1-26-95 ATTACH PHOTO HERE
PHOTO MUST BE TAKEN WITHIN 30 DAYS PRECEDING DATE OF APPLICATION

THE AGENCY FOR HEALTH CARE ADMINISTRATION
BOARD OF MEDICINE
Northwood Centre
[redacted]
Tallahassee, Florida [redacted]
[redacted]

1 APPLICATION METHOD (CHECK ONLY ONE):

a EXAMINATION (Application Fee $410/Exam Fee $675)
Total $1010 ___X___ MALE/SPEX

b ENDORSEMENT (APPLICATION FEE $660)
Total $660 _____ ENDR

APPLICATION FEES ARE NON-REFUNDABLE

APPLICATION SHOULD BE TYPED

2 SOCIAL SECURITY NUMBER: [redacted]

3 NAME: Patrick (FIRST) Joseph (MIDDLE) Kelly (LAST)

4 MAILING ADDRESS: 205 Cherry Street (STREET AND NUMBER) Neptune Beach (CITY) Florida (STATE) 32266 (ZIP)

PERMANENT ADDRESS: Same (STREET AND NUMBER) (CITY) (STATE) (ZIP)

5 PLACE OF BIRTH Des Moines (CITY) Iowa (STATE) USA (COUNTRY) DATE OF BIRTH 09/02/63 (MO) (DAY) (YEAR)

6 TELEPHONE: 904-241-3591 RESIDENCE 904-549-3112 OFFICE NUMBER

7 Have you ever legally CHANGED YOUR NAME? Yes ___ No X

8 DOCTOR OF MEDICINE DEGREE WAS [illegible]NED FROM: University Texas Southwestern Medical (Medical School)

Dallas, Texas (Location) on June 6, 1994 (Month) (Day) (Year)

9 Are you or have you ever held any professional/medical license in any State in the U.S., to include Canada, Guam, Puerto Rico or U.S. Virgin Islands? Yes ___ No X

(If yes, list profession(s), state(s), license number(s) and date(s) of issuance.)

(If yes, list profession(s), state(s), license number(s) and date(s) of issuance.)

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian X Black ___ Hispanic ___ Oriental ___ Native American ___ Other ___
SEX: Male X Female ___

CATEGORY: 02246	EXAM SITE	Rev. Code 1510 AHCA/ME/001 [illegible]:07/94
SCHOOL CODE: [illegible]	EXAM DATE [illegible]	AHCA/ME/031/1-90, Rev 07/94
EDUCATION: 06	EXAM CODE	
CANDIDATE #:		

10

UNDERGRADUATE/GRADUATE EDUCATION

NAME COLLEGE/UNIVERSITY	CITY/STATE/COUNTRY	FROM:	TO:	MAJOR/MINOR COURSE OF STUDY	DID YOU GRADUATE	DEGREE RECEIVED
University of Iowa	Iowa City,IA	8/81	12/85	Microbiology Psychiatry	Yes	B.S.
University of Texas Biomedical Science	Dallas, TX	6/87	6/93	Microbiology	Yes	M.A.

11

PROFESSIONAL/MEDICAL EDUCATION: e.g. JD, Ed.D., Ph.D., RN, PA, MD, DO, DDS, DC, etc.

Did you receive advanced standing into Medical School? Yes ____ No _X_.

If "yes" explain: _____

Was attendance in Medical School for a period other than the normal curriculum? Yes ____ No _X_.

If "yes" explain: _____

NAME SCHOOL/UNIVERSITY	ADDRESS & CITY/STATE/COUNTRY	FROM:	TO:	DOMICILE ADDRESS & CITY/STATE/COUNTRY	DID YOU GRADUATE	DEGREE RECEIVED
University Texas Southwestern	5323 Harry Hines Dallas, Tx USA	6/91	6/94	Dallas,Tx USA	YES	M.D.

All applicants must complete questions 15 through 44:

15

PROFESSIONAL/POSTGRADUATE TRAINING -
List all professional/postgraduate training program(s) began, whether completed or not.

