd Dr. Fadul and Dr. Borgovan's letter was not dated appropriately)
4. Criminal background check
5. Correction to profile (list post graduate training)
6. Provide written explanation and final documents for question #8 on application concerning a conviction

TN Health

Medical Health Administration
665 Mainstream Drive
Nashville, TN 37243
615-532-4384
tn.gov/health
Connect with TDH on Facebook or Twitter @TNDeptofHealth!

Our Mission - To protect, promote and improve the health and prosperity of people in Tennessee.

CONFIDENTIALITY NOTE: The information transmitted, including attachments, is intended only for the person(s) or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use of, or taking of any action in reliance upon this information by persons or entities other than the intended recipient is prohibited.
If you received this in error, please contact the sender and destroy any copies of this information.

Crdenapoles Jul 26, 17:07

___ Two (2) individual letters of professional recommendation from licensed physicians on professional letterhead. Please make sure the letters have been dated and written within the last six (6) months. One (1) letter has been received from

___ Applicants for **initial** licensure in Tennessee **must** obtain a criminal background check. Please follow the directions that are enclosed. (However if you have already submitted your Criminal Background Check to the appropriate reporting agency please feel free to contact the office at (615) 532-4384)

___ Your first set of fingerprints was rejected by TBI/FBI. Please submit new prints.

___ Your second set of fingerprints was rejected by TBI/FBI. You will be required to travel to Tennessee to have your prints taken electronically.

___ The criminal background check that we received was dated _____ by TBI/FBI. This office can only accept criminal background checks that completed within the last six (6) months. Please resubmit an updated criminal background check.

___ Notarized copy of legal entitlement to live or work in the United States (for U.S. Citizens, birth certificate or current passport only). For non-U.S. citizens, if your current visa is expired please notify us in writing and submit proof of waiver, H1B visa, or other pending visa application request.

___ Declaration of Citizenship must accompany all applications for initial licensure or reinstatement of licensure. The "SAVE ACT" requires the Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out of 8 U.S.C. 1621.

☐ Answer question # 5 on page 1 ☐ Remove license number

☐ Complete mailing address on line 2 ☐ List TN license number

___ Completed Mandatory Practitioner Profile Questionnaire (this is a separate document from the application). You may download it from the website and fax the completed form (6 pages) to 615-253-4484, or mail it to this office.

☑ We received your profile, however, the following pages are incomplete or incorrect: list training

___ Notarized copy of your specialty certificate.

___ Application indicates pending legal action, malpractice judgment, or settlement. **Please have a copy of the complaint, answer, and/or final action sent to this office concerning your response to question #_____.**

___ Please submit a written explanation for an affirmative answer to Question(s) #_____ on the application.

___ Affirmative responses require final documents or orders from the issuing states, courts and/or agencies. Please submit these for affirmative response to question(s) #_____.

___ Please submit documentation showing proof of _____ hours of continuing education.

___ Please submit court documents in regards to the arrest date(s) _____

___ Other: _____

It can take up to fourteen (14) days for documents sent by U.S. Mail to reach this office. U.S. mail is delivered to our State Post Office, then distributed. *Overnight and special courier mail* may reduce your mailing time; however, you must use the Zip Code 37228 for all *overnight or special courier mail*.

Courtney Lewis, Board Administrator
(3/2018)

TENNESSEE BOARD OF MEDICAL EXAMINERS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
www.tennessee.gov/health

Today's Date: 8-9-17

Christopher Romano DeNapoles MD
341 S Garcon Point Rd
Milton, FL 32583

TO BE CLOSED DEFICIENCY LETTER

This letter is prepared to notify you of deficiencies remaining in order to complete your application for licensure as a medical doctor in the state of Tennessee. Pursuant to Board rule, applications not complete within ninety days of the initial deficiency letter will be closed. An applicant seeking licensure after the closure of his or her application file will be required to submit a new application and fee. *Please let our office know if additional documents are uploaded to the online system: Medical.Health@tn.gov*

Date of your initial deficiency letter: 6-6-17 Date your application will be closed: 9-6-17

Review of your application on the above date revealed the items checked below are required to complete your file:

✓ We are in receipt of your application; however, page(s) 4 is incomplete and/or incorrect.
Correct intended Specialty

___ $_____ is required to complete payment of licensure fees. **Please remit this amount now.**

___ A recent passport-type photograph.

___ Official graduate transcript, indicating courses taken, grades, and M.D. (or equivalent) degree. **Transcripts must be submitted directly from the University to our office.** International graduates must also submit an official English translation of the transcript and curriculum if original is not in English.

___ If you are an international medical school graduate, please provide proof that your medical school's admission standards meet or exceed those of the Liaison Committee on Medical Education (LCME). Please consult the Board's rules and policy for further clarification on this matter. Tenn. Comp. R. & Regs. 0880-02-.04(3)
https://www.tn.gov/content/dam/tn/health/documents/Foreign_Medical_School_Policy.pdf

✓ A notarized copy of your E.C.F.M.G. certificate. - not certification status report.

