012691

NEW MEXICO BOARD OF MEDICAL EXAMINERS
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe New Mexico 87501

STAFF USE ONLY
AMT. $ 60

RECEIVED
SEP 25 2001
NM BOARD OF MEDICAL EXAMINERS

GARY E. JOHNSON
GOVERNOR

JOHN S. ROMINE, M.D.
PRESIDENT

NOVEMBER 16, 2001 ORIENTATION
Initial License Registration Form

Return by ~~October 16, 2001~~ in order to receive your annual registration and your original wall certificate at orientation. You may not practice medicine in New Mexico until your permanent license has been issued and registered. To register your license you must complete this form and pay a pro-rated fee of **$60.00**. You are required to furnish the Board with a location of your business address. *A post office box alone is not acceptable*. All blanks must contain a response before your form will be processed.

DEA #: BM2990073 INTERIM #: 162

NAME: LAWRENCE W MILLER, M.D.

THIS IS HOW NAME WILL APPEAR ON YOUR LICENSE

BUSINESS ADDRESS: 8184 THACKERAY CT

CITY/ST/ZIP: BROADVIEW HEIGHTS, OH 44147-

BUSINESS PHONE: [redacted]5596

HOME ADDRESS: [redacted]

CITY/ST/ZIP: BROADVIEW HEIGHTS, OH 44147-

HOME PHONE: [redacted]-5596

SPECIALTY: OBSTETRICS AND GYNECOLOGY, MEDICAL MANAGEMENT

List any additional hospitals where you have been granted privileges:

1. _____ 2. _____

List any other state medical licenses you have acquired **since your interview with the New Mexico Board of Medical Examiners.**

STATE: _____ LIC# _____ STATE: _____ LIC# _____

Since your interview with the New Mexico Board, have you been convicted of a felony or had any action against any medical license you hold? ☒ NO ☐ YES (If yes, attach explanation)

☒ I have enclosed the fee for **$60.00**, to register my NM license to attend the **November 16, 2001 Orientation.**

I verify that all above information is true and accurate on this date.

Signature: Lawrence W Miller MD Date: 9/16/01
(Must be signed by physician)

ADMINISTRATION
(505) 827-5022
(505) 827-7377 FACSIMILE

FINANCIAL
(505) 827-6759
(505) 827-4052

INVESTIGATIONS
(505) 827-8491
(505) 827-7362

LICENSING
(505) 827-9933 APPLICATION
(505) 827-7317 PHYSICIANASSISTANT
(505) 827-6784 VERIFICATION

COMMUNITY
Health Partners
3700 Kolbe Road
Lorain, Ohio 44053-1697
(440) 960-4000

TELEFAX TRANSMITTAL FORM

DATE: 6/14/01

TIME: 0710 hr.

TO: Innella FAX # 505-827-7377

LOCATION: New Mexico Board of Medical Examiners

FROM: Lawrence W Miller MD FAX #

RE: New Mexico medical license

MESSAGE: As requested for my application - copies of my medical specialty board certificates - these were notarized 8/99 Please let me know if these are not OK. - Thanks

NUMBER OF PAGES TO FOLLOW: 2

ATTENTION: This document is intended only for the individual to whom it is addressed. It contains information that may be confidential. If you are not the intended recipient, you are hereby notified not to read, copy, or distribute. If you have received this information in error, please notify the sender at the phone number below.

NOTE: If the indicated number of pages is not received or is illegible, please phone (440) 915-1734 as soon as possible.

X-5-963-037-0298

American Board of Obstetrics and Gynecology

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL SOCIETY
AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS
SECTION ON OBSTETRICS AND GYNECOLOGY, AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY-OBSTETRICS
CERTIFIES THAT

LAWRENCE W. MILLER

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC. HE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT HE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HIS PROFICIENCY IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED AND HE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD

NOVEMBER 11, 1977

Frederick P Moore
Frederick P Thompson
C A Hunter, Jr
C C Thiede
Paul W Brown
William J Dignan

Leo J Dunn
Albert B Hebra
I Terry Hayashi
C Lee H Wendel
Brian Little

Jerry A Merrill — SECRETARY AND TREASURER
John Vard Mack
E J Quilligan
Henry C Taylor

Gaston W Taylor — PRESIDENT OF THE BOARD

Subscribed and sworn to before me this 5th day of August, 1999, by Lawrence Whitfield Miller M.D.

ROSE E. BARTHOLOMEW
Notary Public, State of Ohio, Summit Cty.
My Commission Expires April 25, 2001

true copy of the original certificate.

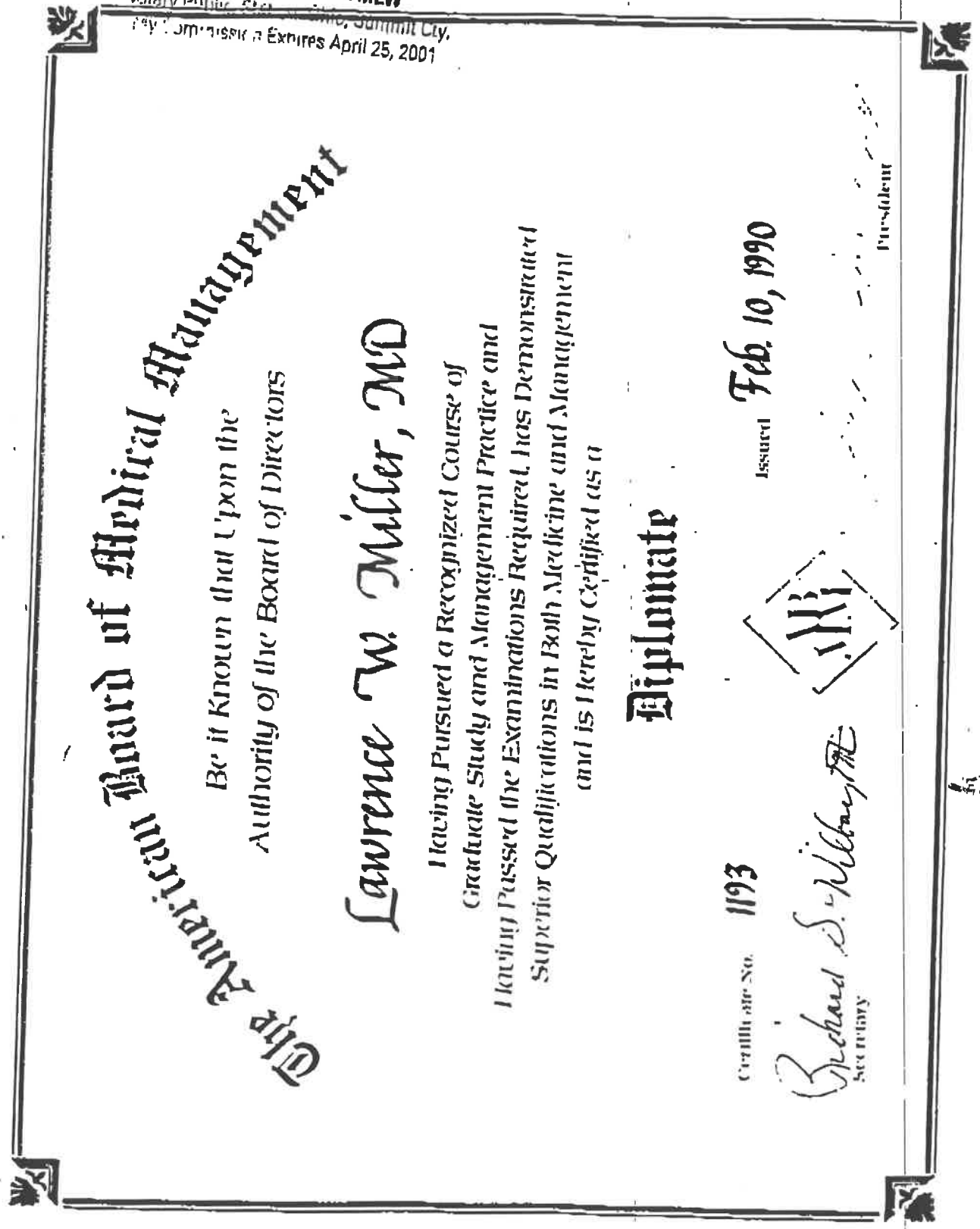
true copy of the original certificate.

Lawrence Whitfield Miller, M.D.

Subscribed and sworn to before me this 5th day of August, 1999, by Lawrence Whitfield Miller, M.D.

Rose C. Bartholomew

ROSE C. BARTHOLOMEW
Notary Public, State of Utah, Summit Cty.
My Commission Expires April 25, 2001



New Mexico Board of Medical Examiners

Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501

RECEIVED
FEB 12 2001
NM BOARD OF MEDICAL EXAMINERS

NMBME Office Use Only:
NM USMLE Exam ☐ Yes ☐ No
Fee Received: 350

000044

1 BIOGRAPHIC INFORMATION

Name: MILLER (Last) LAWRENCE (First) W. (MI) ____ (Maiden)

Address: [redacted] (Number and Street)

BROADVIEW HEIGHTS (City) OH (State) 44147 (Zip/Postal Code)

Office Telephone: (216) 265-4426 Home Telephone [redacted] - 5596

DEA Number: [redacted] 0073 Social Security Number: [redacted] - 5726

Date of Birth: [redacted] (Month Day) / 1942 (Year) US Citizenship: ☒ By Birth ☐ By Naturalization: Certificate #: ____

If you are not a U.S. citizen, what is your current U.S. Immigration status? ____

Have you ever served in the Armed Forces? ☒ Yes ☐ No (If "Yes," you must submit a notarized copy of discharge or separation papers.)

If so, what service? ARMY Dates: 8/68 to PRESENT

If you have served in/or been employed by any of the following as a physician, please indicate dates (MM/YY):

☒ Department of Defense (Including Armed Forces) 8/68 to PRESENT
☐ Indian Health Service ____ to ____
☐ Veterans Administration ____ to ____
☐ Public Health Service ____ to ____
☐ Nat. Health Service Corps ____ to ____

2 AFFIDAVIT OF APPLICANT

Being duly sworn, I depose and say that I am the person described and identified in this application, and that the photograph affixed below is a true likeness of myself and was taken within six months of the date of this application. I have carefully read the questions in this application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that all answers, statements and documents submitted herein and throughout the application process are true and correct.

Lawrence W Miller MD (Signature of Applicant) 9/11/00 (Date of Signature)

County of Cuyahoga)
State of Ohio)

SUBSCRIBED AND SWORN TO before me on: 9 / 11 / 00 (Month / Day / Year)

My commission expires: 4 / 25 / 01 (Month / Day / Year)

Signature of Notary Public: Rose B. Bartholomew
ROSE B. BARTHOLOMEW
Notary Public, State of Ohio, Summit Cty.
My Commission Expires April 25, 2001

3 SPECIALTY AND SPECIALTY BOARD CERTIFICATION

List all specialities and speciality board certification.

Specialty	Board Certified?	Date Certified (MM/DD/YY)
OB-GYN	☒ Yes ☐ No	11 11 77
MEDICAL MANAGEMENT	☒ Yes ☐ No	021090
	☐ Yes ☐ No	
	☐ Yes ☐ No	

4 LICENSURE

List all states or provinces in which you have held or now hold a license or permit to practice medicine.

