QUALIFICATIONS APPLICATION

If you do not complete the application process you will be sent an email with a link to log back in to complete the documents. Be sure to look in your SPAM and JUNK folders. To apply for a Letter of Qualification for licensure through the Interstate Medical Licensure Compact please answer the questions below.

IS THIS A RE-APPLICATION(earned an LOQ in the past and now is reapplying)? YES **NO** X

1. Which IMLC Member State do you want to serve as your State of Principal License (SPL)?: ALABAMA

2. Do you hold a full and unrestricted medical license to engage issued by a medical licensing board in the SPL (SPL Board) ALABAMA MEDICAL LICENSURE COMMISSION? Yes X No

3. What is the license number issued to you by the SPL board? 38134

4. Which of the following apply to you(at least one must apply)?

   a. Your primary residence is in the SPL ALABAMA: Yes No X

      If yes, provide the following:

      Residence Street address_____

      Residence City State Zip _____(City), _____(St), _____(Zip)

   b. At least 25% of your practice of medicine occurs in the SPL ALABAMA Yes X No

      If yes, describe your current practice Hospitalist

      .

   c. Your employer is located in the SPL ALABAMA: Yes X No

      If Yes, Employer name Thomas Hospital

      Employer street address 750 Morphy Ave

      Employer City State Zip Fairhope(City), AL(St), 36532(Zip)

   d. You have designated the SPL ALABAMA as your state of residence for U.S. federal income tax purposes: Yes No X

      If yes, give Tax ID # (SS#, EIN)_____(must be most recent return)

5. Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes X No

6. Have you passed each component of the United State Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes(if in question contact your SPL)? Yes X No

7. Have you successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association? Yes X No

8. Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? Yes X No

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(Please note that answering any of the following questions with a "YES" will result in your application being denied per eligibility Rule 5.4. If eligibility is in question please contact the state board directly for information regarding application through the traditional method.)

9. Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? Yes No X

10. Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? Yes No X

11. Have you ever had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? Yes No X

12. Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? Yes No X

Physician's Signature: [redacted]

Type Name: Christopher Romano DeNapoles

Date: 6/24/2020 | 9:38 CDT

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR AN IMLC LETTER OF QUALIFICATION AND MEDICAL LICENSES IN IMLC MEMBER STATES

I, Christopher Romano DeNapoles (Type in full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of 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 read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and 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 disciplinary action against one or more medical licenses or permits I hold, as well as my being prosecuted under appropriate federal and state laws.

I hereby apply to ALABAMA as my State of Principal License ("SPL") for a Letter of Qualification ("LOQ") to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I hereby authorize and request every person, entity, 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 SPL 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 SPL or any of its agents or representatives to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact.

I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, 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 of any and all liability of every nature and kind arising out of investigation made by the SPL.

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application, and further authorize the SPL to process my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a Letter of Qualification, and revocation, or other disciplinary sanction, of my license(s) or permit(s) to practice medicine in one or more Compact Member States.

Applicant Signature [redacted]

Type Applicant's Name Christopher Romano DeNapoles

Applicant's NPI 1578973715

DATE 6/24/2020 | 9:38 CDT

DocuSign Envelope ID [redacted]

PHYSICIAN'S CORE DATA SHEET

(***Must be the physician's accurate information to avoid delay or rejection***)

Full Legal Name Christopher, Romano, DeNapoles, _____
(Exactly as on DL or Passport) First Middle Last Suffix(Sr., Jr.)

Other names used(maiden, birth) _____ _____ _____
First Middle Last

Mailing address [redacted], [redacted], [redacted], [redacted]
Mailing address City State(XX) Zip

Office address 750 Morphy Ave, Fairhope, AL, 36532
Office address City State(XX) Zip

Date of Birth [redacted] Gender: Male x Female
(mm/dd/yyyy)

Physician's office or practice telephone number of public record 251-928-2375
(###-###-####)

Physician's cellular or alternative telephone number [redacted]
(###-###-####)

Email address delegated by applicant to receive correspondence [redacted]

Social Security Number: [redacted]
(###-##-####)

Physician's National Provider Identifier Number 1578973715

Medical Degree Received: M.D. x D.O.

(Medical school must be accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or be listed in the International Medical Education Directory or its equivalent.)

Medical School Trinity School of Medicine
Name of School (no abbreviations or acronyms)

Date of Degree Issued 04/30/2013
(mm/dd/yyyy)

Physicians must have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. (NOTE: One-year transitional residencies do not meet this requirement)

Residency Program Stamford Hospital/Columbia University
Full Program Name (no abbreviations or acronyms)

Completion Date 06/30/2017
(mm/dd/yyyy)

What is the specialty of the program Family Medicine

Qualifying Licensing exam taken: USMLE X COMLEX Other _____
Must specify by name

Number of attempts taken to pass the USMLE:

Step 1: [redacted]___ Step 2 CS: ____ Step 2 CK: [redacted]___ Step 3: [redacted]___

Number of attempts taken to pass the COMLEX:

Step 1: ____ Step 2 PE: ____ Step 2 CE: ____ Step 3: ____

Number of attempts taken to pass other licensing exam:

Step 1: ____ Step 2: ____ Step 3: ____

Specialty Board Certification must be by an ABMS or AOABOS board.