___ Verification of successful completion of qualifying postgraduate medical education (Attachment 2) must be completed by program director, notarized, and sent directly from the training program to this office. ALL TRAINING completed in the US (including Internships, Residencies, and Fellowships) **must be verified** for every applicant. Forms submitted prior to completion of required training will not be accepted. Any training listed below has not been received:

_____ / _____ / _____

___ NBME, FLEX, LMCC, USMLE or State Board exam scores. This information must come to this office **directly from the testing agency.**

___ Verification of licensure directly from each state, country or province in which you hold or have ever held a license. Clearance form has not been received from:

_____ / _____ / _____ / _____ / _____ / _____

TENNESSEE BOARD OF MEDICAL EXAMINERS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
www.tennessee.gov/health

Today's Date: 8-9-17

Christopher Romano DeNapoles MD
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Date of your initial deficiency letter: 6-14-17 Date your application will be closed: 9-14-17

Review of your application on the above date revealed the items checked below are required to complete your file:

✓ We are in receipt of your application; however, page(s) 4 is incomplete and/or incorrect.
Correct intended Specialty

_____ $_____ is required to complete payment of licensure fees. **Please remit this amount now.**

_____ A recent passport-type photograph, passport-type.

_____ Official graduate transcript, indicating courses taken, grades, and M.D. (or equivalent) degree. **Transcripts must be submitted directly from the University to our office.** International graduates must also submit an official English translation of the transcript and curriculum if original is not in English.

_____ If you are an international medical school graduate, please provide proof that your medical school's admission standards meet or exceed those of the Liaison Committee on Medical Education (LCME). Please consult the Board's rules and policy for further clarification on this matter. Tenn. Comp. R. & Regs. 0880-02-.04(3)
https://www.tn.gov/content/dam/tn/health/documents/Foreign_Medical_School_Policy.pdf

✓ A notarized copy of your E.C.F.M.G. certificate. - not certification status report.

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_____/_____/_____

_____ NBME, FLEX, LMCC, USMLE or State Board exam scores. This information must come to this office directly from the testing agency.

_____ Verification of licensure directly from each state, country or province in which you hold or have ever held a license. Clearance form has not been received from:

_____/_____/_____/_____/_____/_____

Two (2) individual letters of professional recommendation from licensed physicians on professional letterhead. Please make sure the letters have been dated and written within the last six (6) months. One (1) letter has been received from

Applicants for initial licensure in Tennessee must obtain a criminal background check. Please follow the directions that are enclosed. (However if you have already submitted your Criminal Background Check to the appropriate reporting agency please feel free to contact the office at (615) 532-4384).

Your first set of fingerprints was rejected by TBI/FBI. Please submit new prints.

Your second set of fingerprints was rejected by TBI/FBI. You will be required to travel to Tennessee to have your prints taken electronically.

The criminal background check that we received was dated _____ by TBI/FBI. This office can only accept criminal background checks that completed within the last six (6) months. Please resubmit an updated criminal background check.

Notarized copy of legal entitlement to live or work in the United States (for U.S. Citizens, birth certificate or current passport only). For non-U.S. citizens, if your current visa is expired please notify us in writing and submit proof of waiver, H1B visa, or other pending visa application request.

Declaration of Citizenship must accompany all applications for initial licensure or reinstatement of licensure. The "SAVE ACT" requires the Tennessee Department of health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that every adult applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out of 8 U.S.C. 1621.

☒ Answer question # 5 on page 1 ☐ Remove license number

☐ Complete mailing address on line 2 ☐ List TN license number

✓ Completed Mandatory Practitioner Profile Questionnaire (this is a separate document from the application). You may download it from the website and fax the completed form (6 pages) to 615-253-4484, or mail it to this office.

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Notarized copy of your specialty certificate.

Application indicates pending legal action, malpractice judgment, or settlement. **Please have a copy of the complaint, answer, and/or final action sent to this office concerning your response to question #_____.**

Please submit a written explanation for an affirmative answer to Question(s) #_____ on the application.

Affirmative responses require final documents or orders from the issuing states, courts and/or agencies. Please submit these for affirmative response to question(s) #_____

Please submit documentation showing proof of _____ hours of continuing education

Please submit court documents in regards to the arrest date(s) _____

Other: _____

It can take up to fourteen (14) days for documents sent by U.S. Mail to reach this office. U.S. mail is delivered to our State Post Office, then distributed. *Overnight and special courier mail* may reduce your mailing time; however, you must use the Zip Code 37228 for all *overnight or special courier mail*.

Courtney Lewis, Board Administrator

(2/2018)

ECFMG® | EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

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

Issue Date: 16 Jul 2019

To: TENNESSEE STATE BOARD OF MEDICAL EXAMINERS
ADMINISTRATOR
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

State Board Code:
043
Please include this number on all requests.