State/Province	License Number	Date Issued (MM/DD/YY)	Current?
OHIO	35-06-9090-m	09/08/95	☒ Yes ☐ No
So. CAROLINA	15742	10/28/91	☒ Yes ☐ No
CONNECTICUT	017163	4/4/75	☐ Yes ☒ No
CALIFORNIA	G15106	8/1/68	☒ Yes ☐ No
No. CAROLINA	17443	9/21/91	☐ Yes ☒ No
			☐ Yes ☐ No

5 COMPLETE WORK HISTORY

List all hospital staffs/managed care affiliations after the M.D. degree in chronological order, including postgraduate training. All gaps in time must be explained on a separate page. (Continued on next page.)

SEE C.V. ATTACHED - FACULTY, ADMIN., TEACHING, CLINICAL WORK LIST

Dates (MM/YY - MM/YY) Name of Hospital/Affiliation

Address City/State/Zip

Dates (MM/YY - MM/YY) Name of Hospital/Affiliation

Address City/State/Zip

Dates (MM/YY - MM/YY) Name of Hospital/Affiliation

Address City/State/Zip

Dates (MM/YY - MM/YY) Name of Hospital/Affiliation

Address City/State/Zip

Dates (MM/YY - MM/YY) Name of Hospital/Affiliation

Address City/State/Zip

5 COMPLETE WORK HISTORY (continued)

Dates (MM/YY - MM/YY) Name of Hospital/Affiliation

Address City/State/Zip

Dates (MM/YY - MM/YY) Name of Hospital/Affiliation

Address City/State/Zip

Dates (MM/YY - MM/YY) Name of Hospital/Affiliation

Address City/State/Zip

Dates (MM/YY - MM/YY) Name of Hospital/Affiliation

Address City/State/Zip

6 QUESTIONS

1. Have you during the past five (5) years been treated for mental illness? Hospitalized for mental illness? [redacted]
2. Do you have a physical impairment that would affect your ability to practice medicine? [redacted]
3. Have you ever been denied a license by or withdrawn an application for a license from a state licensing board? ☐ Yes ☒ No
4. Has any state licensing board started disciplinary action against your license? ☐ Yes ☒ No
5. Have you ever resigned or withdrawn your application from a hospital staff or professional medical group? ☐ Yes ☒ No
6. Have your hospital privileges ever been revoked or withdrawn for any reason? ☐ Yes ☒ No
7. Has disciplinary action ever been started against you by a hospital staff, county medical society, HMO, PPO, IPA or PRO? ☐ Yes ☒ No
8. Have you surrendered hospital privileges after disciplinary cases or investigations were started? ☐ Yes ☒ No
9. Have you, during the past five (5) years, had personal or legal problems with narcotics, alcohol or other dangerous drugs? [redacted]
10. Have you ever been charged with a violation of a federal, state or local statute? ☐ Yes ☒ No
11. Have you had a malpractice settlement or judgement against you? ☐ Yes ☒ No
12. Do you have any malpractice or medically related claims or lawsuits pending against you? ☒ Yes ☐ No

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, YOU MUST SUBMIT A WRITTEN EXPLANATION ON A SEPARATE PAGE.

Curriculum Vitae

Name: **Lawrence W. Miller, M.D.** June 23, 1999

Home Address: [redacted] Telephone [redacted]5596
Broadview Heights, OH 44147

Office Address: 12301 Snow Road Telephone (216) 265-4426
Parma, OH 44140

Soc. Sec#: 040-34-5726

EDUCATION

1959 to 1963	A.B. Bowdoin College, Brunswick, ME.
1963 to 1967	M.D. Boston University School of Medicine, Boston, MA.
1967 to 1968	Intern, L.A. County, University of Southern California Medical Center, Los Angeles, CA.
1971 to 1975	Resident Women's Hospital, L.A. County, University of Southern California Medical Center, Los Angeles, CA.
1985 to 1986	United States Army Command & General Staff School, Fort Leavenworth, KA.

SPECIALTY CERTIFICATION

American Board of Obstetrics & Gynecology
American Board of Medical Management

LICENSURE South Carolina, North Carolina, Connecticut, California,, Ohio

MILITARY SERVICE

1968 to 1971 and 1981 to 1991 - Active Duty, U.S. Army
1993 to Present - National Guard, U.S. Army

FACULTY APPOINTMENTS

July 1, 1976 to June 30, 1981
Assistant Clinical Professor
Department of OB/GYN
University of Connecticut Medical Center
Farmington, Connecticut

January 1, 1992 to October 1, 1995
Department of OB/GYN
Spartanburg Regional Medical Center
Spartanburg, South Carolina

November 1, 1993 to October 1, 1995
Clinical Assistant Professor of Obstetrics & Gynecology
Medical University of South Carolina
Charleston, South Carolina

HOSPITAL APPOINTMENT

1968 to 1971	Clinical Staff 130 General Hospital Nurenberg, Germany	
1975 to 1981	Clinical Staff Hartford Hospital Hartford, Connecticut	
1976 to 1981	Clinical Staff Department of OB/GYN	John Dempsey Hospital University of Connecticut Medical Center Farmington, Connecticut
1982 to 1983	Assistant Chief Department of OB/GYN	97 General Hospital Frankfurt, Germany
1991	Chief Department of OB/GYN	Womack Army Hospital Ft. Bragg, North Carolina
1992 to 1995	Clinical Staff Department of OB/GYN	Spartanburg Regional Medical Center Mary Black Memorial Hospital Spartanburg, South Carolina
1995 to Present	Clinical Staff Department of OB/GYN	Cleveland Clinic Foundation Cleveland, Ohio

ADMINISTRATIVE APPOINTMENTS

1968 to 1970	Squadron Surgeon	2D. Squadron, 4th Cavalry - U.S. Army Schwabach,, Germany
1983 to 1985	Division Surgeon	3D Armored Division - U.S. Armv Frankfurt, Germany
1985 to 1986	Class President	U.S. Army Command and General Staff School Ft. Leavenworth, Kansas
1986 to 1987	Deputy Commander Clinical Services	Cutler Army Hospital Ft. Devens, Massachusetts
1987 to 1990	Commander	Cutler Army Hospital Ft. Devens, Massachusetts
1990	Corps Surgeon	18th Airborne Corps Ft. Bragg, North Carolina
1995 to 1998	Chief Of Professional Services	112th Medical Brigade Ohio Army National Guard

MEMBERSHIP IN PROFESSIONAL SOCIETIES

American College of Obstetrics and Gynecology - Fellow
American Medical Association

MAJOR TEACHING RESPONSIBILITIES

1992 to 1995	Clinical Supervision - Medical University of South Carolina Resident in OB/GYN Spartanburg Regional Medical Center
1992 - 1995	Clinical Supervision & Didactic Instruction OB/GYN - Family Medicine Residency Program, Spartanburg Regional Medical Center
1992 to 1995	Clinical Supervision/Consultant in OB/GYN - Nurse Midwives and Nurse Practitioners, Spartanburg Regional Medical Center
1976 - 1981	Assistant Clinical Professor, Department of OB/GYN University of Connecticut Medical Center

MAJOR CLINICAL INTERESTS AND RESPONSIBILITIES

Operative Hysteroscopy
Gynecologic Surgery
Laparo/Endoscopic Surgery
Perimenopausal and Menopausal Counseling and Management

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501
(505) 827-5022

AUTHORIZATION FOR RELEASE OF INFORMATION

The Board requires this form to be completed by the applicant in order to allow the Board to make inquiries into the background and/or qualifications of the applicant.

I hereby authorize the New Mexico Board of Medical Examiners (Board) to obtain information in licensure and investigative files, favorable or otherwise. I also authorize all hospitals, medical institutions or organizations, references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Board any information, files or records required by the Board for its evaluation of my professional and ethical qualifications for licensure in the State of New Mexico.

I extend absolute immunity to, and release, discharge and hold harmless from any and all liability: the Board, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board.

Lawrence W Miller MD — 9/24/00
Signature — Date

LAWRENCE W. MILLER MD
Printed Name

8184 THACKERAY COURT
Address (Number and Street)

BROADVIEW HEIGHTS, OHIO — 44147
City — State — Zipcode

(216) 265-4426 — (440) 526-5596
Office Telephone — Home Telephone

South Carolina Medical Malpractice
PATIENTS' COMPENSATION FUND
POST OFFICE BOX 210738
COLUMBIA, SOUTH CAROLINA 29221-0738
Ph. 803-731-1687 • Fax 803-731-1691

Edward W. Catalano, Jr., M.D.
Chairman of the Board

August 7, 2000

Lawrence Miller M.D.
12301 Snow Road
Parma Ohio 44130

Re: Lawrence Miller M.D.
Cert# 018870

Dear Dr Miller:

This will Acknowledge your Request of 8-1-00 for Claims History while a member of the PCF, under the Above Certificate Number.
There is no Record of Any Claim, open or Paid with the PCF.
We Trust this is the information you Need.

Yours Truly!
Joe McConkey
Credentialing Coordinator.

SUPPLEMENTAL EXPLANATION SHEET

R[redacted] AND M[redacted] A[redacted] v. LAWRENCE W. MILLER, MD. et al.

PAGE 8

#10 J.U.A. FILE # [redacted]4951 and 4952

a. NEGLIGENT CARE OF PREGNANCY AND LABOR RESULTING IN FETAL DEMISE, AND FAMILIAL PAIN AND SUFFERING

b. SUIT FILED 12/15/94 - SOUTH CAROLINA

c. CASE IS STILL ~~OPEN~~ closed - REQUEST FOR SUMMARY JUDGEMENT TO DROP MY NAME IS PENDING. - see PCF file

d. R[redacted] A[redacted] WAS A HOSPITAL "STAFF" (RESIDENT MANAGED) OB PATIENT SCHEDULED FOR A CAESAREAN SECTION ON THE MORNING AFTER SHE WAS ADMITTED FOR SPONTANEOUS EARLY LABOR. INJECTIONS OF VARIOUS MEDICATIONS WERE GIVEN DURING THE NIGHT BY THE OB SENIOR RESIDENT IN AN ATTEMPT TO AVOID A CAESAREAN BY HIM DURING THE NIGHT. DURING THE NIGHT THE INFANT DIED IN-UTERO. AN EMERGENCY CAESAREAN WAS THEN DONE BY A HOSPITAL EMPLOYEE PHYSICIAN - BUT DELIVERED A STILLBORN INFANT.

ALL "STAFF" PATIENTS MUST HAVE AN ATTENDING PHYSICIAN - NOT A RESIDENT - LISTED AS THE ADMITTING PHYSICIAN OF RECORD. THE DAILY BASIS. MY NAME WAS ASSIGNED TO THIS CASE. I NEVER SAW THE PATIENT ANTEPARTUM, DURING LABOR, OR POST-PARTUM. I WAS NEVER INFORMED OR CONSULTED ABOUT HER MANAGEMENT. BECAUSE MY NAME WAS LISTED AS THE ADMITTING PHYSICIAN, THE LAWYER SUED ME. MY ATTORNEY, MR. G. DEWEY OXNER JR., ADVISES ME THAT NO PATIENT - PHYSICIAN RELATIONSHIP EXISTED. HE FILED FOR SUMMARY JUDGEMENT TO DROP ME FROM THE SUIT. I HAVE BEEN TOLD THAT THE HOSPITAL - WHOSE EMPLOYEES DID CARE FOR THE PATIENT - PLANS TO SETTLE THIS CASE OUT OF COURT. SEE ATTACHED CORRESPONENCE FROM MR. OXNER.

