Initial Application for Licensure
Florida Board of Medicine
Florida Department of Health

Basic Data

Profession:	MEDICAL DOCTOR
Application Type:	INITAL LICENSURE ENDORSEMENT
Name:	DR. SUSAN LYNN PFLEGER
Date of Birth:	03/21/1956
Place of Birth:	MILWAUKEE, WI
Citizenship:	UNITED STATES
Email Address:	SPFLEGER56@GMAIL.COM
Modifier:	NICA Non-Participating

Mailing Address

7402 N. CROSSWAY RD
MILWAUKEE, WI 53217

Physical Location or Address of Employment

7402 N. CROSSWAY RD
MILWAUKEE, WI 53217

Phone Numbers

Primary:	414-351-5004
Alternate:	

Equal Opportunity Data

Gender:	FEMALE
Race:	WHITE

Education History

Will you be using FCVS to assist you in the licensure process? Your answer: **YES**

School Name:	VANDERBILT UNIVERSITY SCHOOL OF MEDICINE	School Name:	
School Address:	21ST AVENUE SOUTH AT GRAND AVE NASHVILLE, TN 37232	School Address:	
Degree:	MD	Degree:	
Date Attended From:	07/01/1977	Date Attended From:	
Date Attended To:	05/15/1981	Date Attended To:	
Graduation Date:	05/15/1981	Graduation Date:	

Have you ever defaulted on any health education loan or scholarship obligation? Your answer: **NO**

If you are an international medical graduate, did you perform your core clerkships in the United States? Your answer: **NO**

Postgraduate Training

Program Name:	OREGON HEALTH SCIENCES UNIVERSITY	Program Name:	UNIVERSITY OF MIAMI
Program City:	PORTLAND	Program City:	MIAMI
Program State or Country:	OREGON	Program State or Country:	FLORIDA
Program Type:	RESIDENCY	Program Type:	RESIDENCY
Specialty Area:	GS - SURGERY	Specialty Area:	AN - ANESTHESIOLOGY
Date From:	06/19/1981	Date From:	07/01/1984
Date To:	07/19/1984	Date To:	07/01/1985
Did you receive credit?	Yes	Did you receive credit?	Yes

Program Name:	UNIVERSITY OF WISCONSIN/ MT SINAI	Program Name:	
Program City:	MILWAUKEE	Program City:	
Program State or Country:	WISCONSIN	Program State or Country:	
Program Type:	RESIDENCY	Program Type:	
Specialty Area:	OBG - OBSTETRICS AND GYNECOLOGY	Specialty Area:	
Date From:	01/01/1989	Date From:	
Date To:	02/28/1992	Date To:	
Did you receive credit?	Yes	Did you receive credit?	

Have you ever been dropped, suspended, placed on probation, asked to resign or expelled from any postgraduate training program?

Your answer: **NO**

Was attendance in a postgraduate training program for a period other than the established timeframe or were you required to repeat any of your postgraduate training including classes, test/exams, lectures or any other part of the curriculum?

Your answer: **NO**

Did you take any type of break or leave of absence for any reason during your postgraduate training?

Your answer: **YES**

MATERNITY LEAVE 09/1991

Other Name History

Have you ever changed your name through marriage, naturalization or action of a court or have you been known by any other names?

Your answer: **NO**

Other State Licenses

License Number:	29977	License Number:	MD2014-0148
License Type:	MEDICAL DOCTOR	License Type:	MEDICAL DOCTOR
Original Date Issued:	01/01/1989	Original Date Issued:	03/07/2014
Date of Expiration:	10/31/2015	Date of Expiration:	07/01/2014
Country:	UNITED STATES	Country:	UNITED STATES
State:	WISCONSIN	State:	NEW MEXICO

Year Began Practice

1992

Practice Employment

Employment Type:	Employment	Employment Type:	Employment
Employer Name:	AURORA MEDICAL GROUP	Employer Name:	PLANNED PARENTHOOD
Address Line 1:	945 N 12TH ST	Address Line 1:	JACKSON ST
Address Line 2:		Address Line 2:	
City:	MILWAUKEE	City:	MILWAUKEE
State:	WI	State:	WI
Title of Position:	OBG PHYSICIAN/ ASSOCIATE PROFESSOR	Title of Position:	PHYSICIAN
Practice Begin Date:	04/01/1992	Practice Begin Date:	02/01/2000
Practice End Date:	02/28/2013	Practice End Date:	

Have you ever had employment terminated for cause?