During any postgraduate training were you ever on probation, restriction, suspension, revocation, modification, or otherwise acted against (explain "otherwise" actions)? Yes ____ No X.

If "YES", list name(s) and address(es) of postgraduate training institution(s)

If "YES", list name(s) and address(es) of hospital(s)

If "yes" explain

List in chronological order from date of graduation from medical school all professional/postgraduate training (Internship, Residency, Fellowship) to the present.

Program(Internship/Residency/Fellowship) Address	Domicile/Where Lived	MONTH/YEAR FROM		TO	
University of Florida Health Science Center & Jacksonville	205 Cherry St. Neptune Bch., Fl. 32266	7	94	present	
253 W. 8th St. Jacksonville, Fl.					

16

PRACTICE/EMPLOYMENT - List in chronological order from date of graduation to present date, all practice employment and/or unaccounted periods of time.

(Type of Practice and/or Employment)	Name and Address (Street number, City, State, Territory, Country) of Employment and/or Practice Setting	MONTH/YEAR FROM		TO	
"Up With People" musical org.	traveled USA continuously	12	85	6	86
Biomedical research @ U.T. Southwestern Medical Center	Continuous research in Dallas, Texas	6	86	8	90
1 month between medical school graduation and residency	moved to Jacksonville, Fl	6	94	7	94

17

STAFF PRIVILEGES -

Have you ever been denied any staff privileges? Yes ____ No _x_.

_____

If "YES", list name(s) and address(es) of hospital(s)

_____

If "YES", list name(s) and address(es) of hospital(s)

Have you ever been asked to or allowed to resign from any hospital, institution, clinic or medical facility in lieu of disciplinary action? Yes ____ No _x_.

_____

If "YES", please explain and list name(s) and address(es) of practice setting.

_____

If "YES", please explain and list name(s) and address(es) of practice setting.

Have you ever had any staff privileges suspended, revoked, modified, restricted, placed on probation, asked to resign or asked to take a temporary leave of absence or otherwise acted against (explain "otherwise" actions)? Yes ____ No _x_.

_____

If "YES", list name(s) and address(es) of hospital(s)

_____

If "YES", list name(s) and address(es) of hospital(s)

Have you ever been asked, or allowed to resign from any hospital, institution, clinic or medical facility in lieu of disciplinary action or during any pending investigations into your practice? Yes ____ No _x_.

_____

If "YES", please explain and list name(s) and address(es) of practice setting from which you resigned.

_____

If "YES", please explain and list name(s) and address(es) of practice setting from which you resigned.

List any hospital(s) where you have staff privileges (Do Not List Training Privileges).

(Name of Hospital)	Address (City/State/Zip)	MONTH/YEAR	
		FROM	TO

18

MEDICAL AFFILIATIONS

Have you ever had an application for membership rejected for medical society membership? Yes ____ No _X_.

If "yes" explain: _____

Have you ever had a medical society membership suspended? Yes ____ No _X_.

If "yes" explain: _____

Have you ever been notified to appear before a medical society in regard to charges/complaints filed against you? Yes ____ No X_.

_____

IF "YES", GIVE NAME(S) AND ADDRESS(ES) OF MEDICAL SOCIETY.

_____

IF "YES", GIVE NAME(S) AND ADDRESS(ES) OF MEDICAL SOCIETY.

LIST MEDICAL AFFILIATIONS: State, county, national, including date(s) and complete address (street, city, state)

American College OB/GYN 409 12th St. Washington, D.C. 20024-2188 1994

American Medical Association 1990 to present

American Academy of Family Physicians P.O.BOx 0723 Kansas City Mo. 1990 to present

19 IF FOREIGN BORN, give date and place of Naturalization: _____

20 Are you a citizen of the United States? Yes _X_ No ____.

21 Have you ever been in the United States Military and/or Public Health Service? Yes ____ No _X_.

_____

(IF "YES" LIST BRANCH OF SERVICE, RANK, DATES OF SERVICE > > >ENCLOSE COPY OF DISCHARGE FORM)