PAGE 8
#10

SUPPLEMENTAL EXPLANATION SHEET

S[redacted] J[redacted], GUARDIAN AD LITEM FOR K[redacted] J[redacted]
V. LAWRENCE W. MILLER, M.D. et al

J.U.A. FILE # [redacted]5290

a. NEGLIGENT CARE OF PREGNANCY AND LABOR RESULTING IN PERMANENT, SEVERE INJURY FROM PROLONGED ASPHYXIA DURING LABOR

b. SUIT FILED 7/7/95 - SOUTH CAROLINA

c. CASE IS ~~STILL OPEN~~ closed - see PCF file - MY ATTORNEY, MR. G. DEWEY OXNER, JR., IS REQUESTING SUMMARY JUDGEMENT TO DROP MY NAME.

d. S[redacted] J[redacted] WAS A HOSPITAL "STAFF" (RESIDENT MANAGED) OB PATIENT WHO WAS ADMITTED POST-DATES FOR LABOR. DURING THE COURSE OF HER LABOR THERE WERE SIGNS OF POSSIBLE ASPHYXIA. SHE WAS MANAGED BY THE RESIDENTS AND A FULL-TIME HOSPITAL FACULTY OB PHYSICIAN. AT EVENTUAL DELIVERY, THE INFANT WAS SEVERELY DEPRESSED AND CORD ARTERY BLOOD GASSES SHOWED SEVERE ASPHYXIA-RELATED VALUES. THE INFANT HAS PERMANENT NEUROLOGIC DEFICIT.

ALL "STAFF" PATIENTS MUST HAVE AN ATTENDING PHYSICIAN - NOT A RESIDENT - LISTED AS THE ADMITTING PHYSICIAN OF RECORD. THE NAME OF MY NAME WAS ASSIGNED TO THIS CASE. I NEVER SAW THE PATIENT ANTEPARTUM, DURING LABOR, OR POST-PARTUM. I WAS NEVER INFORMED OR CONSULTED ABOUT HER MANAGEMENT. BECAUSE MY NAME WAS LISTED AS THE ADMITTING PHYSICIAN, THE LAWYER CHOSE TO SUE ME. MY ATTORNEY, MR. OXNER, ADVISES ME THAT NO PATIENT - PHYSICIAN RELATIONSHIP EXISTED. HE HAS TOLD ME THAT HE IS FILING FOR JUDICIAL SUMMARY JUDGEMENT TO REMOVE MY NAME FROM THIS CASE

OPMG Liability History

Provider: Miller, Lawrence, M.D. OB/GYN
Hire Date: 10/02/1995
Term Date:
Liability History: YES

CLAIMANT	DESCRIPTION	FILE DATE	PENDING	DISPOSITION	I	DATE REFILED	REFILE DATE
B[redacted]	Laceration of uterus during delivery; TAH performed.	12/07/1998	NO	Vol Dismissal		6/2000	
K[redacted], MINOR	Child sustained a severe injury to her right brachial plexus at time of delivery.	12/21/1999	YES				
F[redacted]	Alleged failure to f/u on abnormal pap.	07/22/1998	YES				

SUPPI MENTAL CLAIM INFC MATION

Please supply the following information regarding any instance of claim, suit or incident which may give rise to a claim whether dismissed, settled out of court, judgement or pending. Answer all questions completely. This form should be photocopied and filled out separately for each claim. Please type or print clearly.

Applicant (Defendant's) name: LAWRENCE MILLER, M.D. et al

Claimant (Plaintiff's) name: [redacted]

Date of alleged error: 24 JULY 1997 Date of Claim: 12/7/98

Indicate whether: X Claim ___ Suit or ___ Incident that has been reported to your insurance carrier

Name of Insurer: KAISER PERMANENTE Agent: PATRICIA SCHENK Phone: (216) 479-5487

Location of court where original complaint was filed: CUYAHOGA COUNTY, OHIO

Case #: 371420

Defendant's Legal Representative: (include name, address and telephone #) WILLIAM A. MEADOW, REMINGER & REMINGER, THE 113TH ST. CLAIR BLDG. CLEVELAND, OHIO 44114 (216) 687-1311

Plaintiff's Legal Representative: (include name, address and telephone #) PAMELA PANTAGES, 159 S. MAIN ST. SUITE 820, AKRON, OH. 44308 (330) 376-6766

STATUS OF COMPLAINT

If closed please indicate:

___ Court Judgement — Finding for: YOU ___ PLAINTIFF ___ Date: ___/___/___

Determined by: JUDGE ___ JURY ___

___ Out-of-Court Settlement — Date of Settlement: ___/___/___

Amount paid on your behalf: $ ___

Compensation: $ ___ Punitive: $ ___

Total Settlement amount: $ ___

X Case Dismissed: Against YOU X Against ALL DEFENDANTS ___ Date: 2/16/00

If pending please indicate: Claimant's settlement demand: $[redacted] Defendant's offer for settlement: $ ___

Insurer's loss reserve: $ ___ Defense reserve: $ ___ Deductible: $ ___

Claim in suit ___ Yes ___ No If Yes, amount asked in summons: $ ___ Compensation: $ ___

Punitive: $ ___

DESCRIPTION OF CLAIM

Provide enough information to allow evaluation:

1. Incident Location: CLEVELAND CLINIC FOUNDATION : LABOR & DELIVERY
2. Alleged act, error or omission upon which Claimant bases claim: "DEPARTED FROM ACCEPTABLE STANDARDS OF CARE IN THEIR MANAGEMENT OF MRS. BAMFIELD'S PREGNANCY, LABOR AND DELIVERY [illegible]

AT PRIMARY CAESAREAN. (AN) LSC FOLLOWING UTERINE RUPTURE AND HEMORRHAGE

4. Patient's Condition at point of your involvement: NORMAL PREGNANCY AT APPROX. 28 WEEK GESTATION CONSULTED REGARDING WHETHER TO REMOVE A SMALL CERVICAL POLYP
5. Patient's Condition at end of treatment: DIAGNOSED SMALL CERVICAL POLYP. PLAINTIFF WAS FEELING NORMAL FOR HER STAGE IN PREGNANCY. ROUTINE PRENATAL CARE CONTINUED
6. Give a complete narration of the case, relating events in chronological order emphasizing the dates of service and stating in detail what was done each time the patient was seen professionally. Use reverse side for additional space required. (Please type or print)

DATES PLAINTIFF EXPERIENCED A PROTRACTED LABOR, MANAGED BY A PHYSICIAN OTHER THAN MYSELF. CAESAREAN SECTION WAS DONE. UNCONTROLLED HEMORRHAGE OCCURRED AND UTERINE RUPTURE FOUND. CONTROL REQUIRED HYSTERECTOMY

Signature Lawrence W. Miller MD

IMPORTANT: IN ADDITION TO THE INFORMATION ABOVE, PLEASE ATTACH COPIES OF THE COMPLAINT, YOUR DEPOSITION, FINAL JUDGEMENT, SETTLEMENT & RELEASE, OR OTHER FINAL DISPOSITION OF THE CLAIM.

FRM 138 1/94

SUPPLEMENTAL CLAIM INFORMATION

Please supply the following information regarding any instance of claim, suit or incident which may give rise to a claim whether dismissed, settled out of court, judgement or pending. Answer all questions completely. This form should be photocopied and filled out separately for each claim. Please type or print clearly.

Applicant (Defendant's) name: LAWRENCE MILLER MD. et al

Claimant (Plaintiff's) name: M [redacted] F [redacted]

Date of alleged error: ON OR BEFORE 22 JAN 98 Date of Claim: 22 JAN 98

Indicate whether: X Claim ___ Suit or ___ Incident that has been reported to your insurance carrier

Name of Insurer: KAISER PERMANENTE Agent: PATRICIA SCHENK Phone: (216) 479-5482

Location of court where original complaint was filed: CUYAHOGA COUNTY, OHIO

Case #: 359940

Defendant's Legal Representative: (include name, address and telephone #) WILLIAM A. MERROWS - REMINGER & REMINGER, THE 113TH ST. CLAIR BLDG. CLEVELAND, OH 44114 (216) 687-1311

Plaintiff's Legal Representative: (include name, address and telephone #) THOMAS MESTER, NURNBERG, PLEVIN, et al LPA, 1370 ONTARIO ST. CLEVELAND, OH. 44113-1792 (216) 621-2300

STATUS OF COMPLAINT

If closed please indicate:

___ Court Judgement — Finding for: YOU ___ PLAINTIFF ___ Date: ___/___/___

Determined by: JUDGE ___ JURY ___

___ Out-of-Court Settlement — Date of Settlement: ___/___/___

Amount paid on your behalf: $ ___

Compensation: $ ___ Punitive: $ ___

Total Settlement amount: $ ___

___ Case Dismissed: Against YOU ___ Against ALL DEFENDANTS ___ Date: ___/___/___

If pending please indicate:

Claimant's settlement demand: $ ___ Defendant's offer for settlement: $ ___

Insurer's loss reserve: $ ___ Defense reserve: $ ___ Deductible: $ ___

Claim in suit ___ Yes ___ No If Yes, amount asked in summons: $ ___ Compensation: $ ___

Punitive: $ ___

DESCRIPTION OF CLAIM

Provide enough information to allow evaluation:

1. Incident Location: PARMA, OHIO

2. Alleged act, error or omission upon which Claimant bases claim: the defendants negligently failed to provide competent, safe and acceptable care and treatment.

4. Patient's Condition at point of your involvement: Never saw or attended the patient. Reviewed "Kaiser" Pap and breast exam done by physician Assistant & "co-signed" them as back-up consultant

5. Patient's Condition at end of treatment: Pt. was feeling well at end of encounter 4/15/97. Seven months later she developed pelvic infection.

6. Give a complete narration of the case, relating events in chronological order emphasizing the dates of service and stating in detail what was done each time the patient was seen professionally. Use reverse side for additional space required. (Please type or print)

DATES PAP SMEAR DONE 4/15/97 HAD ACTINOMYCES SPORES REPORTED. PAP TRACKING LETTER SENT BY KAISER REPORTED "NORMAL" PAP. PELVIC INFECTION 7 MONTHS LATER RESULTED IN TAH/BSO. PLAINTIFF CLAIMS (SEE CONTINUATION)

Signature Lawrence W. Miller MD

IMPORTANT: IN ADDITION TO THE INFORMATION ABOVE, PLEASE ATTACH COPIES OF THE COMPLAINT, YOUR DEPOSITION, FINAL JUDGEMENT, SETTLEMENT & RELEASE OR OTHER FINAL DISPOSITION OF THE CLAIM.

FRM 138 1/94

[redacted] (CONT.)

INFECTION IN LEG NOT HAVE OCCURRED IF ACTINOMYCOSIS HAD BEEN TREATED. KAISER PERMANENTE AT ALL WERE AT FAULT FOR OVERLOOKING HER ACTINOMYCOSIS AND NOT TREATING IT WHEN IT WAS INCIDENTALLY FOUND ON HER PAP SMEAR. NO ACTINOMYCOSES WAS CULTURED FROM HER TISSUES AT THE TIME OF HER TRANSO.