Your answer: **NO**

Faculty Appointment

Do you currently hold a faculty appointment at a medical school?

Your answer: **NO**

Graduate Medical Education

Have you had responsibility for graduate medical education within the last 10 years?

Your answer: **YES**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility?

Your answer: **YES**

Name of institution:	OUT OF STATE
Name of Institution:	AURORA SINAI MEDICAL CENTER
City:	MILWAUKEE
State:	WISCONSIN
Date From:	04/01/1992
Date To:	05/19/2014
Types of privileges:	GYNECOLOGY

Specialty Board Certification

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Your answer: **YES**

Specialty Board:	AMERICAN BOARD OF OBSTETRICS & GYNECOLOG
Certification:	OBG - OBSTETRICS AND GYNECOLOGY
Date of Certification:	12/14/1994

Drug Enforcement Administration Questions

Have you ever been warned or called before the United States Drug Enforcement Administration (DEA)?

Your answer: **NO**

Have you ever been made an offer to compromise or entered into any arrangement plea, or agreement instead of a federal prosecution for a drug violation regulated by DEA?

Your answer: **NO**

Have you ever been denied or surrendered a DEA registration?

Your answer: **NO**

Mandatory Continuing Medical Education (CME)

I have NOT completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education as defined by s. 456.013(7), Florida Statutes.

Electronic Fingerprinting

The Florida Care Provider Background Screening Clearinghouse is unavailable at this time.

Acknowledgement Statement

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy, and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

Your answer: **YES**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?

Your answer: **NO**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or similar national organization?

Your answer: **NO**

Discipline History

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country?

Your answer: **NO**

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility?

Your answer: **NO**

Have you ever been asked, or allowed to resign from any facility instead of disciplinary action or during any pending investigations into your practice?

Your answer: **NO**

Have you ever had any staff privileges restricted or not renewed by any facility instead of disciplinary action?

Your answer: **NO**

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

Your answer: **NO**

Have you ever been allowed to withdraw an application for medical licensure for any reason or during a pending investigation in any jurisdiction in lieu of your license being denied?

Your answer: **NO**

Have you ever been notified, invited or required 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, involving unprofessional or unethical conduct? Your answer: **NO**

Have you ever been denied or been excluded from Medicare and/or state health care programs? Your answer: **NO**

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes? Your answer: **NO**

United States Military and/or Public Health Service

Have you ever been in the United States Military and/or Public Health Service? Your answer: **NO**

Questions related to Section 456.0635(2), Florida Statutes

Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? Your answer: **NO**

For the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation? Your answer: **N/A**

For the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes). Your answer: **N/A**

For the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation? Your answer: **N/A**

Have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? Your answer: **N/A**

Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? Your answer: **NO**

Has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? Your answer: **N/A**

Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? Your answer: **NO**

If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? Your answer: **N/A**

Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? Your answer: **NO**

Have you been in good standing with a state Medicaid program for the most recent five years? Your answer: **N/A**

Did the termination occur at least 20 years before the date of this application? Your answer: **N/A**

Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? Your answer: **NO**

On or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health? Your answer: **N/A**

Additional Information

Availability for disaster

As a Florida licensed physician, are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters? Your answer: **YES**

Financial Responsibility

I do not practice medicine in the State of Florida.