ECFMG® CERTIFICATION STATUS REPORT

Received By:
AUG 19 2019
BME Unit

USMLE®/ECFMG Identification Number: 0-824-016-0
Applicant's Name: Christopher R. Denapoles
Applicant's Date of Birth: 02 Jan 1986
ECFMG Certified: Yes
Certificate Issue Date: 11 Jun 2013
English Test Valid Through: Valid Indefinitely
Clinical Skills Assessment Valid Through: Valid Indefinitely

Passing Performance on Medical Science Examinations:

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

Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
USMLE Step 2 CS	14 Aug 2012

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

How to Verify the Authenticity of this Report:

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

Report Verification Code: S4V2P537AG

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

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Courtney Lewis

From: Courtney Lewis
Sent: Wednesday, September 11, 2019 8:41 AM
To: 'Christopher.DeNapoles@hcahealthcare.com'
Subject: RE: Chris DeNapoles MD application

Good morning,

We are requesting a notarized copy of your ECFMG certificate and not the certification status report that was received in our office.

Thank you,

TN Health

Courtney Lewis, Administrative Services Assistant 3
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
Courtney.Lewis@tn.gov
tn.gov/health

From: Christopher.DeNapoles@hcahealthcare.com [mailto:Christopher.DeNapoles@hcahealthcare.com]
Sent: Tuesday, September 10, 2019 1:27 PM
To: Courtney Lewis
Subject: [EXTERNAL] Chris DeNapoles MD application

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Good Afternoon Courtney,

I received a deficiency letter for my application and would appreciate your help in correcting this. There was a request for my ECFMG certificate to be notarized. I paid the ECFMG to have a copy of my ECFMG certificate sent directly to the TN board which was received late July per USPS tracking. This is the most direct way to validate my certification so I'm unsure why I still have this deficiency. Please advise.

Thank you,
Dr. DeNapoles

Courtney Lewis

From: Courtney Lewis
Sent: Wednesday, September 11, 2019 9:34 AM
To: 'Christopher.DeNapoles@hcahealthcare.com'
Subject: RE: Chris DeNapoles MD application

If you have a paper copy of your ECFMG certificate, you would need to get that copy notarized and email it to me.

Thank you,

TN Health

Courtney Lewis, Administrative Services Assistant 3
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
Courtney.Lewis@tn.gov
tn.gov/health

From: Christopher.DeNapoles@hcahealthcare.com [mailto:Christopher.DeNapoles@hcahealthcare.com]
Sent: Wednesday, September 11, 2019 8:44 AM
To: Courtney Lewis
Subject: [EXTERNAL] Re:Chris DeNapoles MD application

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Can you please send me a copy of what they sent you? I have been going back and forth with them trying to have this resolved.

I have a paper copy of my ECFMG certificate. Would it be sufficient to have this copy notarized and sent to you?

Can you please also tell me if there is anything else you need for my application.

Thank you for your help,
Dr. DeNapoles

From: Courtney Lewis <Courtney.Lewis@tn.gov>
Sent: Wednesday, September 11, 2019 8:41 AM
To: DeNapoles Christopher <Christopher.DeNapoles@hcahealthcare.com>
Subject: {EXTERNAL} RE: Chris DeNapoles MD application

Good morning,

Courtney Lewis

From: Christopher.DeNapoles@hcahealthcare.com
Sent: Wednesday, September 11, 2019 9:38 AM
To: Courtney Lewis
Subject: [EXTERNAL] Re:Chris DeNapoles MD application

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Good Morning Courtney,
I just got off the phone with the ECFMG and they informed me that the status report is all they are able to send. If you need a copy of my certificate, I will send you my official certificate. It is the only copy that I have so I will include return postage. Please let me know if this will be sufficient or if there is an alternative.
Please advise.
Dr. DeNapoles

> **From:** DeNapoles Christopher
> **Sent:** Wednesday, September 11, 2019 8:44 AM
> **To:** 'Courtney Lewis' <Courtney.Lewis@tn.gov>
> **Subject:** RE: Chris DeNapoles MD application
>
> Can you please send me a copy of what they sent you? I have been going back and forth with them trying to have this resolved.
>
> I have a paper copy of my ECFMG certificate. Would it be sufficient to have this copy notarized and sent to you?
>
> Can you please also tell me if there is anything else you need for my application.
>
> Thank you for your help,
> Dr. DeNapoles
>
> > **From:** Courtney Lewis <Courtney.Lewis@tn.gov>
> > **Sent:** Wednesday, September 11, 2019 8:41 AM
> > **To:** DeNapoles Christopher <Christopher.DeNapoles@hcahealthcare.com>
> > **Subject:** {EXTERNAL} RE: Chris DeNapoles MD application
> >
> > Good morning,
> >
> > We are requesting a notarized copy of your ECFMG certificate and not the certification status report that was received in our office.
> >
> > Thank you,

Courtney Lewis

From: Christopher.DeNapoles@hcahealthcare.com
Sent: Wednesday, September 11, 2019 9:39 AM
To: Courtney Lewis
Subject: [EXTERNAL] Re:Chris DeNapoles MD application

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Thank you. I will have the document notarized and e-mailed to you tomorrow. Is there anything else required of my application?