(Turn)

SUPPLEMENTAL CLAIM INFORMATION

Please supply the following information regarding any instance of claim, suit or incident which may give rise to a claim whether dismissed, settled out of court, judgement or pending. Answer all questions completely. This form should be photocopied and filled out separately for each claim. Please type or print clearly.

Applicant (Defendant's) name: LAWRENCE W. MILLER, MD, KAISER PERMANENTE et. al

Claimant (Plaintiff's) name: [redacted] & A [redacted] for M [redacted] K [redacted]

Date of alleged error: 12/21/99 Date of Claim: _____

Indicate whether: ✓ Claim X Suit or ____ Incident that has been reported to your insurance carrier

Name of Insurer: KAISER PERMANENTE Agent: REMINGER & REMINGER Phone: (216) 687-1311

Location of court where original complaint was filed: CUYAHOGA Co.

Case #: 398851

Defendant's Legal Representative: (include name, address and telephone #) WILLIAM A. MEADOWS 113 ST. CLAIR AVE. CLEVELAND, OH 44114

Plaintiff's Legal Representative: (include name, address and telephone #) _____

STATUS OF COMPLAINT

If closed please indicate: ____ Court Judgement Finding for: YOU ____ PLAINTIFF ____ Date: ____/____/____

Determined by: JUDGE ____ JURY ____

____ Out-of-Court Settlement Date of Settlement: ____/____/____

Amount paid on your behalf: $ _____

Compensation: $ _____ Punitive: $ _____

Total Settlement amount: $ _____

____ Case Dismissed: Against YOU ____ Against ALL DEFENDANTS ____ Date: ____/____/____

If pending please indicate: Claimant's settlement demand: $ _____ Defendant's offer for settlement: $ _____

Insurer's loss reserve: $ _____ Defense reserve: $ _____ Deductible: $ _____

Claim in suit ___ Yes ___ No If Yes, amount asked in summons: $ _____ Compensation: $ _____

Punitive: $ _____

DESCRIPTION OF CLAIM

Provide enough information to allow evaluation:

1. Incident Location: Cleveland Clinic Foundation
2. Alleged act, error or omission upon which Claimant bases claim: Child sustained a severe injury to her right brachial plexus at the time of delivery. Injury is alleged to have occurred during negligent management of a severe shoulder dystocia.
3. Description of type and extent of injury or damage allegedly sustained. Innervation to right arm is severely compromised, with permanent loss of most use of the arm.
4. Patient's Condition at point of your involvement: Plaintiff, Natalie, was assumed to have been normal while in utero, with normal arm innervation, until shoulder entrapment during delivery.
5. Patient's Condition at end of treatment: Infant was delivered, with reduction of entrapped body parts, without permanent brain or body injury other than the right arm.
6. **Give a complete narration of the case, relating events in chronological order emphasizing the dates of service and stating in detail what was done each time the patient was seen professionally. Use reverse side for additional space required. (Please type or print)**

DATES 12/21/99 - Labor, in the multiparous mother, was progressing rapidly after reduction of an edematous, swollen cervix. The 2nd stage of labor was very rapid to delivery of the infants head - then there was suddenly no further progress - (over)

Signature Lawrence W Miller MD

IMPORTANT: IN ADDITION TO THE INFORMATION ABOVE, PLEASE ATTACH COPIES OF THE COMPLAINT, YOUR DEPOSITION, FINAL JUDGEMENT, SETTLEMENT & RELEASE, OR OTHER FINAL DISPOSITION OF THE CLAIM.

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Endorsement of Certification

This document was prepared by
National Board of Medical Examiners (NBME)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

Recipient: New Mexico State Bd of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501

Date: 08/09/2000

Examinee: Lawrence W. Miller

Examinee ID: 3-093-210-7
Date of Birth: [redacted]1942

NBME Certification Date: 06/24/1968

Certificate#: 093210

It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

			Total		Individual Subject Scores					
Test Date	Pass/Fail	Score Scale	Score	(Min.Pass)	Anat	Phys	Bioc	Path	Micr	Phar
06/22/1965	Pass	Three-Digit								
		Two-Digit	82.8	(75)	84	86	82	86	78	81

NBME PART II

			Total		Individual Subject Scores					
Test Date	Pass/Fail	Score Scale	Score	(Min.Pass)	Med	Surg	ObGyn	Prev	Peds	Psych
04/18/1967	Pass	Three-Digit								
		Two-Digit	86	(75)	86	88	87	85	82	82

NBME PART III

			Total	
Test Date	Pass/Fail	Score Scale	Score	(Min.Pass)
03/13/1968	Pass	Three-Digit		
		Two-Digit	86.3	(75)

*** END OF DOCUMENT ***

NM1250

See reverse side for explanation of information reported above.

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
Licensing Program
1426 Howe Avenue #56
Sacramento, CA 95825
(916) 263-2360

September 21, 2000

New Mexico Board of Medical Examiners
Lamy Bldg, 2nd Floor
491 Old Santa Fe Trail
Santa Fe, NM 87501

TO WHOM IT MAY CONCERN:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

PHYSICIAN:	Lawrence W. Miller
LICENSE NUMBER:	G 15106
ISSUED:	08/01/68
EXAM TYPE:	a written examination
EXPIRATION DATE:	04/30/02
STATUS:	Renewed/Current

This certification is the only information provided by this office. If additional information is needed, it must be obtained directly from the individual, agency or institution which initially generated the information. To expedite the certification process, this is the standard format prepared for all professions regulated by the Medical Board of California.

If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

Kim Marquardt

KIM MARQUARDT, Manager
Licensing Operations

SEAL

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501
(505) 827-5022

VERIFICATION OF LICENSURE

I am applying for medical licensure in the State of New Mexico. The New Mexico Board of Medical Examiners requires that your Board complete this form in order that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, to the New Mexico Board of Medical Examiners.

LAWRENCE W. MILLER MD
Print/Type Full Name

Lawrence W Miller MD
Signature

Date

G 15106
License Number

8/1/68
Date Issued

[redacted]
Address

BROADVIEW HEIGHTS OH 44147
City State Zip Code

THE SECTION BELOW SHOULD BE COMPLETED BY THE MEDICAL BOARD

Name of Licensing Authority: _____

Name of Licensee: _____

License Number: _____ Date Issued: _____
Month Day Year

The license to practice medicine was issued on the basis of Endorsement by or Reciprocity with _____

☐ FLEX ☐ NBME ☐ USMLE ☐ LMCC ☐ State Exam

1. Is license current? ☐ Yes ☐ No If "No," why not? _____

2. Has licensee ever been disciplined by your Board? ☐ Yes ☐ No Dates: _____
   If "yes:" Revoked? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No
   Stipulated? ☐ Yes ☐ No On Probation? ☐ Yes ☐ No

3. Has this licensee's license ever been:
   Allowed to lapse for non-payment of fees? ☐ Yes ☐ No
   Placed on Retired or Inactive status? ☐ Yes ☐ No
   Surrendered voluntarily? ☐ Yes ☐ No

4. Are there any formal charges pending against this license? ☐ Yes ☐ No

5. Has licensee ever been investigated or requested to appear before your Board? ☐ Yes ☐ No

If you answer "Yes" to questions 2-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Please Affix Board Seal Here

_____
Printed Name of Board Official

_____
Signature of Board Official Date

_____
Title

Please return this form directly to:

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501

Thank you for your cooperation.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

September 29, 2000

NEW MEXICO BOARD OF MEDICAL EXAMINERS
SECOND FLOOR, LAMY BUILDING 491 OLD SANTA FE TRAIL
SANTA FE, NM 87501

TO WHOM IT MAY CONCERN:

LICENSURE VERIFICATION

Please be advised that Connecticut General Statutes Section 20-13e, effective July 1, 1985, mandates that certain matters involving the investigation and rehabilitation of physicians remain confidential. Therefore, in response to your inquiry regarding the status of the physician identified below, at this time we are providing only publicly disclosable information. In order for this office to confirm or deny whether there is any confidential information relevant to your inquiry, a release from such physician must be provided.

IF YOU WISH TO ESTABLISH WHETHER CONFIDENTIAL INFORMATION EXISTS CONCERNING THIS PHYSICIAN, PLEASE HAVE HIM/HER SIGN THE REVERSE SIDE OF THIS FORM, WHICH CONSTITUTES A RELEASE FOR SUCH INFORMATION, AND RETURN IT TO THIS OFFICE. PLEASE NOTE THAT ONLY THIS DEPARTMENT'S RELEASE FORM WILL BE ACCEPTED.

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

LAWRENCE W. MILLER MD
[redacted]
BROADVIEW HEIGHTS, OH 44147

Was issued Connecticut:	Physician/Surgeon License
Date of Issuance:	04/04/1975
License Number:	017163
Expiration Date:	04/30/1997
Status of License:	Expired
License Granted by:	Endorsement
Disciplinary History:	There has been no public disciplinary action taken.
Validation number	95-764006

Sincerely,

(seal)

Not valid unless affixed with seal of
Department of Public Health

Debra J. Tomassone
Public Health Services Manager
Division of Health Systems Regulation

DJT:MG

Phone: (860) 509-7596, 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12MQA
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer
Website for licensure verification http://www.ct-clic.com

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501
(505) 827-5022

VERIFICATION OF LICENSURE

I am applying for medical licensure in the State of New Mexico. The New Mexico Board of Medical Examiners requires that your Board complete this form in order that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, to the New Mexico Board of Medical Examiners.

LAWRENCE W. MILLER MD
Print/Type Full Name

Lawrence W Miller MD
Signature

Date

017163
License Number

4/4/75
Date Issued

[redacted]
Address

BROADVIEW HEIGHTS, OH 44147
City State Zip Code

THE SECTION BELOW SHOULD BE COMPLETED BY THE MEDICAL BOARD

Name of Licensing Authority: _____

Name of Licensee: _____

License Number: _____ Date Issued: _____
Month Day Year

The license to practice medicine was issued on the basis of Endorsement by or Reciprocity with _____

☐ FLEX ☐ NBME ☐ USMLE ☐ LMCC ☐ State Exam

1. Is license current? ☐ Yes ☐ No If "No," why not? _____

2. Has licensee ever been disciplined by your Board? ☐ Yes ☐ No Dates: _____
   If "yes:" Revoked? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No
   Stipulated? ☐ Yes ☐ No On Probation? ☐ Yes ☐ No

3. Has this licensee's license ever been:
   Allowed to lapse for non-payment of fees? ☐ Yes ☐ No
   Placed on Retired or Inactive status? ☐ Yes ☐ No
   Surrendered voluntarily? ☐ Yes ☐ No

4. Are there any formal charges pending against this license? ☐ Yes ☐ No

5. Has licensee ever been investigated or requested to appear before your Board? ☐ Yes ☐ No

If you answer "Yes" to questions 2-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Please Affix Board Seal Here

_____
Printed Name of Board Official

_____
Signature of Board Official Date

_____
Title

Please return this form directly to:

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501

Thank you for your cooperation.

17443

RECEIVED
SEP 25 2000
NM BOARD OF MEDICAL EXAMINERS

New Mexico Board of Medical Examiners

Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501
(505) 827-5022

VERIFICATION OF LICENSURE

I am applying for medical licensure in the State of New Mexico. The New Mexico Board of Medical Examiners requires that your Board complete this form in order that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, to the New Mexico Board of Medical Examiners.

