

## Details for Christopher Romano DeNapoles

### License Information

Name: Christopher Romano DeNapoles  
City, State, Zip, Country: Pensacola FL 32534 United States  
Profession: Physician  
License Type: Physician & Surgeon  
Under Interstate Compact  
License Number: 12382109-1205  
Obtained By: Interstate Compact - Member Board State  
License Status: Active  
Original Issue Date: 07/07/2021  
Expiration Date: 01/31/2024  
Agency and Disciplinary Action\*: NO DISCIPLINARY ACTIONS OR NO DISCIPLINARY ACTIONS WITHIN THE TIME FRAME ESTABLISHED IN UTAH CODE 63G-4-106 AND 107  
Docket Number: N/A

### Education:

Education Institution	Program	Completion Date	Credential
Stamford Hospital/Columbia University	PGT: Family Medicine	2017-06-30	Certificate of Completion
Trinity School of Medicine	ECFMG	2013-04-30	MD / ECFMG

This information is accurate as far as is contained in the Division's official records. It does not reflect whether an entity required to maintain a current registration with the Division of Corporations is current in that registration. You can verify such status at <https://secure.utah.gov/bes/bes>. Additionally, this verification does not show a complete license history or interruptions of licensure. Original issue dates listed as 01/01/1910 and 01/01/1911 were unknown at the time the Division implemented its first electronic licensing database.

\*NOTE: The disciplinary documents linked to this website include final orders issued by DOPL, with the exception of citations. [Click here for citations.](#)

### 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

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  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

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  No

If yes, describe your current practice Hospitalist

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

If Yes, Employer name Thomas Hospital

Employer street address 750 Morphy Ave

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

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

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  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  No

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

---

***(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

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

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

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

DocuSigned by:  
Physician's Signature: Christopher Romano DeNapoles  
BD6334321FC94C4...  
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 DeNapoli (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  DocuSigned by:  
BD6334321FC94C4...

Type Applicant's Name Christopher Romano DeNapoles

Applicant's NPI 1578973715

DATE 6/24/2020 | 9:38 CDT

### 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]  
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  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.  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 Completion Date 06/30/2017  
Full Program Name (no abbreviations or acronyms) (mm/dd/yyyy)

What is the specialty of the program Family Medicine

Qualifying Licensing exam taken: USMLE  COMLEX  Other \_\_\_\_\_  
Must specify by name

Number of attempts taken to pass the USMLE:

Step 1: 1 Step 2 CS: 1 Step 2 CK: 2 Step 3: 1

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:  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:  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](http://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 \_\_\_\_\_  
DocuSigned by:  
*Tiffany B. Seamon*

Type Name TITANY 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



# Letter of Qualification

IS THIS A RE-APPLICATION? YES NO

Date 07/24/2020  
mm/dd/yyyy

Name: Christopher Romano DeNapoles

Address: [REDACTED]

CityStZip [REDACTED]

Dear Dr. DeNapoles:

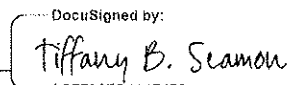
RE: Your application for IMLC Letter of Qualification

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   
Type Name Tiffany B. Seamon

Title of Authorized SPL Director of Credentialing

DATE 7/24/2020 | 3:14 CDT



# MEDICAL LICENSE ISSUANCE INFORMATION

**Physician's Name** Christopher Romano DeNapoles  
First Name Middle Name 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 

Type Name Paulette Richmond

DATE 8/10/2020 | 1:50 CDT



# Alabama Medical Licensure Commission

848 Washington Avenue  
Montgomery, AL 36104

## License Details - MD/DO/L

### Personal Information

Licensee name: Christopher Romano DeNapoles  
Location: Fairhope, Alabama

### License Information

License type: MD  
License status: Active  
COQ status:  
License number: MD.38134  
License description: Full Unrestricted MD  
Issue date: 04/04/2019  
Expiration date: 12/31/2021  
Practice Type: Family Medicine  
School Name: Trinity School of Medicine  
School Dates: 09/09-04/13  
School Location: Kingstown West Indies  
Public file: No

### Alabama Controlled Substances Certificate

Status: Active  
License number: ACSC.38134  
Issue date: 01/01/2020

Expiration date: 12/31/2021  
 Schedules: 2, 2N, 3, 3N, 4, 5  
 Description: Full Unrestricted ACSC  
 Restricted: None  
 Comments:  
 Dispensing physician: No

### **Collaborative Practice Agreement**

<u>Name</u>	<u>Number</u>	<u>Hours</u>	<u>Status</u>
Monica Phillips	CP.22841	0	Terminated
Iesha Shanae Bell	CP.22840	0	Terminated
Sakeena Spencer		40	Withdrawn
Crystal Genika Nwagwu	CP.21938	0	Terminated
Kimkeisha Mitchell Morgan	CP.22572	0	Terminated
Ashley Nicole Wagner	CP.23968	0	Terminated
Deacqueline Lashaun Bell	CP.23706	0	Terminated
Maria Rachuonyo	CP.23614	0	Terminated

### **Registration Agreement Information**

No Registration Agreements found.