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

Your answer: **NO**

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

Your answer: **NO**

Military Veteran Fee Waiver

Date of Discharge:

Your answer: **N/A**

Confidential Information

Name: DR. SUSAN LYNN PFLEGER
Social Security Number: [redacted]

This information is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Examination History

Exam:	NBME	Exam:	
Exam Date:	06/15/1982	Exam Date:	

This information is exempt from public records disclosure because it contains exam grades as described by section 456.014 (1), Florida Statutes.

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? Your answer: [redacted]

In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? Your answer: [redacted]

In the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the last five years? Your answer: [redacted]

In the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine? Your answer: [redacted]

In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder, or if you were previously in such a program, did you suffer a relapse within the last five years? Your answer: [redacted]

During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the past five years? Your answer: [redacted]

This information is exempt from public records disclosure because it contains medical information as described by Section 456.014 (1), Florida Statutes.

Application Statement

☒ I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, 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 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. I state 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 constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the Board within 30 days. I understand that my records are protected under 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 federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR 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 upon it.

NAME [illegible] DATE [illegible]

CAMERA II ROLL [illegible]

RECEIVED
APR 30 1984
MEDICAL/NATUROPATH
OSTEOPATH

BOARD OF MEDICAL EXAMINERS
ENDORSEMENT APPLICATION

FEE OF $250 MUST ACCOMPANY APPLICATION. NOTE: FEE IS NONREFUNDABLE. TYPE OR USE BLACK INK. ANSWER ALL QUESTIONS. IF THE ANSWER TO ANY QUESTION IS "YES", GIVE DETAILS IN A NOTARIZED AFFIDAVIT AND ATTACH TO APPLICATION (PLEASE SEE PAGE 3 OF APPLICATION INSTRUCTIONS)

On the basis of certification by the National Board of Medical Examiners ✓ OR Federation of State Medical Boards of the United States, Inc., (FLEX) _____ I hereby, apply for licensure to practice medicine/surgery in Florida.

NAME: SUSAN LYNN PEGGLER (name as it should appear on certificate) SOCIAL SECURITY #: [redacted]

ADDRESS: 1132 SW Broadway Dr (street and number) PORTLAND (city) OREGON (state) 97201 (zip)

PERMANENT ADDRESS: 14-13 Santa Cruz Avenue Coral Gables FL 33134
(C/O) 7018 N CLAIR CT (street and number) MILWAUKEE (city) WI (state) 53217 (zip)

TELEPHONE NUMBER: (503) 228-2463 (area code) number DATE OF BIRTH: 3 (mo.) 31 (day) 56 (year)

PLACE OF BIRTH: MILWAUKEE (city) WISCONSIN (state) USA (country)

HAVE YOU EVER LEGALLY CHANGED YOUR NAME? NO If so, enclose notarized copy of legal document giving change. If changed in naturalization we need proof of change.

We are required to ask that you furinsh the following information as part of your voluntary compliance with Section 2, Uniform 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 candidacy for licensure

RACE: CAUCASIAN ✓ BLACK ____ ORIENTAL ____ NATIVE AMERICAN ____ OTHER ____

SEX: FEMALE ✓ MALE ____

DOCTOR OF MEDICINE DEGREE WAS OBTAINED FROM: VANDERBILT UNIVERSITY (name of medical school and location)
NASHVILLE, TN on _____ (exact date)

ARE YOU OR HAVE YOU EVER BEEN LICENSED IN ANOTHER STATE? YES ✓ NO ____ (IF YES, LIST STATE(S), LICENSURE NUMBER, AND DATE ISSUED):
OREGON #38313 7/10/82

* * * * * * * * * *

FOR OFFICE USE ONLY
PLEASE DO NOT WRITE BELOW THIS LINE

CATEGORY: _____ P
SCHOOL CODE: _____
EDUCATION: _____

Rev. 3/84

NAME [illegible] DATE [illegible]

CAMERA II ROLL [illegible]