LAWRENCE W. MILLER MD
Print/Type Full Name

Lawrence W. Miller MD
Signature

Date

17443
License Number

9/21/91
Date Issued

[redacted]

BROADVIEW HEIGHTS OH 44147
City State Zip Code

THE SECTION BELOW SHOULD BE COMPLETED BY THE MEDICAL BOARD

Name of Licensing Authority: North Carolina Medical Board

Name of Licensee: Lawrence Whitfield Miller

License Number: 34685 Date Issued: 9/21/91
Month Day Year

The license to practice medicine was issued on the basis of Endorsement by or Reciprocity with _____

☐ FLEX ☑ NBME ☐ USMLE ☐ LMCC ☐ State Exam

1. Is license current? ☐ Yes ☑ No If "No," why not? inactive since 4/15/98

2. Has licensee ever been disciplined by your Board? ☐ Yes ☑ No Dates: _____
   If "yes:" Revoked? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No
   Stipulated? ☐ Yes ☐ No On Probation? ☐ Yes ☐ No

3. Has this licensee's license ever been:
   Allowed to lapse for non-payment of fees? ☑ Yes ☐ No
   Placed on Retired or Inactive status? ☐ Yes ☐ No
   Surrendered voluntarily? ☐ Yes ☐ No

4. Are there any formal charges pending against this license? ☐ Yes ☑ No

5. Has licensee ever been investigated or requested to appear before your Board? ☐ Yes ☑ No

If you answer "Yes" to questions 2-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

00 SEP 18 AM 9:41 NORTH CAROLINA MEDICAL BOARD

Please Affix Board Seal Here

Ann Z Norris
Printed Name of Board Official

Ann Z Norris
Signature of Board Official

9/18/2000
Date

Executive Secretary
Title

Please return this form directly to:

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501

Thank you for your cooperation.

South Carolina Board of Medical Examiners

Koger Office Park, Kingstree Building
110 Centerview Drive
Post Office Box 11289
Columbia, SC 29211-1289

(803) 896-4500
FAX: (803) 896-4515

09/18/00 04 SOUTH CAROLINA LICENSE VERIFICATION

NAME: LAWRENCE WHITFIELD MILLER MD BIRTH DATE: [redacted]42
MAILING ADDRESS: [redacted]

BROADVIEW HGHTS OH 44147-1396

LICENSE NO: 015742 DATE ISSUED: 10/28/1991 EXPIRATION: 12/31/2001
BASIS: NB'68 SPECIALTY: OBG*

NO DISCIPLINARY ACTION TAKEN BY THIS BOARD. THIS CERTIFIES THAT THE ABOVE LICENSEE IS IN GOOD STANDING AS OF 09/18/2000.

Verified by: Patricia A. Browy
Patricia A. Browy, Administrative Specialist

Approved by: Karen Y Newton
Karen Y. Newton
Assistant Administrator/Records Management
or
Carolyn J. Coats, Administrative Specialist

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501
(505) 827-5022

VERIFICATION OF LICENSURE

I am applying for medical licensure in the State of New Mexico. The New Mexico Board of Medical Examiners requires that your Board complete this form in order that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, to the New Mexico Board of Medical Examiners.

LAWRENCE W. MILLER MD
Print/Type Full Name

Lawrence W Miller MD
Signature Date

15742
License Number

10/28/91
Date Issued

[redacted]
Address

BROADVIEW HEIGHTS OH 44147
City State Zip Code

THE SECTION BELOW SHOULD BE COMPLETED BY THE MEDICAL BOARD

Name of Licensing Authority: _____

Name of Licensee: _____

License Number: _____ Date Issued: _____
Month Day Year

The license to practice medicine was issued on the basis of Endorsement by or Reciprocity with _____

☐ FLEX ☐ NBME ☐ USMLE ☐ LMCC ☐ State Exam

1. Is license current? ☐ Yes ☐ No If "No," why not? _____

2. Has licensee ever been disciplined by your Board? ☐ Yes ☐ No Dates: _____
   If "yes:" Revoked? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No
   Stipulated? ☐ Yes ☐ No On Probation? ☐ Yes ☐ No

3. Has this licensee's license ever been:
   Allowed to lapse for non-payment of fees? ☐ Yes ☐ No
   Placed on Retired or Inactive status? ☐ Yes ☐ No
   Surrendered voluntarily? ☐ Yes ☐ No

4. Are there any formal charges pending against this license? ☐ Yes ☐ No

5. Has licensee ever been investigated or requested to appear before your Board? ☐ Yes ☐ No

If you answer "Yes" to questions 2-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Please Affix Board Seal Here

_____
Printed Name of Board Official

_____
Signature of Board Official Date

_____
Title

Please return this form directly to:

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501

Thank you for your cooperation.

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

October 11, 2000

Kristen A. Hedrick, Executive Director
New Mexico State Board of Medical Examiners
491 Old Santa Fe Trail
Second Floor, Lamy Bldg.
Santa Fe, NM 87501

RE: Lawrence Whitfield Miller, M.D.

Dear Ms. Hedrick:

In response to a request for verification of licensure, when applying for Ohio licensure in August, 1995, Doctor Miller did inform the State Medical Board of Ohio of two malpractice actions that were pending at that time . The State Medical Board of Ohio does not know the outcome of those actions.

After review of Doctor Miller's application, he was issued an Ohio license and it is current and in good standing.

This is provided for your information only and is considered ***confidential*** in accordance with Ohio statutes (copy enclosed).

Very truly yours,

Terrill D. McLaughlin
Assistant Director

TDM:jh
cc: Debra L. Jones, Chief of Records

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501
(505) 827-5022

STATE MEDICAL BOARD
SEP 18 2000

VERIFICATION OF LICENSURE

I am applying for medical licensure in the State of New Mexico. The New Mexico Board of Medical Examiners requires that your Board complete this form in order that I may be considered for licensure. This is my authorization to release all information in your files, favorable or otherwise, to the New Mexico Board of Medical Examiners.

LAWRENCE W. MILLER MD
Print/Type Full Name

Lawrence W Miller MD
Signature Date

35-06-9090-M 9/8/95
License Number Date Issued

[redacted]
Address

BROADVIEW HEIGHTS OH 44147
City State Zip Code

THE SECTION BELOW SHOULD BE COMPLETED BY THE MEDICAL BOARD

Name of Licensing Authority: Ohio State medical Board

Name of Licensee: Lawrence W. Miller

License Number: 69090 Date Issued: 9/8/95
Month Day Year

The license to practice medicine was issued on the basis of Endorsement by or Reciprocity with _____

☐ FLEX ☑ NBME ☐ USMLE ☐ LMCC ☐ State Exam

1. Is license current? ☑ Yes ☐ No If "No," why not? expires 7/01/02
2. Has licensee ever been disciplined by your Board? ☐ Yes ☑ No Dates: _____
   If "yes:" Revoked? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No
   Stipulated? ☐ Yes ☐ No On Probation? ☐ Yes ☐ No
3. Has this licensee's license ever been:
   Allowed to lapse for non-payment of fees? ☐ Yes ☑ No
   Placed on Retired or Inactive status? ☐ Yes ☑ No
   Surrendered voluntarily? ☐ Yes ☑ No
4. Are there any formal charges pending against this license? ☐ Yes ☑ No
5. Has licensee ever been investigated or requested to appear before your Board? ☐ Yes ☑ No

If you answer "Yes" to questions 2-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

Please Affix Board Seal Here

DEBRA L. JONES
Printed Name of Board Official

Debra L. Jones
Signature of Board Official Date

Chief C.M.E. Records & Renewal
Title

Please return this form directly to:

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501

Thank you for your cooperation.

OHIO REVISED CODE SECTION 4731.22 (F) (5)

Information received by the board pursuant to an investigation is confidential and not subject to discovery in any civil action.

The board shall conduct all investigations and proceedings in a manner that protects the confidentiality of patients and persons who file complaints with the board. The board shall not make public the names or any other identifying information about patients or complainants unless proper consent is given or, in the case of a patient, a waiver of the patient privilege exists under division (B) of section 2317.02 of the Revised Code, except that consent or a waiver of that nature is not required if the board possesses reliable and substantial evidence that no bona fide physician-patient relationship exists.

The board may share any information it receives pursuant to an investigation, including patient records and patient record information, with other licensing boards and governmental agencies that are investigating alleged professional misconduct and with law enforcement agencies and other governmental agencies that are investigating or prosecuting alleged criminal offenses. A board or agency that receives the information shall comply with the same requirements regarding confidentiality as those with which the state medical board must comply, notwithstanding any conflicting provision of the Revised Code or procedure of the board or agency that applies when the board or agency is dealing with other information in its possession. The information may be admitted into evidence in a criminal trial in accordance with the Rules of Evidence, but the court shall require that appropriate measures are taken to ensure that confidentiality is maintained with respect to any part of the information that contains names or other identifying information about patients or complainants whose confidentiality was protected by the state medical board when the information was in the board's possession. Measures to ensure confidentiality that may be taken by the court include sealing its records or deleting specific information from its records.

New Mexico Board of Medical Examiners

Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501
(505) 827-5022

RECEIVED
OCT 20 2000
NM BOARD OF MEDICAL EXAMINERS

REC'D OPSA SEP 28 2000

HOSPITAL AFFILIATIONS

I am applying for medical licensure in the State of New Mexico. The New Mexico Board of Medical Examiners requires this form to be completed by the Chief of Staff or Administrator in each hospital where I have held privileges, consultation or teaching appointments during the past five years (not including internship and/or residency). This is my authorization to release all information in your files, favorable or otherwise, to the New Mexico Board of Medical Examiners.

LAWRENCE W. MILLER MD
Print/Type Full Name

Lawrence W Miller MD
Signature — Date

[redacted]
Address

BROADVIEW HEIGHTS OH 44147
City — State — Zip Code

THE SECTION BELOW SHOULD BE COMPLETED BY THE HOSPITAL

(Chief of Staff or Administrator only. Form must include hospital seal or notarization of signature.)

Name of Hospital: CLEVELAND CLINIC FOUNDATION

Address: 9500 EUCLID AVE.
Number and Street

CLEVELAND — OH — 44195
City — State — Zip Code

Telephone Number of Medical Staff Registrar: (216) 444-7025

Affiliated Hospitals: _____

What privileges were extended to the applicant?
Gynecology & Obstetrics

Inclusive Dates: From: 9/29/95 To: present

Were limitations imposed on such privileges? ☐ Yes ☒ No If "Yes," please explain below.

Were staff privileges ever removed or restricted? ☐ Yes ☒ No If "Yes," please explain below.

Derogatory information, if any: _____

Please Affix Hospital or Notarial Seal Here

Robert Kay, M.D.
Printed Name of Chief of Staff/Administrator

Robert Kay
Signature of Chief of Staff/Administrator — Date

Title

Signature of Notary (if applicable) — Date

Please return this form directly to:

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe, NM 87501

Thank you for your cooperation.

