

Medical Doctor Application for Licensure

Board of Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 488-0596
Email: BOM_InitialApps@flhealth.gov

Do Not Write in this Space
For Revenue Receipting Only

3000095

Select the application method for Medical Doctor (1501) Licensure:

☐ Examination (1024) ☒ Endorsement (1021)

Select the appropriate fee based on residency/fellowship status:

Not in a residency/fellowship \$705.00 + NICA fee

☐ NICA Exempt: \$0.00- **Total \$705.00** (Submit proof of exemption)

☒ NICA Non-Participating: \$250.00- **Total \$955.00**

☐ NICA Participating: \$5,000.00- **Total \$5,705.00**

In a residency/fellowship \$555.00 (NICA Exempt)

(Training director must submit a letter verifying dates of training)

☐ Dispensing* (Optional) + \$100.00 see description on page 3

Total fee includes the following:

Application Fee (non-refundable)	\$350.00
Initial License Fee	
Non-resident:	\$350.00
Resident:	\$200.00
Unlicensed Activity Fee	\$5.00
NICA Exempt Fee	\$0.00
NICA Non-Participating Fee	\$250.00
NICA Participating Fee	\$5,000.00
Dispensing (optional)	\$100.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: **Kumar Bhavik** Date of Birth: **01/19/1985**
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

3262 Westheimer Road #901 Houston
Street/P.O. Box Apt. No. City
Texas 77098 512 639 9582
State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

4600 Gulf Freeway Houston
Street (Place of Employment) Suite No. City
Texas 77023 713 831 6537
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☒ Male ☐ Female Race: ☐ Native Hawaiian or Pacific Islander ☐ Hispanic or Latino ☐ White
☐ American Indian or Alaska Native ☐ Black or African American ☒ Asian
☐ Two or More Races

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☒ Yes ☐ No Email Address: **Bhavik.Kumar@ppgulfcoast.org**

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Applicants who do not currently have a practice address are required to update their online practitioner profile with a practice address when it is available.

2. SOCIAL SECURITY DISCLOSURE

Bhavik Kumar

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: Kumar

First Name: Bhavik

Middle Name: _____

Social Security Number:
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: Bhavik Kumar

3. APPLICANT BACKGROUND

- A. Are you using the Federation Credentials Verification Service (FCVS) to verify your core credentials?
☒ Yes ☐ No

FCVS is **not a requirement** for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their website at www.fsmb.org/fcvs/.

- B. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.
N/A

- C. List the year you legally began to practice medicine (*may be the date you began your postgraduate training*).

Year: 2010
YYYY

- D. Do you hold, or have you ever held a license to practice medicine or any other regulated professional license(s)? ☒ Yes ☐ No

- E. List all regulated professional licenses (active, inactive or lapsed). Attach additional sheets if necessary.

License Type	License #	State/Jurisdiction or Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License
MD	Q2321	Texas	11/07/2014	11/30/2023	Active
MD	312179	Louisiana	04/03/2019	01/31/2013	Active
MD	269339	New York	03/22/2013	12/31/2016	Inactive

- ☐ **Submit a License Verification form to ALL state(s) of licensure.** License verifications must be received directly from the licensing authority or www.veridoc.org regardless of the status of the license. Check www.veridoc.org for states that use the online verification service. Applicants educated outside the U.S. may be required to request **international license verification(s)**. You will be notified in writing if international license verification is required.

- F. Have you practiced medicine in any jurisdiction for two of the last four years, or completed a board approved post-graduate training program within the last two years? ☒ Yes ☐ No

- G. If you responded "No" to F, have you passed a board-approved clinical competency exam within the last year? ☐ Yes ☐ No

- ☐ If "Yes" to G, request supporting documentation.

- H. If you have ever served in the United States (U.S.) Military or Public Health Service (PHS), have you ever been disciplined by any branch of the U.S. Military or PHS? ☐ Yes ☒ No ☐ N/A

If "Yes," provide the following:

- ☐ **A self-explanation** on a separate sheet providing accurate details (including, but not limited to, the date(s), location(s), and specific circumstances).

- ☐ **Documentation from the U.S. Military/PHS** regarding the disciplinary action and charge(s)/event(s).

4. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☒ No

Name: Bhavik Kumar

5. EDUCATION / TRAINING HISTORY

A. Have you completed the equivalent of two academic years of preprofessional, postsecondary education including courses in anatomy, biology and chemistry prior to entering medical school? ☒ Yes ☐ No

B. List in chronological order all medical schools attended, whether completed or not. Attach a separate sheet if necessary.