ARE YOU A CITIZEN OF THE UNITED STATES? Yes. IF FOREIGN BORN GIVE DATE AND PLACE OF NATURALIZATION: _____

DID YOU ATTEND A COLLEGE OR UNIVERSITY? Yes IF SO, GIVE NAME AND LOCATION, DATE(S) IN ATTENDANCE: Macalester College St Paul, Mn 8/77-5/77

DID YOU RECEIVE A DEGREE OTHER THAN A M.D.? BA Philosophy

LIST ALL PLACES OF RESIDENCE (WHERE LIVED) SINCE INITIATION OF MEDICAL TRAINING:

Nashville TN (city, state or country) FROM: August, 1977 TO: May, 1981

Portland Ore (city, state or country) FROM: May, 1981 TO: Present, 19__

(city, state or country) FROM: _____, 19__ TO: _____, 19__

(city, state or country) FROM: _____, 19__ TO: _____, 19__

MEDICAL EDUCATION: BE SPECIFIC. ACCOUNT FOR EACH YEAR. LIST ALL UNIVERSITIES/COLLEGES WHERE ATTENDED CLASSES/RECEIVED TRAINING AS A MEDICAL STUDENT.

Vanderbilt Univ Nashville TN (name of medical school/location) FROM: August, 1977 TO: May, 1981

(name of medical school/location) FROM: _____, 19__ TO: _____, 19__

(name of medical school/location) FROM: _____, 19__ TO: _____, 19__

(name of medical school/location) FROM: _____, 19__ TO: _____, 19__

ACCOUNT FOR ALL TIME FROM GRADUATION TO PRESENT. NOTE: DO NOT LEAVE OUT ANY TIME. TRAINING: List chronologically residency/post graduate training. Give name and address of hospital, exact date(s), and specify type of training. If currently in ******* training, give name of department chief.

Oregon Health Sciences Univ 3181 sw Sam Jackson Park Rd
Portland, Ore 97201
General Surgery 6/26/81 present
William Kittredge M.D.

List chronologically location(s) practiced and/or employed. Give addresses, dates, specify type of practice and/or employment.

NAME [illegible] DATE [illegible]

CAMERA II ROLL [illegible]

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

Multnomah Co Medical Society 1992

3199 SW Pine Pl SW Portland Or. 97205

Has your application for any medical society membership been rejected? NO

Have you ever had your medical society membership suspended? NO

Have you ever been notified to appear before a medical society in regard to charges/complaints filed against you? NO

IF ANY OF THESE QUESTIONS ARE ANSWERED "YES" GIVE NAME(S) AND ADDRESS(ES) OF MEDICAL SOCIETY.

List civic organizations of which you are now or ever have been a member.

NONE

RECOMMENDATIONS: Give the names and complete addresses of two (2) physicians who are submitting letters of recommendation on your behalf. If you are in training, give two names and addresses of physicians whom you have practiced with writing letters of reccommendation on your behalf. (NOTE: THESE LETTERS MUST BE ADDRESSED TO THE FLORIDA BOARD.)

Clare Peterson M.D. Assoc Chairman Dept Surgery

OHSU 3181 SW Sam Jackson Park Portland Or 97201

Daniel Lowe, M.D.

c/o Dept Surgery OHSU (Co worker)

* ** ** ** ** ** ** ** ** ** ** ** ** *

PLEASE NOTE: YOUR APPLICATION PROCESS WILL NOT BE CONSIDERED COMPLETE UNLESS YOU COMPLY WITH THE FOLLOWING:

ALL DOCUMENT(S) SUBMITTED MUST BE NOTARIZED AS TRUE AND CORRECT COPIES OF THE ORIGINAL DOCUMENT(S) AND STATED SO BY THE NOTARY PUBLIC. NOTARY PUBLICS MUST SEE THE ORIGINAL DOCUMENT(S) AND THE COPY IN ORDER TO STATE REQUIREMENT.