Specialty Board Certification: American Board of Family Medicine
Full Specialty Board Name (i.e. American Board of Pediatrics)(no abbreviations or acronyms)

Expiration of Specialty Board Certification:

Lifetime:

Time limited: X Expiration date of time limited 07/01/2027
(mm/dd/yyyy)

Physicians must possess a full and unrestricted medical license issued by an IMLC Member Board.

License # 38134 Date of Original Licensure 04/04/2019 (not renewal)
(mm/dd/yyyy)

Expiration Date 12/31/2020 Status of License: Current: X Not Current:
(mm/dd/yyyy)

Thank you for applying through the Interstate Medical Licensure Compact.

The state will contact you to give instructions on obtaining your fingerprints for a criminal background check. ***YOU HAVE 60 DAYS TO COMPLY WITH REQUESTS FROM THE STATE*** *to avoid automatic withdraw. Background checks may take some time, so please be patient. If you have any concerns contact your SPL. SPL contact numbers can be found at www.IMLCC.org. You will receive an email regarding the status of your qualification. Be sure to check your spam folder and set your email to accept messages from the @docusign.net and @docusign.com domains.*

FOR USE OF STATE OF PRINCIPAL LICENSE

I have conducted the verification process of this physician's application.

State Authorized Signature [redacted]

Type Name Tiffany B. Seamon

Title Director of Credentialing

Warning: The signature tab will default to your Board's name. Please change it to your name in Adopt and Sign.

CORE DATA CORRECTION SHEET

To process corrections please use the below freeform text boxes. The corrections will be passed to the Member Boards selected to issue licenses. If you use this sheet there is no need to send any correction emails.

Core Data to be changed	Incorrect data	Correction
spec bd cert	07/01/2027	reverification 02/15/21

DocuSign Envelope ID: [redacted]

Letter of Qualification

IS THIS A RE-APPLICATION? YES NO X

Date 07/24/2020
mm/dd/yyyy

Name: Christopher Romano DeNapoles

Address: [redacted]

CityStZip [redacted]

Dear Dr. DeNapoles:

RE: Your application for IMLC Letter of Qualification

The Alabama Board of Medical Examiners ("Board"), on behalf of the State of Principal Licensure ("SPL") you selected, has received and reviewed your application for a Letter of Qualification ("LOQ") for licensure through the Interstate Medical Licensure Compact ("IMLC").

Based upon the information you submitted with your application, data in the Board's files regarding your licensure by the Board, verifications of your credentials, and the results of the check of national databases, the Board has determined that you are ELIGIBLE to be licensed through the IMLC. Therefore, this notice will serve as your LOQ for licensure in IMLC Member States through the IMLC, and will remain in effect for 365 days from date of issuance, set out above.

An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license in by each.

All medical licenses issued by Member Boards through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions including, but not limited to, each Member Board's continuing medical education requirements. It is also your obligation to keep your SPL, the Member Boards which have licensed you, and the IMLC Commission informed of any changes in your contact information or qualifications and eligibility for licensure through the IMLC.

Authorized Signature from SPL [redacted]

Type Name Tiffany B. Seamon

Title of Authorized SPL Director of Credentialing

DATE 7/24/2020 | 3:14 CDT

DocuSign Envelope ID: [redacted]

PAYMENT FOR LICENSES

Below are the selected states in which you have indicated you wish to be licensed to practice medicine. Please sign as a payment agreement.

MEMBER BOARD(S)	COST OF LICENSE
MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE	$600.00

TOTAL $ 600

The selected state medical board(s) will be notified of your selection and issue the license(s).

Please note: All medical licenses issued through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions.

Physician's Signature [redacted]

Type Name Chris R DeNapoles

DATE 7/26/2020 | 7:16 CDT

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Christopher (First Name) Romano (Middle Name) DeNapoles (Last Name)

Please fill in your respective Member Board's information for the qualified Physician named above.

National Provider Identifier Number 1578973715

Medical Board Name MS State Board of Medical Licensure

Member Board License Number 28014

Date License Issued 08/10/2020
mm/dd/yyyy

Date of Expiration 06/30/2021
mm/dd/yyyy

Warning: The signature tab will default to your Board's name. Please change it to your name in Adopt and Sign

Member Board Signature [redacted]

Type Name Paulette Richmond

DATE 8/10/2020 | 1:50 CDT

Interstate Medical Licensure Compact
A faster pathway to medical licensure

MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Christopher (First) Romano (Middle) DeNapoles (Last)

Please fill in your respective Member Board's information for the qualified Physician named above.

National Provider Identifier Number 1578973715

Medical Board Name ILLINOIS DIVISION OF PROFESSIONAL REGULATION

Member Board License Number 036.157731

Date License Issued 7/18/2021 (mm/dd/yyyy)

Date of Expiration 7/31/2023 (mm/dd/yyyy)

Member Board Signature [redacted]

Name Karen S Schlindwein
Date 7/18/2021