American Medical Association

Physicians dedicated to the health of America

Physician Profile Service

515 North State Street
Chicago, Illinois 60610

Division of Survey and Data Resources
Department of Data Services

Name and Mailing Address:

LAWRENCE W MILLER MD
[redacted]
BROADVIEW HTS OH 44147

Primary Office Address:

OH PERMANENTE MED GRP-OB G
12301 SNOW RD
PARMA HEIGHTS OH 44130

Birthdate: [redacted]1942
Birthplace: NEW YORK, NY USA

Phone: 1-216-265-4426

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Self Designated Practice Specialties (SDPS):

Primary Specialty: OBSTETRICS AND GYNECOLOGY
Secondary Specialty: MEDICAL MANAGEMENT

AMA membership: MEMBER

Following Data Provided by the Primary Sources

Medical School:

BOSTON UNIV SCH OF MED, BOSTON MA 02118 (VERIFIED)

Year of Graduation: 1967 (VERIFIED)

Current and/or Prior Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Institution: L A CO-USC MED CTR	**State:** FLORIDA
Specialty : FLEXIBLE OR TRANSITIONAL YEAR	06/1967 - 06/1968 (VERIFIED)
Institution: L A CO-USC MED CTR	**State:** FLORIDA
Specialty : OBSTETRICS AND GYNECOLOGY	07/1971 - 06/1975 (VERIFIED)

Note: **Additional information, used for appointments and privileges, is not solicited, nor is it received from the residency program directors. If additional information is required, please contact the program director(s).**

American Medical Association

Physicians dedicated to the health of America

Physician Profile Service

515 North State Street
Chicago, Illinois 60610

Division of Survey and Data Resources
Department of Data Services

National Board of Medical Examiners (NBME) Certification Year: MD: 1968

License(s): State	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
OHIO	MD	09/08/1995	07/01/2002	ACTIVE	UNLIMITED	08/15/2000
SOUTH CAROLINA	MD	10/28/1991	12/31/2001	ACTIVE	UNLIMITED	07/31/2000
NORTH CAROLINA	MD	09/21/1991	04/15/1998	INACTIVE	UNLIMITED	07/28/2000
CONNECTICUT	MD	04/04/1975	04/30/1997	INACTIVE	UNLIMITED	04/18/2000
CALIFORNIA	MD	08/01/1968	04/30/2002	ACTIVE	UNLIMITED	04/01/2000

Note: **When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.**

ECFMG Certfication:

Applicant Number:

Note: **The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.**

Federal Drug Enforcement Administration:

AS OF 08/02/2000, FEDERAL DEA REGISTRATION IS VALID. EXPIRATION DATE IS 01/31/2001.

Note: **Many states require their own controlled substances registration/license.**
Please check with your state licensing authority as the AMA does not maintain this information.

Specialty Board Certification(s):

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

Certifying Board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS AND GYNECOLOGY
Certificate Type: GENERAL

Effective: 12/01/1999 **Expiration:** NONE REPORTED TO DATE **Last Reported:** 07/15/2000 RE-CERT
Effective: 01/01/1977 **Expiration:** NONE REPORTED TO DATE **Last Reported:** 07/15/2000 INITIAL

Note: **For certfication dates, a default value of "01" appears in the month field if data was not provided to AMA. Please contact the appropriate specialty board directly for this information.**

American Medical Association

Physicians dedicated to the health of America

Physician Profile Service

515 North State Street
Chicago, Illinois 60610

Division of Survey and Data Resources
Department of Data Services

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the Physician Profile is intended as an instrument to assist with credentialing. Appropriate use of the Physician Masterfile data contained on this profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, residency training and board certification.

If you note any discrepancies, please mark them on a copy of the profile and fax to (312) 464-5827 or return to:

American Medical Association
Department of Data Services
515 N. State Street
Chicago, IL 60610

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name: Lawrence Whitfield Miller
SSN: [redacted]5726
DOB: [redacted]1972
Recipient: New Mexico State Board of Medical Examiners

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician 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. All documents bearing the official FCVS seal are ceritified 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.

The Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. The Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Lawrence Whitfield Miller**	
Other Name Used:	**N/A**	
Gender:	**Male**	
Date of Birth:	[redacted]/1942	
Place of Birth:	**Manhattan, NY USA**	
SSN:	[redacted]-5726	
Current Address:	**8184 Thackeray Court** **Broadview Heights, OH 44147**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**216-265-4426**
	Fax:	**216-362-2779**
	Home:	[redacted]5596
	Other:	**N/A**
Physical Description:	Height:	**5' 10"**
	Weight:	**172 lbs**
	Eye Color:	**Blue**
	Hair Color:	**Blond**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

Premedical Education (Reported by physician. Not verified by FCVS)**:**

Institution:	**Bowdoin College, Brunswick, ME 04011**
Dates of Attendance:	**09/1959 - 07/1963**
Degree Awarded:	**Bachelor of Arts**

Medical Education:

Current, valid ECFMG	**N/A**
ECFMG Number:	**N/A**
Date Issued:	**N/A**
Medical School:	**Boston University School of Medicine** **Office of the Registrar** **715 Albany Street/Room A-414** **Boston, MA 02118**
Dates of Attendance:	**09/09/1963 - 05/27/1967**
Graduation Date:	**05/28/1967**
Degree Awarded:	**Doctor of Medicine**

Unusual Circumstance: **None**

Post Graduate Medical Education:

Institution: **Los Angeles County-USC Medical Center**
1200 North State Street/PO Box 540
Los Angeles, CA 90033

Post Graduate Year: **1**
Program Type: **Internship**
Department: **Rotating**
Dates of Attendance: **06/24/1967 - 06/24/1968**
Completion: **Yes**
Accreditation: **ACGME**

Unusual Circumstance: **Not Reported by the Primary Source**

Institution: **Women's and Children's Hospital**
Department of Obstetrics/Gynecology
Room L1009
1240 North Mission Road
Los Angeles, CA 90033

Post Graduate Year: **1**
Program Type: **Internship**
Department: **Obstetrics and Gynecology**
Dates of Attendance: **07/01/1971 - 06/24/1972**
Completion: **Yes**
Accreditation: **ACGME**

Post Graduate Year: **2-4**
Program Type: **Residency**
Department: **Obstetrics and Gynecology**
Dates of Attendance: **07/01/1972 - 06/30/1975**
Completion: **Yes**
Accreditation: **ACGME**

Unusual Circumstance: **None**

Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For: **NBME Part I**
NBME Part II
NBME Part III
SPEX

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Omission / Discrepancy Report

Physician Identification:

Name:	Lawrence Whitfield Miller
DOB:	[redacted]1942
SSN:	[redacted]5726
Packet ID:	16025
Request ID:	5292892

REPORT OF OMISSIONS

Omission 1:

Section of Profile:	**Medical Education**
Omission:	Boston Univ Sch Med indicated on the Medical Education form that it has a premedical education requirement; however, the courses taken section was omitted.
Follow-Up:	See Comments on Verification of Medical Education Form.

Omission 2:

Section of Profile:	**Examination History**
Omission:	The applicant did not report sitting for the SPEX Examination.
Follow-Up:	The SPEX transcript indicates an examination on 09/1991.

REPORT OF DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Examination History**
Discrepancy:	The applicant reports sitting for NBME Part III in 06/1968. The NBME Part III transcript indicates the examination date was 03/1968.
Follow-Up:	Left to Recipient`s discretion.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile:	**Continuity of Education**
Issue:	There is a gap of approximately 3 years between postgraduate training programs at Los Angeles County-USC Medical Center (ends 06/24/1968) and Womens and Children's Hospital (begins 06/24/1971).
Follow-Up:	This information is provided as information only. No follow up performed.

End of report for Lawrence Whitfield Miller

Packet Id: 16025 Request Id: 5292892 Report Created By: TJL

Board Action Databank Search

State Queried For:	**New Mexico State Board of Medical Examiners**
Physician's Name:	**Miller, Lawrence Whitfield**
Date of Birth:	[redacted]**1942**
Medical School:	**022010 - Boston Univ Sch Med**
Year of Graduation:	**1967**
Social Security Number:	**040-34-5726**
ECFMG Number:	**N/A**

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PERSON

DEC 15 2000

JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make are true, that I am the 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 I furnish with my application are strictly true.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS 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 my being prosecuted under appropriate federal and state laws.

I authorize every person, hospital, clinic, government agency (local, state, federal or foreign), 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, or true and correct copies of documents or records.

I hereby release, discharge and hold harmless the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, records or documents of any and all liability. 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.

Lawrence W. Miller
Applicant's Signature (must be signed in the presence of a notary)

MILLER
Applicant's **Printed** Last Name

LAWRENCE W.
Applicant's **Printed** First Name, Middle Initial, and Suffix (e.g., Jr.)

7 aug. 2000
Date of Signature (must correspond to date of notarization)

State of Ohio, County of Cuyahoga.

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 applicants 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 7th day of August, 2000.

Notary Public signature: Rose B. Bartholomew

My commission expires: ROSE B. BARTHOLOMEW
Notary Public, State of Ohio, Summit Cty.
My Commission Expires April 25, 2001

The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

PACKET ID: 0016025

VR 115 150M (3/00) P.O. NO.0004970

DOCUMENT NO. 789949

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH

VITAL RECORDS

CERTIFICATION OF BIRTH

This is a certification of name and birth facts on file in the Bureau of Vital Records, Department of Health, City of New York.

DATE OF BIRTH [redacted] 1942

CERTIFICATE NO. [redacted]1156

BOROUGH MANHATTAN

DATE FILED [redacted]42

DATE ISSUED 08-04-00

NAME LAWRENCE WHITFIELD MILLER ***

SEX MALE

MOTHER'S MAIDEN NAME DOROTHY CECELIA PROTHRO

FATHER'S NAME JOHN ROBERT MILLER

Steven P. Schwartz

STEVEN P. SCHWARTZ
CITY REGISTRAR

DEPARTMENT OF HEALTH THE CITY OF NEW YORK

Do not accept this transcript unless it bears the raised seal of the Department of Health. The reproduction or alteration of this certification is prohibited by Section 3.21 of the New York City Health Code if the purpose is the evasion or violation of any provision of the Health Code or any other law.

The Secretary of State
of the United States of America
hereby requests all whom it may concern to permit the citizen/
national of the United States named herein to pass
without delay or hindrance and in case of need to
give all lawful aid and protection.

Le Secrétaire d'Etat
des Etats-Unis d'Amérique
prie par les présentes toutes autorités compétentes de laisser passer
le citoyen ou ressortissant des Etats-Unis titulaire du présent passeport,
sans délai ni difficulté et, en cas de besoin, de lui accorder
toute aide et protection légitimes.

Lawrence Whitfield Miller

SIGNATURE OF BEARER/SIGNATURE DU TITULAIRE

NOT VALID UNTIL SIGNED

UNITED STATES OF AMERICA

PASSPORT

USA

Type/Catégorie: P — Code of issuing State/Code du pays émetteur: USA — PASSPORT NO./NO. DU PASSEPORT: [redacted]5465

Surname / Nom: MILLER

Given names / Prénoms: LAWRENCE WHITFIELD

Nationality / Nationalité: UNITED STATES OF AMERICA

Date of birth / Date de naissance: [redacted] AVR 42

Sex / Sexe: M — Place of birth / Lieu de naissance: NEW YORK, U.S.A.