From: Courtney Lewis <Courtney.Lewis@tn.gov>
Sent: Wednesday, September 11, 2019 9:34 AM
To: DeNapoles Christopher <Christopher.DeNapoles@hcahealthcare.com>
Subject: {EXTERNAL} RE: Chris DeNapoles MD application

If you have a paper copy of your ECFMG certificate, you would need to get that copy notarized and email it to me.

Thank you,

TN Health

Courtney Lewis, Administrative Services Assistant 3
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
Courtney.Lewis@tn.gov
tn.gov/health

From: Christopher.DeNapoles@hcahealthcare.com [mailto:Christopher.DeNapoles@hcahealthcare.com]
Sent: Wednesday, September 11, 2019 8:44 AM
To: Courtney Lewis
Subject: [EXTERNAL] Re:Chris DeNapoles MD application

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Can you please send me a copy of what they sent you? I have been going back and forth with them trying to have this resolved.

Courtney Lewis

From: Courtney Lewis
Sent: Thursday, September 12, 2019 9:48 AM
To: 'crdenapoles@gmail.com'
Cc: 'Christopher.DeNapoles@hcahealthcare.com'
Subject: Christopher DeNapoles MD
Attachments: {84A5E100-CB22-CDFF-928C-6B9189B00000}; Practitioner Profile.pdf

The file has been reviewed and the following is missing:

- Correct your intended specialty on the attached page 4 of the online application
- List all US post graduate training on the online practitioner profile or the attached page 7 of the profile

Initial, date, and email the corrected pages back to me.

Thank you,

TN Health

Courtney Lewis, Administrative Services Assistant 3
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
Courtney.Lewis@tn.gov
tn.gov/health

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)	**No**
Type of intended primary specialty practice in Tennessee:	**Hospitalist**
Have you previously applied for a medical license in Tennessee?	**No**

Educational Information

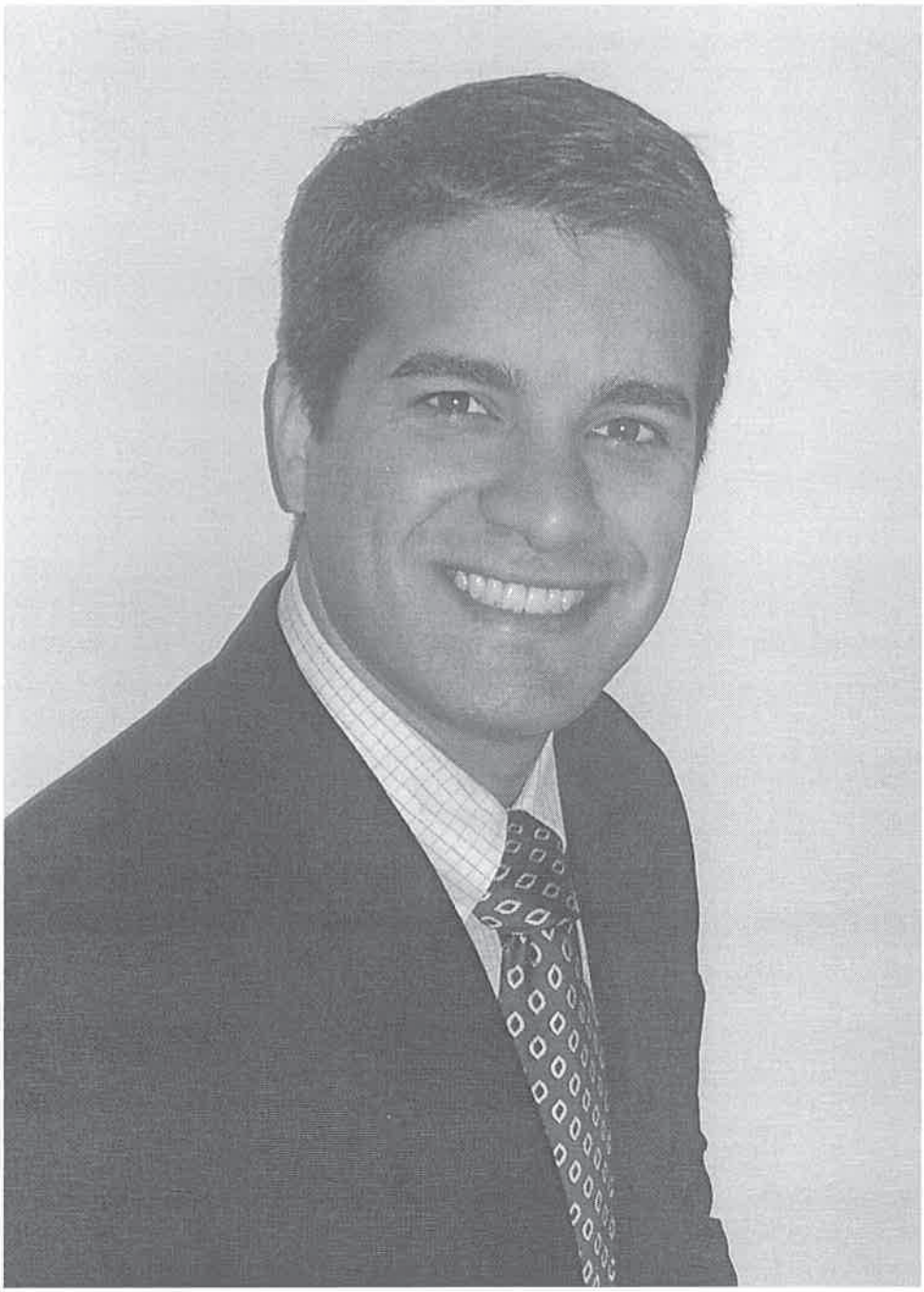
Name of educational institution attended:	**SEE FCVS**
City:	**SEE FCVS**
State:	**Florida**
Degree/certificate earned:	**SEE FCVS**
Program Major:	**SEE FCVS**
Start date of education program:	**11/11/1111 (mm/dd/yyyy)**
Completion date of education program:	**11/11/1111 (mm/dd/yyyy)**
Graduation date of education program:	**11/11/1111 (mm/dd/yyyy)**