NAME / / DATE

CAMERA II ROLL

List hospital(s) where you have staff privileges. (Give addresses, date(s) of service, and chief of staff)

NONE

Have you ever been denied staff privileges in any hospital? NO Have you ever had your staff privileges suspended? NO If either of these questions are answered "YES", give name(s) address(es) of hospital(s).

HAVE YOU EVER BEEN IN THE UNITED STATES MILITARY? NO IF SO, ATTACH COPY OF SEPARATION FROM SERVICE

(branch of service, rank, dates of service)

FOREIGN MEDICAL GRADUATES: ECFMG STANDARD CERTIFICATE NUMBER ISSUED AFTER PASSING ENGLISH AND MEDICAL EXAMINATION. ATTACH A COPY, NOTARIZED AS TRUE AND CORRECT COPY OF THE ORIGINAL BY THE NOTARY.

Have you ever studied to become, or do you hold licensure in any state as a Chiropractor, Naturopathic or Osteopathic physician? NO

Have you ever failed STATE BOARD/FLEX/NATIONAL BOARD EXAMINATION? NO

Have you ever been denied an application for licensure to practice medicine by any state board or other governmental agency of any state or country? NO

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? NO

Have you ever had a license to practice medicine/surgery revoked, suspended, or other disciplinary action taken in any state, territory, or country? NO

Are you certified by an American Specialty Board? NO If "YES", give name of Board

Enclose copy of Board certificate or letter verifying eligibility)

Are you a diplomate of the National Board of Medical Examiners? YES If "YES", state year of certification 1993

Have you ever been convicted of a felony? NO ; a misdemeanor? NO Have any judgements ever been entered against you? NO Have you ever been sued for malpractice? NO

Have you ever had to discontinue practice for any reason for a period of one month or longer? NO

Are you now or have you ever been emotionally/mentally ill? [redacted] Have you ever received psychotherapy? [redacted]

Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or any other medication? [redacted]

Have you ever voluntarily or otherwise been a patient in an institution for the treatment of mental/emotional illness, drug addiction/abuse, or excessive use of alcohol? [redacted]

NAME [illegible] DATE [illegible]

CAMERA II ROLL [illegible]

IF THE ANSWER TO ANY OF ABOVE QUESTIONS ARE ANSWERED "YES", GIVE DETAILS INCLUDING DATES, NAMES AND ADDRESSES OF HOSPITALS, TREATING PHYSICIANS. IN ADDITION, FOR FELONY, MISDEMEANOR, MALPRACTICE APPLICANT MUST FURNISH COPY OF CERTIFIED COMPLAINT AND DISPOSITION OF SAME. FOR PSYCHOTHERAPY, APPLICANT MUST FUPNISH DETAILED EVALUATION FROM TREATING PHYSICIAN(S) INCLUDING DIAGNOSIS/PROGNOSIS AND A STATEMENT THAT APPLICANT CAN PRACTICE MEDICINE WITH REASONABLE SKILL AND SAFETY.

Have you ever been warned or called before the Bureau of Narcotics and Dangerous Drugs? NO In connection with the Harrison Narcotic Law? Have you ever made an offer to compromise Have you ever been denied, or surrendered, a narcotic tax stamp? NO

* ** ** ** ** ** ** ** ** ** ** ** ** *

TO BE COMPLETED BY APPLICANT

DATE 31 March 1984 COLOR OF EYES Brown

AGE 38 COLOR OF HAIR Brown

HEIGHT 5'4" WEIGHT 115 OTHER MEANS OF IDENTIFICATION ∅

AFFIDAVIT OF APPLICANT:

I, Susan Lynn Pfeffer, 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 Florica State Board of Medical Examiners 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 is 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.

COUNTY OF Multnomah

STATE OF Oregon

[signature] (signature of applicant)

Subscribed and sworn to before me this 19th day of April, 1984.

Lyle M Staple (notary public)

My commission expires 4-3-87 (notary seal/stamp)

FOR USE OF BOARD SECRETARY ONLY

LICENSE NUMBER

DATE ISSUED