22 Are you a diplomate of the National Board of Medical Examiners? Yes ____ No _X_.

a. If "yes", state date of certification _____

23 Have you ever failed State Board/FLEX/National Board/USMLE Examination? Yes ____ No _X_.

24 Are you certified by an American Specialty Board? Yes ____ No _X_.

a. If "yes", List name of Board(s)_____

(ENCLOSE COPY OF BOARD CERTIFICATE OR LETTER VERIFYING ELIGIBILITY)

25 Have you ever studied to become, or do you hold any other professional license in any state, e.g. JD, Ed.D., Ph.D., RN, PA, DO, DDS, DC, etc.? Yes ____ No _X_.

26 Have you had any application for professional license or any application to practice medicine/surgery denied by any state board or other governmental agency of any state or country? Yes ____ No _X_.

If "yes" explain: _____

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

If "yes" explain: _____

28 Have you ever had any professional license or license to practice medicine/surgery revoked, suspended, or other disciplinary action taken in any state, territory or country? Yes ____ No x.

If "yes" explain: _____

29 Regardless of adjudication have you ever been convicted of a violation of, or pled Nolo Contendere, to, any Federal, State, Local statute, regulation or ordinance, or entered into any plea or bargain relating to a misdemeanor or felony? Yes x No ____.

If "yes" explain: March 1984 Misdemeanor - purchased and resold stolen radar detector. Plead guilty

30 Have any actions in bankruptcy court or any civil judgments ever been entered against you? Yes ____ No x.

If "yes" explain: _____

31 Have you ever been sued for malpractice? Yes ____ No x.

If "yes" explain: _____

32 Have you ever discontinued practice for any reason for a period of one month or longer? Yes ____ No x.

If "yes" explain: _____

33 Do you have a chronic medical illness or any medical condition that might affect your ability to practice your profession?

If "yes" explain: _____

34 Have you ever been emotionally/mentally ill?

If "yes" explain: _____

35 Have you ever received psychotherapy?

If "yes" explain: _____

36 Have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or any other medication?

If "yes" explain: _____

37 Have you ever voluntarily or otherwise been a patient in a hospital, institution, clinic or medical facility for the treatment of mental/emotional illness, drug addiction/abuse, or excessive use of alcohol?

If "yes" explain: _____

38 Have you ever been warned or called before the Drug Enforcement Agency (DEA)? Yes ____ No x.

If "yes" explain: _____

43 PERSONAL DATA:

DATE: 1/24/95 — COLOR OF EYES: hazel

AGE: 31 — COLOR OF HAIR: brown

HEIGHT: 5'8" — WEIGHT: 180 lbs.

OTHER MEANS OF IDENTIFICATION: _____

44 AFFIDAVIT OF APPLICANT

I, Patrick Joseph Kelly, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents, and that the attached photograph is a true likeness of myself.
I hereby authorize all hospital(s), institution(s) or organization(s), my references, personal physicians, employers, (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Medicine any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/surgery in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(specification of date, event or condition upon which this consent expires)

_____

(Signature of Applicant)

The foregoing instrument was acknowledged before me this 24th day of January, 19 95, by

Patrick Joseph Kelly, who is personally known to me or who has

produced _____ as identification and did did not take an oath.

_____ Commission No. 078046

Signature of Notary

My Commission Expires:

Notary Public, State of Florida
My Commission Expires: Feb. 11, 1997

Sharon K. Johnson

Name of Notary Typed, Printed or Stamped

8541

Attention Notary: Although the information requested below is OPTIONAL, it could prevent fraudulent attachment of this certificate to an unauthorized document.

THIS CERTIFICATE MUST BE ATTACHED TO THE DOCUMENT DESCRIBED AT RIGHT:

Title or Type of Document Application for Medical Licensure-Florida

Number of Pages _____ Date of Document _____

Signer(s) Other than Names Above _____