Postgraduate Training History

Educational Institution where you completed your postgraduate training:	**SEE FCVS**
City where the postgraduate training was completed:	**SEE FCVS**
State or Country were the postgraduate training was completed:	**Florida**
Date Started:	**11/11/1111 (mm/dd/yyyy)**
Date Ended:	**11/11/1111 (mm/dd/yyyy)**
Specify the total number of years you have spent in postgraduate medical training:	**1111**

Employment Information

Have you ever been employed in healthcare in any position?	**Yes**



A-Z MEDICAL SERVICES

P.O. BOX 21506
MESA, AZ 85277

June 13, 2019

To Whom It May Concern,

I serve as a Flight Surgeon in the US Air Force along with Captain Chris DeNapoles. I met him during our shared Family Medicine Residency though we were not serving in the program at the same time. We became friends as several faculty of the program encouraged me to mentor him as he became an Attending Physician. As I have worked with him and attempted to guide him for several years, I have been impressed by his commitment to the core principles of our profession, which mirror those of the Air Force. Integrity First, Service Above Self and Excellence in all that we do. Chris embodies those in all the areas of medicine I have witnessed. He is an outstanding contributor to our profession and will be an asset for your community. You are welcome to reach out for any questions or concerns.

Respectfully,

Major Zaid Fadul, MD

Lifespan

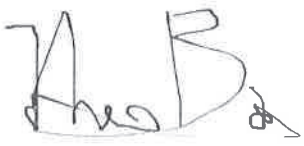
Delivering health with care.

To Whom It May Concern,

This letter is to endorse Christopher DeNapoles M.D. I have had the opportunity to work with Dr. DeNapoles for several years. I also had the opportunity to work with him during his training at Stamford Hospital.

He is an outstanding physician who takes pride in maintaining his academic and clinical knowledge. He is a true patient advocate and delivers terrific care while managing his patients. He is a team player and will be an asset to whatever health care system is fortunate enough to have him. I endorse him without reservation.

Sincerely,



Dr. Theo Borgovan
Physician, Hematology/Oncology
Brown University
716 640 2817
TB2182@columbia.edu

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

Pursuant to T.C.A. § 4-58-101 et seq, the Eligibility Verification for Entitlements Act (also known as the "SAVE Act") requires the Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) Medical Doctor _____.
Healthcare Profession (Please Print) **License number if applicable**

Please Print Legibly

1. Name: DeNapoles Christopher R
   Last First Middle Maiden
2. Mailing Address: 341 S. Garcon Point RD Milton, FL 32583
3. Phone Number: Home: (203) 667-4773 Office: (___)_____-_____ Fax: (___)___-_____
4. I am a United States Citizen: ✓Yes ____No
5. I am a foreign national not physically present in the United States _____Yes ✓No. If you answered yes to this question, please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
   a) Tennessee Driver's License, or photo ID issued by the Tennessee Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Tennessee Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not qualify.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s e-i above.
   k) An SSN that is verifiable with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4, please indicate from the list below which category applies to you: (circle one)
   a) Permanent Resident
   b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).

c) Asylees who meet the qualifications set out in 8 U.S.C. 1158.
d) Refugees who meet the qualifications set out in 8 U.S.C. 1157.
e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980.
g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

ALL APPLICANTS MUST SIGN AND HAVE NOTARIZED

I affirm under the penalty of perjury that the above is true and correct.

Signed this 25 day of June, 2019.

Signature

Sworn to before me this 25th day of June, 2019.

Vincent Bradley

NOTARY PUBLIC

VINCENT BRADLEY
MY COMMISSION # GG 305086
EXPIRES: June 22, 2023
Bonded Thru Notary Public Underwriters

My Commission Expires: June 22, 2023

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status, state governmental entities and local health departments must also file a criminal complaint with the Office of the Attorney General and/ or the United State Attorney.