Printed from <http://www.albme.org> Present Date 07/07/2021  
 (<http://www.albme.org/>)

\* Please note that the Alabama Board of Medical Examiners and the Alabama Medical Licensure Commission have no authority over Nurse Practitioners or Midwives. For more information on these licenses, please visit the Alabama Board of Nursing, [www.abn.alabama.gov](http://www.abn.alabama.gov)



SPENCER J. COX  
Governor

DEIDRE M.  
HENDERSON  
Lieutenant Governor

State of Utah  
Department of Commerce  
Division of Occupational and Professional Licensing

MARGARET W. BUSSE  
Executive Director

MARK B. STEINAGEL  
Division Director

July 7, 2021

CHRISTOPHER ROMANO DENAPOLES

**SUBJECT: IMLCC MEMBER BOARD LICENSURE**  
**RESPONSE DEADLINE: AUGUST 7, 2021**

Dear Dr. DeNapoles,

The Utah Division of Occupational and Professional Licensing has received an application for Utah IMLC Member Board Licensure. Your license has been issued. You are responsible for complying with Utah statute and regulations associated with your license and the practice of medicine in the state of Utah. Additional documentation is required for your licensure in Utah to remain in compliance.

- **Designation of Contact.** Submit the "Designation of Contact Person for Access to Medical Records" in accordance with Utah code 58-67-302(1)(j) **or** 58-68-302(1)(j). These contacts are for your patients to access their records, the contact information you provide is Public Record. You are welcome to list a medical records department, office administrator, the practice you are currently at or will be at, etc. The form is included for your convenience. Please complete all highlighted portions.
- **Lawful Presence.** Submit a current (non-expired) copy of your driver license or document (front and back) to verify the lawful presence in the United States as required by Utah code 63G-12-402.
- **NPDB Report.** Submit a current National Practitioner Data Bank Report of Action per Utah code R156-67-302a(4) **or** R156-68-302a(4). NPDB website: <http://www.npdb.hrsa.gov>. If the report shows any history of claims/disciplinary action you must submit a narrative in your own words of the event(s) in question. Additional information may be required.

You are responsible to submit all requested materials listed above, **no later than August 7, 2021**. Failure to comply with this request is considered unprofessional conduct and may result in disciplinary action up to and including revocation of licensure.

This is the only notice you will receive.

**Review the Interstate Medical Licensure Compact statute regarding your responsibilities prior to and once you have obtained a state issued IMLC license these can be found in:**

IMLCC Rule Chapter 5 Expedited Licensure Amended November 17 2017

**Response Procedure:**

Please respond by the deadline given above by submitting the item(s) listed above, email address is in signature and is the preferred method of submitting these required documents or you may mail items to the following address:

↓ Division of Occupational and Professional Licensing (DOPL)  
160 East 300 South  
Salt Lake City, Utah 84114-6741

**Failure to Timely Respond:**

If you fail to respond by the deadline given above and later wish to obtain a license, you will be required to submit a new application and comply with the licensing requirements then in effect.

**Presumption a Response is Complete:**

Unless you specify otherwise, the Division will treat any response received from you by the deadline given above as a complete and final response, and may take final action immediately.

**Questions or Request for Additional Information:**

If you have any questions, please email the person who signed this letter, prior to your deadline to respond.

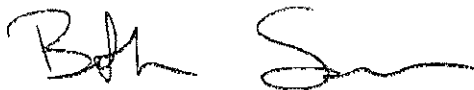
**Due Process after Deadline to Respond:**

You may request agency review of the denial of your incomplete application for licensure, **(1) no later than 30 days after the deadline to correct your incomplete licensure**. If you choose to file a request for agency review, you must adhere to the attached procedures.

**Certificate of Mailing:**

I certify that I properly served this document on the date of the letter by mailing it by first class mail with postage prepaid to the addressee shown above.