Date of issue / Date de délivrance: 12 APR/AVR 95 — Date of expiration / Date d'expiration: 11 APR/AVR 05

Authority / Autorité: PASSPORT AGENCY

Amendments/Modifications: SEE PAGE

NATIONAL PASSPORT CTR 24

P<USAMILLER<<LAWRENCE<WHITFIELD<<<<<<<<<<<<<

[redacted]4117<<<<<<<<<<<<<<4

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: Boston University School of Medicine

Complete Address: 715 ALBANY STREET
Street Address

BOSTON, MA 02118
Street Address

City State Zip Code(Postal Code)

If name of institution was different when this individual attended, please note this name below:

Enrollment and Participation: Our records indicate that MILLER, LAWRENCE, WHITFIELD
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 36 weeks of continuous on-campus education on the following dates (mm/dd/yy):

From	To
9 / 9 / 63	5 / 23 / 64
9 / 9 / 64	5 / 28 / 65
9 / 13 / 65	5 / 28 / 66
6 / 13 / 66	5 / 27 / 67
/ /	/ /

This individual (check one):

X was awarded the degree of DOCTOR OF MEDICINE on 5 / 28 / 67 (mm/dd/yy)

_____ was NOT awarded a degree (please attach an explanation)

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response. **"Yes" responses to any of these questions requires a written explanation.**

Questions	Response	
Did this individual ever take a leave of absence or break from their medical education?	Yes	No
Was this individual ever placed on probation?	Yes	No
Was this individual ever disciplined or under investigation?	Yes	No
Were any negative reports regarding this individual ever filed by instructors?	Yes	No
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes	No

Premedical Education: Does your school have a premedical education requirement? Yes No

If yes, include where your records indicate the individual completed his/her premedical education and the basic science courses taken (attach additional pages if necessary):

Premedical Institution(s): BOWDION COLLEGE

TRANSCRIPTS NOT AVAILABLE

Check Courses Taken: _____ Physics _____ Biology/Zoology

_____ Organic Chemistry _____ Inorganic Chemistry

Certification: By my signature, I, ELLEN J. DIFIORE (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized).

SEAL VERIFIED

Signature: Ellen J. DiFiore

Title: REGISTRAR

Date of Signature: OCTOBER 3, 2000

Telephone: (617)638-4160

Fax: (617)638-4155

Email: _____

ACADEMIC RECORD

Boston University SCHOOL OF MEDICINE

LAST NAME	FIRST	MIDDLE	I. D. NUMBER	DATE OF BIRTH (YEAR)	SEX
Miller	Lawrence	Whitfield	035-399	[redacted] 1942	M

ADDRESS AT ADMISSION (PERMANENT): [redacted], West Hartford 7, Conn

ADMITTED FROM HIGH SCH[redacted] DEGREES: Bowdoin College - A.B. 1963

DATE DEGREE AWARDED	DEGREE – HONORS	MAJOR FIELD
May 28, 1967	M.D.	4 year

COURSE NO.	TITLE	CR. HRS.	GRADE	~~HONOR POINTS~~ OR FACTOR
Sept. 9, 1963 - May 23, 1964				
	Gross Anatomy	280	87	25
	Neuroanatomy	80	83	7
	Histology	160	89	15
	Psychiatry	21	77	1.5
	Midyear Average 86.74			
	Class Standing 14/70			
	Biochemistry	282	79	23
	Physiology	294	89	24
	Psychiatry	21	80	1.5
	Endocrinology	48	79	
	Final Average 85.21			
	Class Standing 20/68			
Sept. 9, 1964 - May 28, 1965				
	Pharmacology	168	71	21
	Microbiology	231	78	21
	Pathology	135	80	10.5
	Psychiatry	20	89	2.5
	Midyear Average - 76.21			
	Class Standing - 60/67			
	Pathology	135	81	10.5
	Clin. Path. & Med.	135	85	13
	Neuropathology	30	82	2
	Physical Diagnosis	135	82	13
	Obstetrics	31	90	2
	Surgery	28	79	2
	Psychiatry	37	86	2.5
	Average 79.33			
	Cumulative Average 82.27			
	Class Standing 35/63			

COURSE NO.	TITLE	CR. HRS.	GRADE	~~HONOR POINTS~~ OR FACTOR
Sept. 13, 1965 - May 28, 1966				
	Medicine	443	86	30
	Surgery	448	81	31
	Ob-Gyn	141	78	10
	Psychiatry	104	82	7
	Health Conservation	99	78	7
	Pediatrics	150	80	10
	Neurology	33	75	3
	Dermatology	26	(64)70	2
	Average - 81.44			
	Cumulative Average - 81.99			
	Class Standing - 33/65			
June 13, 1966 - May 27, 1967				
	Medicine - V.A.	400	89	33
	Surgery - UH	400	89	33
	Home Medicine	200	90	17
	Psychiatry - UH	200	81	17
	Average - 87.81			
	Cumulative Average - 83.44			
	N.B. Average - 85.			
	Final Average-83.75 (yearly averages + N.B. average)			
	Final Class Standing 26/62			
	Electives: Dr. Hawkins - 90			
	Dr. Shapiro - 84			
	Dr. Stanzler (Tufts)			
	Dr. Levinsky - 75			
	Clinical Gyn.			

Ellen J. D. Lane
REGISTRAR

N. B. Part I	82.8
N. B. Part II	86.0

OCT. 11.2000

Boston University School of Medicine

Grade: For promotion and graduation an average of 75% with no grade below 70% is required.

Factor: Weight given grade in computing average, based on number of hours in each subject.

Length of year: 2 semesters, 16 weeks each. Elective courses not computed in average.

NOT VALID AS A TRANSCRIPT WITHOUT THE AUTHORIZED SIGNATURE AND SEAL OF THE UNIVERSITY. UNLESS OTHERWISE STATED, THIS STUDENT IS ENTITLED TO HONORABLE DISMISSAL.

AUTHORIZED SIGNATURE

TITLE | DATE

LAST NAME INITIALS

UNIVERSITATIS BOSTONIENSIS

IN REPUBLICA MASSACHUSETTENSI

SENATUS ET CURATORES

OMNIBUS AD QUOS HAE LITERAE PERVENERINT, SALUTEM.

Cum **Laurence Whitfield Miller, A.B.**

ingenio bono praeditum moribusque probis ornatum ac studiis in Schola hujus Universitatis Medicae requisitis addidicisset, et interrogationibus rigidis a professoribus singulis propositis, se in arte medicinae et in scientiis ei inservientibus bene eruditum esse probavisset, idcirco nobis placuit professoribus Scholae antedictae consentientibus eum gradu

MEDICINAE DOCTORIS

adornare, et ei omnia insignia, jura, honores et privilegia ad eum gradum hic aut usquam spectantia concedere.

In cujus rei testimonium literis hisce Universitatis sigillo munitis die XXVIII *mensis Maii anno salutis nostrae* MCMLXVII *Reique publicae* CLXXXXI *Nos pro auctoritate nobis commissa nomina subscripsimus.*

Decanus. — *Praeses.*

Scriba Facultatis. — *Scriba Curatorum.*

SEAL
VERIFIED

I HEREBY CERTIFY THAT THIS IS A TRUE COPY OF THE ORIGINAL DOCUMENT ISSUED ON MAY 28, 1987

Ellen J. DiFiore

ELLEN J. DIFIORE, REGISTRAR 10/3/00

BOSTON UNIVERSITY MEDICAL CENTER
BOSTON UNIVERSITY SCHOOL OF MEDICINE / SCHOOL OF PUBLIC HEALTH • BOSTON UNIVERSITY GOLDMAN SCHOOL OF DENTAL MEDICINE • BOSTON MEDICAL CENTER

Boston University
School of Medicine

Office of the Registrar
715 Albany Street, A414
Boston, Massachusetts
02118-2526
Tel: 617 638-4160
Fax: 617 638-4155

BOSTON UNIVERISTY
IN THE COMMONWEALTH OF MASSACHUSETTS

THE SENATE AND TRUSTEES EXTEND GREETINGS
TO ALL THOSE TO WHOM THIS DOCUMENT MAY BECOME KNOWN.

SINCE LAWRENCE WHITFIELD MILLER BEING POSSESSED OF A PROPER DISPOSITION AND ENDOWED WITH AN UPRIGHT CHARACTER, HAS DEVOTED HIMSELF TO THE REQUIRED STUDIES IN THE MEDICAL SCHOOL OF THIS UNIVERSITY AND, AFTER A RIGID EXAMINATION SET BY INDIVIDUAL PROFESSORS, HAS PROVEN HIMSELF TO THOSE CONCERNED WITH HIM TO BE WELL VERSED IN THE ART AND SCIENCE OF MEDICINE.

THEREFORE, IT HAS PLEASED US, THE PROFESSORS OF THE ABOVE-NAMED SCHOOL, BY UNANIMOUS RESOLVE, TO AWARD TO HIM THE DEGREE OF

DOCTOR OF MEDICINE

AND TO CONFER ON HIM ALL THE BENEFITS, RIGHTS, HONORS AND PRIVILEGES ACCORDED THAT DEGREE HERE OR IN ANY PLACE WHERE THIS IS DISPLAYED.

IN TESTIMONY OF WHICH, BY VIRTUE OF THE AUTHORITY VESTED IN US WE HAVE SUBSCRIBED OUR NAMES TO THIS DOCUMENT, SECURED BY THE SEAL OF THE UNIVERISTY THE 18TH DAY OF MAY, 1986 IN THE 210TH YEAR OF THE FOUNDING OF OUR COMMONWEALTH.

JOHN I. SANDSON
DEAN

JOHN R. SILBER
PRESIDENT

JOHN F. O'CONNOR
SECRETARY
OF THE FACULTY

CHARLES W. SMITH
SECRETARY
OF THE BOARD OF TRUSTEES

SEAL
VERIFIED

Section IV

Postgraduate Training

ederation Credentials Verification Servic CVS)
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **Los Angeles County-USC Medical Center**
Address: 1200 North State Street/PO Box 540, Los Angeles, CA 90033
Attention: Department of Graduate Medical Education
Affiliated University: University of Southern California

Verification For:
Name: **Miller, Lawrence Whitfield**
SSN: [redacted]-5726
DOB: [redacted]1972
Physician's Name on Record (If different from above): _____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress, report the *expected* completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per department. If the department is rotating or transitional, please provide a schedule of rotations.