A-Z MEDICAL SERVICES

P.O. BOX 21508
MESA, AZ 85[illegible]

June 13, 2019

To Whom It May Concern,

I serve as a Flight Surgeon in the US Air Force along with Captain Chris DeNapoles. I met him during our shared Family Medicine Residency though we were not serving in the program at the same time. We became friends as several faculty of the program encouraged me to mentor him as he became an Attending Physician. As I have worked with him and attempted to guide him for several years, I have been impressed by his commitment to the core principles of our profession, which mirror those of the Air Force. Integrity First, Service Above Self and Excellence in all that we do. Chris embodies those in all the areas of medicine I have witnessed. He is an outstanding contributor to our profession and will be an asset for your community. You are welcome to reach out for any questions or concerns.

Respectfully,

Major Zaid Fadul, MD

June 11, 2019

To Whom It May Concern,

This letter is to endorse Christopher DeNapoles M.D. I have had the opportunity to work with Dr. DeNapoles for several years. I also had the opportunity to work with him during his training at Stamford Hospital.

He is an outstanding physician who takes pride in maintaining his academic and clinical knowledge. He is a true patient advocate and delivers terrific care while managing his patients. He is a team player and will be an asset to whatever health care system is fortunate enough to have him. I endorse him without reservation.

Sincerely,

Dr. Theo Borgovan
Physician, Hematology/Oncology
Brown University
716 640 2817
TB2182@columbia.edu

Educational Commission for Foreign Medical Graduates

The ECFMG® certifies that

Christopher R. Denapoles

has successfully passed the required examinations, satisfied all the requirements of the Commission, and has been awarded this Certificate.

Steven E Hinnick MD
Chair, Board of Trustees

Emmanuel Papadakis M.D.
President and Chief Executive Officer

Certificate Number	0-324-0164
Medical Science	
USMLE Step 1	September 21, 2011
USMLE Step 2 CK	October 2, 2012
Clinical Skills	
USMLE Step 2 CS	August 14, 2012

Date Issued June 11, 2013

State of FLORIDA
County of ESCAMBIA

On 9/11, 2019, CHRISTOPHER DENAPOLES, personally appeared before me,

K who is personally know to me
___ whose identity I proved on the basis of FLDL D510111686002
___ whose identity I proved on the oath/affirmation of
_____, a credible witness

to be the signer of the above document, and he/she acknowledged that he/she signed it.

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

Notary Public Signature

3/18/21
My Commission Expires

Educational Commission for Foreign Medical Graduates

The ECFMG® certifies that

Christopher R. Denapoles

has successfully passed the required examinations, satisfied all the requirements of the Commission, and has been awarded this Certificate.

Certificate Number	0-824-016-0
Medical Science	
USMLE Step 1	September 21, 2011
USMLE Step 2 CK	October 2, 2012
Clinical Skills	
USMLE Step 2 CS	August 14, 2012

Steven E. Minnick MD
Chair, Board of Trustees

Emmanuel Gabranthis M.D.
President and Chief Executive Officer

Date Issued June 13, 2013

Courtney Lewis

From: Christopher.DeNapoles@hcahealthcare.com
Sent: Wednesday, September 11, 2019 12:31 PM
To: Courtney Lewis
Subject: [EXTERNAL] Re:Chris DeNapoles MD application
Attachments: ECFMG DeNapoles.pdf

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Ms. Lewis,
Per request, please see the attached document. This should complete my application. Please confirm receipt and let me know if there is anything else you need from my end. Thank you for your help.
Dr. DeNapoles

From: Courtney Lewis <Courtney.Lewis@tn.gov>
Sent: Wednesday, September 11, 2019 9:34 AM
To: DeNapoles Christopher <Christopher.DeNapoles@hcahealthcare.com>
Subject: {EXTERNAL} RE: Chris DeNapoles MD application

If you have a paper copy of your ECFMG certificate, you would need to get that copy notarized and email it to me.

Thank you,

TN Health

Courtney Lewis, Administrative Services Assistant 3
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
Courtney.Lewis@tn.gov
tn.gov/health

From: Christopher.DeNapoles@hcahealthcare.com [mailto:Christopher.DeNapoles@hcahealthcare.com]
Sent: Wednesday, September 11, 2019 8:44 AM
To: Courtney Lewis
Subject: [EXTERNAL] Re:Chris DeNapoles MD application

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Application Summary

Application Detail

License Type:	**Medical Doctor**
Application:	**Medical Doctor: Initial International Graduate Application**
Application Date:	**06/25/2019 (mm/dd/yyyy)**

Application Questions

Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	**No**
At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	**No**
Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	**No**
Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	**No**
Have you ever held or applied for a license, privilege, registration or certificate to practice medicine in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	**No**
Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	**No**

Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	**No**
Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	**Yes**
Have you ever been rejected or censured by a professional association or society?	**No**
In relation to the performance of your professional services in any profession: Have you ever had a final judgment rendered against you?	**No**
In relation to the performance of your professional services in any profession: Have you ever entered into any settlement of any legal action?	**No**
In relation to the performance of your professional services in any profession: Are there any legal actions pending against you or to which you are a party?	**No**
Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	**No**
My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)?	**No**

Personal Detail

First Name:	**Christopher**
Middle Name:	**Romano**
Last Name:	**DeNapoles**
Professional Qualifier:	**MD**