Sincerely,



Utah Licensing Specialist  
FOR THE BUREAU MANAGER  
esorenson@utah.gov  
801-530-6222



## INFORMATION ABOUT AGENCY REVIEW

Department of Commerce  
160 East 300 South, Box 146701  
Salt Lake City, UT 84114-6701  
[umedical@utah.gov](mailto:umedical@utah.gov), FAX 801-530-6446

If you have been denied a license, received disciplinary action on your license, lost a citation hearing, or have otherwise been adversely impacted by a decision from one of the Divisions at the Department of Commerce, please be aware that you may request agency review of that decision by the Department's Executive Director. Upon review, the Executive Director could uphold, reverse, or modify the Division's decision, or might return the case to the Division for further consideration.

*If you choose to file a request for agency review, please keep in mind all of the following:*

- **Written Request and Due date:** Your request for agency review ("Request") must be received no later than 30 days from the date of the Division order that you wish reviewed. The Request must be in writing and must be addressed to the Executive Director, Utah Department of Commerce, at the above address.
- **Copy of Order:** You must include with your Request a copy of the letter or order you wish reviewed;
- **Transcript of Hearing:** If a hearing was held in your case, and you are challenging the order on the grounds that the evidence presented at the hearing did not support the order, you must, at your expense, order a transcript of the hearing and file it with the Department. You must also file with the Department your certification verifying that you have ordered a transcript of the proceeding and stating the date by which you expect to file the transcript with this Department. (You may use the form titled "Certification Regarding Transcript," accessed at: <http://www.commerce.utah.gov/agencyrev.html>) For instructions on how to order a transcript, you may contact the hearing officer or administrative law judge who conducted the hearing. However if the hearing involved a DOPL Citation, contact Kim Lesh at (801) 530-6628; if the hearing was before the Division of Real Estate, contact Maelynn Valentine at (801) 530-6750.
- **Memorandum in Support of Your Request:** You may file a memorandum to support your Request. If you are required to file a transcript of the hearing with the Department, your memorandum must be filed no later than fifteen (15) days after the filing of the transcript. Otherwise, your memorandum must be filed at the time you file your Request.
- **Reply Memorandum:** If the Division files a response, you may file a final reply memorandum no later than ten (10) days after service of any response from the Division.
- **Basis for Request:** In order to succeed on agency review, you must be able to show that you were substantially prejudiced as a result of any of the grounds identified in Utah Code Ann. §63G-4-403; and
- **Copies to Division:** You must provide the Division copies of all documents that you file with the Department.

Please note that the Utah Administrative Procedures Act (UAPA), Utah Code Ann. Sections 63G-4-101 *et seq.*, and the Department's UAPA Rules, Utah Admin. Code R151-4-101 *et seq.*, govern requests for agency review. Nothing contained in this document supersedes the referenced statutes and rules. You may access the applicable provisions at your local library or on the Department of Commerce web site:

<http://www.commerce.utah.gov/agencyrev.html>

If you have any questions about how to proceed, you are encouraged to seek legal advice from an attorney. You may contact Masuda Medcalf, Administrative Law Judge, at (801) 530-7663, with any technical or procedural questions, but the merits of the case cannot be discussed.

Revision Date: April 14, 2020



Physician Name Chris DeNapoles MD

Utah License Number 12382109-1205

**DESIGNATION OF CONTACT PERSON FOR ACCESS TO MEDICAL RECORDS**

You must provide both a primary and alternate contact person for access to medical records. *This information is considered public information.*

Primary Contact: Olive Branch Medical Records Telephone: 850-898-8000

Address: 8325 University Pkwy Pensacola, FL 32514  
Street Address (including Apt/Unit/Ste #) and/or PO Box City State Zip

Alternate Contact: Director of Nursing: Lisa Gonzalez Telephone: 850-898-8000

Address: 8325 University Pkwy Pensacola, FL 32514  
Street Address (including Apt/Unit/Ste #) and/or PO Box City State Zip

**Note:** *If a hospital, clinic or other facility is the owner of your patient's medical records, the facility's records department may be listed as the primary contact. All applicants must still list a second, unique contact.*

Please identify the method of notifying patients of location of records (check all that apply). If listing email, please provide an email that the patient will receive information from:

Phone  Mail  In Person  Other: \_\_\_\_\_

Driver License or State ID Card: \_\_\_\_\_  
State of Issue License Number Expiration Date

# Florida

## DRIVER LICENSE



9 CLASS E



4D DLN [REDACTED]

1 DENAPOLES  
2 CHRISTOPHER ROMANC

5 [REDACTED]

3 DOB [REDACTED] 15 SEX M SAFE DRIVER

4D EXP 01/02/2026 16 HGT 5'-09"

12 REST NONE 9a END NONE

4a ISS 08/21/2017

5DD X631805200833

REPLACED 05/29/2018

Operation of a motor vehicle constitutes consent to any sobriety test required by law.



*Chris Romanc*