PGY: 1
__ Internship
__ Residency
__ Fellowship
__ Research
Department: Rotating Internship
From: 6/24/67 To: 6/24/68
Successfully Completed?: X Yes ___ No ___ In Progress
Accredited by: X ACGME __ AOA __ Not Accredited Other: _____

PGY: _____
__ Internship
__ Residency
__ Fellowship
__ Research
Department: _____
From: ___/___/_____ To: ___/___/_____
Successfully Completed?: ___ Yes ___ No ___ In Progress
Accredited by: __ ACGME __ AOA __ Not Accredited Other: _____

PGY: _____
__ Internship
__ Residency
__ Fellowship
__ Research
Department: _____
From: ___/___/_____ To: ___/___/_____
Successfully Completed?: ___ Yes ___ No ___ In Progress
Accredited by: __ ACGME __ AOA __ Not Accredited Other: _____

Unusual Circumstances:

Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

Did this individual ever take a leave of absence or break from their training?	Yes ~~No~~
Was this individual ever placed on probation?	Yes ~~No~~
Was this individual ever disciplined or placed under investigation?	Yes ~~No~~
Were any negative reports ever filed by instructors?	Yes ~~No~~
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes ~~No~~

Please explain any "Yes" response from above:
_____
_____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: Edward T. Wong, M.D. Signature: Lawrence Goo for E. Wong
Title: Director, Graduate Medical Education Date of Signature: 11/28/00
Tel: (323) 226-6931 Fax: (323) 226-6651 E-Mail: _____

LAC+USC

Los Angeles County
University of Southern California
Medical Center

1200 North State Street
Los Angeles, CA 90033

Phone: [213]

County of Los Angeles
Department of Health Services

November 27, 2000

(323) 226-6931
(323) 226-6651

Lawrence W. Miller, M.D. was a Rotating intern and has rotated in the following services:

Obstetrics/Gyn	June 24, 1967-July 25
Obstetrics/Gyn	July 24-Aug. 22
Gynecology	Aug. 23-Sept. 19
Surgery	Sept. 20-Oct. 17
Orthopedic	Oct. 18-Nov. 14
Metabolism	Nov. 15-Dec. 12
Radiology	Dec. 13-Jan. 9, 1968
Medicine	Jan. 10-Feb. 6
Medicine	Feb. 7-Mar. 5
Jail Ward	Mar. 6-Apr. 2
Medicine	Apr. 3-Apr. 30
New Born	May 1-May 28
Pediatrics	May 29-June 24, 19685

Federation Credentials Verification Service (FCVS)
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **Los Angeles County-USC Medical Center**
Address: 1200 North State Street/PO Box 540, Los Angeles, CA 90033
Attention: Department of Graduate Medical Education
Affiliated University: _____

Verification For:
Name: **Miller, Lawrence Whitfield**
SSN: **040-34-5726**
DOB: **04/15/1972**
Physician's Name on Record (If different from above): _____

Program Participation:

Important: Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress, report the *expected* completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per department. If the department is rotating or transitional, please provide a schedule of rotations.

PGY: I ✓ Internship ___ Residency ___ Fellowship ___ Research	Department: Obstetrics & Gynecology From: 06/24/71 To: 06/24/72 Successfully Completed?: ✓ Yes ___ No ___ In Progress Accredited by: ✓ ACGME ___ AOA ___ Not Accredited Other: _____
PGY: II-IV ___ Internship ✓ Residency ___ Fellowship ___ Research	Department: OB/GYN From: 07/01/72 To: 06/30/75 Successfully Completed?: ✓ Yes ___ No ___ In Progress Accredited by: ✓ ACGME ___ AOA ___ Not Accredited Other: _____
PGY: _____ ___ Internship ___ Residency ___ Fellowship ___ Research	Department: _____ From: ___/___/_____ To: ___/___/_____ Successfully Completed?: ___ Yes ___ No ___ In Progress Accredited by: ___ ACGME ___ AOA ___ Not Accredited Other: _____

Unusual Circumstances:

Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

Did this individual ever take a leave of absence or break from their training?	Yes (No)
Was this individual ever placed on probation?	Yes (No)
Was this individual ever disciplined or placed under investigation?	Yes (No)
Were any negative reports ever filed by instructors?	Yes (No)
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes (No)

Please explain any "Yes" response from above: _____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only)

Name: Paul Brenner MD Signature: Paul Brenner MD
Title: Professor + Vice Chairman/Dept Ob/Gyn Date of Signature: November 2, 2000
Tel: 323-226-3423 Fax: 323-226-3567 E-Mail: _____

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

STATE OF CALIFORNIA }
COUNTY OF Los Angeles } SS.

On 11-2-00 before me, the undersigned, a Notary Public in and for said State personally appeared PAUL BRENNER M.D.
Name(s) of Signer(s)

☐ Personally known to me **OR** ☑ proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

Witness my hand and official seal.

ENRIQUE FUENTES
COMM. # 1210857
NOTARY PUBLIC-CALIFORNIA
LOS ANGELES COUNTY
My Commission Expires Feb. 13, 2003

Signature of Notary

ENRIQUE FUENTES
Name (Typed or Printed)

(Area above for official notarial seal)

Capacity Claimed by Signer	Description of Attached Document
☑ Individual(s) ☐ Corporate Officer(s) - Title(s) _____ ☐ Partner(s) ☐ Attorney-in-Fact ☐ Trustee(s) ☐ Guardian/Conservator ☐ Other: _____ **Signer is Representing:** Name of person(s) or Entity(ies) _____	(Although this information is **optional**, it could prevent fraudulent attachment of this certificate to another document.) This certificate is for attachment to the document described below: Title or type of document Verification of Post-graduate Medical Education Number of pages 1 Date of document 11-2-00 Signer(s) other than named above NONE.

SAV-191A (7/98)

Section V

Examination History/Score Transcripts

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Record of Scores

This document was prepared by
National Board of Medical Examiners (NBME)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

Recipient: To Whom It May Concern **Date:** 09/29/2000

Examinee: Miller, Lawrence W **Examinee ID:** 3-093-210-7
Date of Birth: [redacted]1942

This record shows a complete Part history for this examinee.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores Anat	Phys	Bioc	Path	Micr	Phar
06/22/1965	Pass	Three-Digit								
		Two-Digit	82.8	(75)	84	86	82	86	78	81

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores Med	Surg	ObGyn	Prev	Peds	Psych
04/18/1967	Pass	Three-Digit								
		Two-Digit	86	(75)	86	88	87	85	82	82

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/13/1968	Pass	Three-Digit		
		Two-Digit	86.3	(75)

*** * * END OF DOCUMENT * * ***

See reverse side for explanation of information reported above.

1250

16025 5292892 SJJ

PLAS

Post-Licensure Assessment System

Post-Licensure Assessment System (PLAS)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Federation Credentials Verification Service
ATTN: New Mexico

Examinee: Miller, Lawrence Whitfield
USMLE ID#: 2-055-487-9
DOB: [redacted]1942
Alt Name(s):

It is certified that the above named physician took the Special Purpose Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: 420415505 **Date of Certification:** 12/07/2000

Date of Exam	State Exam Taken For	State ID	SPEX
09/01/1991	SOUTH CAROLINA		85

SPEX is a cognitive examination to assist licensing jurisdictions in their assessment of current competence requisite for general, undifferentiated medical practice by physicians who hold or have held a valid, unrestricted license in a United States or Canadian jurisdiction.

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

16025 SJV

New Mexico Board of Medical Examiners
Second Floor, Lamy Building
491 Old Santa Fe Trail
Santa Fe New Mexico 87501

RECEIVED
APR 26 2002
NM BOARD OF
MEDICAL EXAMINERS

Triennial Renewal 6/30/2002 – 6/30/2005

Current Information **License # 2001-260** **Corrections**

Gender: ☒ Male ☐ Female SSN: [redacted]5726 DEA: [redacted]0073

Preferred Mailing Address:

Lawrence W Miller, MD
[redacted]

Broadview Heights, OH 44147

fax # e-mail

Business Phone: 440-526-5596 Website:

Business or Public Address, if different from above:
8184 Thackeray Ct

Broadview Heights, OH 44147

fax # e-mail [redacted]@AOL.COM

NM Physician Assistant(s) currently under your supervision: 0

SPECIALTIES: OB-GYN, MEDICAL MANAGEMENT

DUE and payable by JULY 1, 2002*	**DUE and payable AFTER JULY 1, 2002***
RENEWAL FEE: $310	**LATE RENEWAL FEE: $410**
Your license will expire July 1, 2002	Renewals postmarked after July 1, 2002 require payment of a late fee of $100

I request the following change in license status:

- ☐ **Inactive Status/$25 Fee**: I am not practicing medicine in New Mexico. I understand that a license in inactive status does not require payment of the triennial renewal fee or compliance with CME requirements. I further understand that I may not engage in the practice of medicine or write prescriptions as long as my license is inactive.
- ☐ **Retired Status/No Fee**: I am retired and no longer practice medicine in New Mexico. I understand that I may not engage in the practice of medicine or write prescriptions.
- ☐ **Voluntary Lapsed Status/No Fee**: I choose not to renew my New Mexico medical license. I understand that I may not engage in the practice of medicine or write prescriptions.

Do not submit CME documentation unless a CME audit form is included with your renewal.

Staff Only
Payment Information: Fee received: $_____ By: ___ Visa ___ Master Card ___ Check ___ Money Order
Credit card # _____ Expires_____

All questions must be answered

Since the last renewal:

1. Has any action, including any disciplinary action, limitation, restriction, order for a competency examination, or any agreement, for any reason including rehabilitation, been taken or started by any state licensing board?..... ☐ Yes ☒ No
2. Has there been any denial, restriction, suspension or loss/revocation of your DEA or Controlled Substance license?..... ☐ Yes ☒ No
3. Have you been treated for use or misuse of any chemical substance or alcohol?...(if you are currently a voluntary participant in a Board approved monitoring program you may answer "No")..... [redacted]
4. Do you have any medical or mental condition that in any way impairs or limits your ability to safely practice medicine?..... [redacted]
5. Have you been denied a license in another state?..... ☐ Yes ☒ No
6. Are you currently more than a month in arrears in court-ordered child support payments in New Mexico or in any other state?..... ☐ Yes ☒ No
7. Have you been reported to the National Practitioner Data Bank?..... ☐ Yes ☒ No
8. Have you been arrested, convicted of, or pled no contest to a crime?..... ☐ Yes ☒ No
9. Have there been any malpractice court judgments or awards (settlements, arbitrations, mediations) against you?..... ☐ Yes ☒ No

If you answered "Yes" to any of the above, please provide a complete written explanation with this application.

Practice Information:

1. Do you practice full-time in New Mexico?..... ☐ Yes ☒ No
   If yes, estimate the % of time you spend in the following areas (total = 100): Direct patient care _____%
   Indirect patient care _____%; Administration _____%; Teaching _____%; Research _____%; Other _____%
2. Do you practice part-time in New Mexico? ..... ☐ Yes ☒ No
   If yes, estimate the % of time you spend in the following areas (total = <100): Direct patient care _____%
   Indirect patient care _____%; Administration _____%; Teaching _____%; Research _____%; Other _____%
3. Are you retired but maintain an active license? ..... ☐ Yes ☒ No
4. Please indicate number of work location(s)
   Office(s): 1 (2) 3 4 5 6 ≥7 Clinic(s): 1 2 3 4 5 6 ≥7 Hospital(s): 1 2 3 4 ≥5
   City(s)/Town(s): 1 (2) 3 4 ≥5 Rural: 1 2 3 4 ≥5

Jcm I hereby certify, under penalty of perjury, that all information on this form is currently accurate.

Jcm I certify that if I was licensed during 7/1/99 – 7/1/02 and I have completed a minimum of 75 AMA Category 1 hours of Continuing Medical Education as required by 16.10.4 NMAC, or

___ I have not completed a minimum of 75 CME hours as required by 16.10.4 NMAC and am requesting an emergency deferral, of up to 90 days, as allowed under 16.10.4.15 NMAC. I understand I will be assessed a late renewal penalty of $100 between (7/2/2002 – 8/15/2002) or $150 between (8/16/2002 – 10/1/2002) if my CME is not completed and submitted to the Board by July 1.

Laurence W Miller MD 4/22/02

Signature of Licensee (Signature stamp is not accepted) Date