Birthdate:	**01/02/1986 (mm/dd/yyyy)**
Gender:	**Male**
Race:	**White**
Social Security Number:	*********

Addresses

Mailing Address

Address:	**341 S GARCON POINT RD** **Milton** **SANTA ROSA** **Milton, FL** **32583** **US**
Phone Number:	**203-667-4773**
Extension:	
E-mail Address:	**crdenapoles@gmail.com**

License Attributes Selected

Specialty	**Aerospace Medicine** **Family Medicine** **Public Health and General Preventive Medicine**

General Information

Have you been known by any other names?	**No**
Are you a U. S. Citizen?	**Yes**
Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.)	**No**

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)	**No**
Type of intended primary specialty practice in Tennessee:	**Hospitalist**
Have you previously applied for a medical license in Tennessee?	**No**

Educational Information

Name of educational institution attended:	**SEE FCVS**
City:	**SEE FCVS**
State:	**Florida**
Degree/certificate earned:	**SEE FCVS**
Program Major:	**SEE FCVS**
Start date of education program:	**11/11/1111 (mm/dd/yyyy)**
Completion date of education program:	**11/11/1111 (mm/dd/yyyy)**
Graduation date of education program:	**11/11/1111 (mm/dd/yyyy)**

Postgraduate Training History

Educational Institution where you completed your postgraduate training:	**SEE FCVS**
City where the postgraduate training was completed:	**SEE FCVS**
State or Country were the postgraduate training was completed:	**Florida**
Date Started:	**11/11/1111 (mm/dd/yyyy)**
Date Ended:	**11/11/1111 (mm/dd/yyyy)**
Specify the total number of years you have spent in postgraduate medical training:	**1111**

Employment Information

Have you ever been employed in healthcare in any position?	**Yes**

Company/Employer:	**SEE FCVS**
City and state/country/province where you last practiced:	**SEE FCVS**
Position:	**SEE FCVS**
Duties:	**SEE FCVS**
From Date:	**SEE FCVS**
To Date:	**SEE FCVS**

Exam History

National Boards (NBME)?	**No**
FLEX examination?	**No**
Licensure by the Medical Council of Canada (LMCC)?	**No**
USMLE?	**Yes**
State board examination administered prior to 1972?	**No**
Are you ABMS Board certified?	**Yes**
If yes, identify board of specialty/subspecialty:	**Family Medicine**

Fitness and Competency Questions

Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	**No**

Other Licensure

Are you or have you ever been licensed in this profession in another state/country/province?	**Yes**
License number:	**132255**
State/country/province where you held the license:	**Florida**
Status of the license:	**Licensed**
Name used when licensed:	**Christopher Denapoles**
Are you or have you ever been licensed in any other profession in Tennessee or another state/country/province?	**No**

Are you or have you ever been licensed in any other profession in Tennessee or another state/country/province?	

Additional Information

If you have an NPI number, please provide:	**1578973715**
Do you intend to perform Level II Office Based Surgery which is integral to a planned treatment regiment and not performed on an urgent or emergent basis? If you intend to perform Level III Office Based Surgery, you must apply for and obtain a permit prior to engaging in such practice.	**No**
Do you have a DEA number?	**Yes**
If yes, what is the number?	**6985646**

Fees

State Regulatory Fee	**$10.00**
Initial Application Fee	**$400.00**
Total Amount Due:	**$410.00**

Attestation

I, being duly sworn and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a medical doctor in the State of Tennessee. I HEREBY: SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview. RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a medical doctor. AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications. RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification. ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary. This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

TN Department of Health

Online Payment Receipt

Receipt Issued By:
Board of Medical Examiners - Medical Doctors & Genetic Counselors

Receipt Issued To:
Christopher Romano DeNapoles
341 S GARCON POINT RD
Milton, FL 32583

Date: 06/25/2019
Transaction Identifier: 3760879523
Trace Number: 429194

License Type	Licensee	Transaction	Application #	Account #	Amount
Medical Doctor	Christopher Romano DeNapoles	Medical Doctor: Initial International Graduate Application	1606-314286	**********0712	$410.00

Application Summary

Application Detail

License Type:	**Medical Doctor**
Application:	**Initial Mandatory Practitioner Profile Questionnaire**
Application Date:	**07/04/2019 (mm/dd/yyyy)**

Application Questions

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed?(This question refers to any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Association, American Podiatry Association, American Chiropractic Association, American Dental Association, APN certifications or any other specialty certifying body as determined by your Tennessee licensing board.)	**Yes**
Do you currently hold staff privileges at a hospital?	**Yes**
Do you participate in any managed care plans?	**Yes**
Do you participate in any TennCare plan(s)?	**Yes**
Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by an agency regulating your license, in this state or any other jurisdiction?(The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable board issued an agreed order or consent decree. The term disciplinary action includes, but is not limited to: • Probation • Limitation/Restriction • Suspension • Revocation • Voluntary relinquishment in lieu of disciplinary action • Compulsory surrender of license or privilege	**No**

• Civil or other monetary fine or penalty
• Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character)

Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body?(The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable governing body or the hospital issued an agreed order or consent decree. The term disciplinary action against your privileges includes, but is not limited to: • Curtailed • Limited • Suspended • Revoked • Any other adverse action taken against a privilege by a medical/health related institution • Compulsory surrender of license or privilege • Civil or other monetary fine or penalty.)	**No**
Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character?(The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable governing body or the hospital issued an agreed order or consent decree. The term disciplinary action includes, but is not limited to: • Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character • Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character)	**No**
Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction?(This part requires you to report any state or federal felony criminal offense	**No**

also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.)	
Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998?(You are required to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed within the previous ten (10) years. That means if the act or event leading to the claim occurred greater than ten (10) years but was finally adjudicated against you within the last ten (10) years, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED. Pending malpractice claims are not required to be reported unless/until final adjudication against you. A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below $75,000 are not required to be B) For Chiropractors, judgments or settlements below $50,000 are not required to be submitted. submitted. C) For Dentists, judgments or settlements below $25,000 are not required to be submitted. D) For all other professions, judgments or settlements below $10,000 are not required to be submitted.)	**No**

Addresses

Practice Address

Name:	**DeNapoles, Christopher**
Address:	**341 S GARCON Point Rd**

	SANTA ROSA
	Milton, FL
	32583
	US
Phone Number:	**203-667-4773**
Extension:	
E-mail Address:	**crdenapoles@gmail.com**

Practice Address Questions for Clarification

Is your practice address your home address?	**Yes**
If yes, do you want it contained in your profile as your official mailing or practice address?	**No**

Medical, Professional or Training Schools

What school(s)/educational programs have you attended?	**Family Medicine Residency**
City:	**Stamford**
State:	**Connecticut**
Country:	**United States of America**
Date graduated from institution:	**06/30/2017 (mm/dd/yyyy)**
What type of degree do you hold from the institution?	**Doctor of Medicine**

Responsibility for Graduate Medical Education (optional)

Have you had the responsibility for graduate medical education within the last ten (10) years?	**Yes**

Attestation

Date of Profile Submission:	**07/04/2019 (mm/dd/yyyy)**

Specialty Board Certifications

Name of certifying body or board institution which issued the recognized specialty:	**ABFM**
Name of the recognized certification, specialty or subspecialty:	**Family Medicine Board Certified**

Staff Privileges

Name of hospital where you currently hold staff privileges:	**West Florida Hospital**
State hospital located in:	**Florida**

Managed Care Plans

Name of Managed Care Plan you currently participate or accept as a provider:	**Dependent on nursing home facility.**

TennCare Plans

Name of TennCare Plan you currently participate or accept as a provider:	**N/A**

Attestation

PRACTITIONER PROFILE ATTESTATION: I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-32-113 and/or 63-32-118. I understand that by submitting this profile questionnaire, I realize that I willnot receive a confirmation report before this information is published online.

Practitioner's Name Chris DeNapoles MD TN License # 129773 (if applicable)

Profession Physician

II. MEDICAL, PROFESSIONAL OR TRAINING SCHOOLS AND GRADUATE MEDICAL EDUCATION OR OTHER GRADUATE-LEVEL TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal.

PROGRAM/INSTITUTION	CITY/STATE/COUNTRY (IF NOT COMPLETED IN THE U.S.)	DATE OF GRADUATION MM/DD/YYYY	TYPE OF DEGREE
1.			
2.			
3.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal.

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY, STATE OR COUNTRY IF NOT COMPLETED IN THE U.S.)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1. Stamford Hospital / Columbia University	Stamford, CT	06/01/2014	07/01/2017
2.			

III. SPECIALTY BOARD CERTIFICATIONS (if applicable):

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES ✓ NO ___

If "Yes", complete section below

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1. ABFM	Family Medicine
2.	
3.	
4.	
5.	

CD 9/12/19

Courtney Lewis

From: Christopher.DeNapoles@hcahealthcare.com
Sent: Thursday, September 12, 2019 2:57 PM
To: Courtney Lewis
Subject: [EXTERNAL] Re:Christopher DeNapoles MD
Attachments: TN docs.pdf

*** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. ***

Ma'am,
Please see attached document.
Thank you,
Dr. DeNapoles

From: Courtney Lewis <Courtney.Lewis@tn.gov>
Sent: Thursday, September 12, 2019 9:48 AM
To: crdenapoles@gmail.com
Cc: DeNapoles Christopher <Christopher.DeNapoles@hcahealthcare.com>
Subject: {EXTERNAL} Christopher DeNapoles MD

The file has been reviewed and the following is missing:

- Correct your intended specialty on the attached page 4 of the online application
- List all US post graduate training on the online practitioner profile or the attached page 7 of the profile

Initial, date, and email the corrected pages back to me.

Thank you,

TN Health

Courtney Lewis, Administrative Services Assistant 3
Board of Medical Examiners
665 Mainstream Drive
Nashville, TN 37243
Courtney.Lewis@tn.gov
tn.gov/health