School Name	School Address	Dates of Attendance: From-To (MM/DD/YYYY)	Date Degree Received (MM/DD/YYYY)
Texas Tech University Health Sciences Center School of Medicine	3601 4th Street Lubbock, Texas 79430 United States	07/01/2006 to 05/22/2010	05/22/2010
		to	
		to	
		to	

☐ All applicants *except those using FCVS* must have the "Medical Degree Verification" form (found at the back of the application) submitted directly to the board office from the school from which they received their medical degree. Any information not verifiable by FCVS may require the applicant to submit it.

C. Are you currently certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?
☐ Yes ☒ No

☐ All applicants who are certified by the ECFMG *except those using FCVS* must have ECFMG Certification Status Report submitted to the board office directly from the ECFMG. Contact ECFMG Applicant Information Services at:

ECFMG
3624 Market Street
Philadelphia, PA 19104-2685 USA
Phone: (215) 386-5900 (Mon-Fri, 9:00 AM to 5:00 PM EST)
Fax: (215) 386-9196
www.ecfm.org

Include your USMLE/ECFMG Identification Number, if one has been assigned, when communicating with ECFMG.

D. List in chronological order from date of graduation from medical school to the present all postgraduate training (internship/residency/fellowship). List all programs you began, whether or not you completed or received credit for the training.

Program Name/Address	Specialty Area	Dates of Attendance: From-To (MM/DD/YYYY)	Credit Received?
Montefiore Medical Center/Albert Einstein College of Medicine / 111 East 210th Street Bronx, New York 10467 United States	Family medicine	07/01/2010 to 06/30/2013	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
		to	<input type="checkbox"/> Y <input type="checkbox"/> N
		to	<input type="checkbox"/> Y <input type="checkbox"/> N

☐ All applicants *except those using FCVS* must have the "Postgraduate Training Verification" form (found at the back of the application) submitted directly to the board office from the Chairman/Director of each post-graduate training program attended, whether completed or not. Any information not verifiable by FCVS may require the applicant to submit it.

E. 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? ☒ Yes ☐ No

If you responded "Yes," complete the following:

Board Name	Certification/Specialty/Subspecialty	Date of Certification (MM/YYYY)
American Board of Family Medicine	Family Medicine	07/2013

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6. FIFTH PATHWAY CERTIFICATE HOLDERS ONLY ** N/A to all of the following; not a 5th pathway cert holder.
Answer the questions in this section only if you hold a Fifth Pathway Certificate.

- A. Did you attend an international medical school and do not possess a valid ECFMG Certificate? ☐ Yes ☐ No
- B. Did you receive a bachelor's degree from an accredited United States college or University? ☐ Yes ☐ No
- C. Did you study at a medical school which is recognized by the World Health Organization? ☐ Yes ☐ No
- D. Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National Board of Medical Examiners or the Educational Commission for Foreign Medical Graduates Examination equivalent? ☐ Yes ☐ No
- E. Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must request verifications be sent to the board office directly from the appropriate entity.

All Fifth Pathway Certificate holders must submit the following:

- ☐ Verification of your Fifth Pathway program
- ☐ Verification of NBME I & II examination, USMLE or ECFMG examination equivalent score reports

7. EXAMINATION HISTORY

Select from the following which exam(s) you have passed:

- ☐ State Board (prior to 1974)
- ☐ State Board (after 1974) and SPEX
- ☐ LMCC and SPEX
- ☒ National Examination (NBME, FLEX, or USMLE III)
- ☐ Combination (prior to 2000)- View <https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64B8-5> for more information.

Exam Taken	Exam Date (MM/DD/YYYY)
USMLE Step 3	11/21/2011

- ☐ **All applicants *except those using FCVS* must request all examination score reports to be submitted to the board office directly from the score reporting entity. The applicant is responsible for any associated fees to furnish this information. Use the following information to contact the appropriate reporting entity.**

National Board score report
National Board of Medical Examiners Inc.
3750 Market Street
Philadelphia, PA 19104-3190
(215)590-9500
www.nbme.org

SPEX, FLEX, or USMLE score report
Federation of State Medical Boards
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3855
(817)868-4000
www.fsmb.org

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8. EMPLOYMENT HISTORY

List in chronological order all employment including practice employment for the last four years.

Name of Employer	Employer Address	Position Title	Employment Dates: From-To (MM/DD/YYYY)
Whole Woman's Health	3256 Lackland Rd Fort Worth, Texas 76116 United States	Medical Director & Staff Physician	08/01/2016 to 10/31/2018
Whole Woman's Health	4100 Duval Road Building 2, Suite 201 Austin, Texas 78759 United States	Medical Director & Staff Physician	08/01/2016 to 10/31/2018
Whole Woman's Health	802 S Main St Mcallen, Texas 78501 United States	Medical Director & Staff Physician	08/01/2016 to 10/31/2018
Whole Woman's Health	4025 E Southcross Bldg #5, Ste. #30 San Antonio, Texas 78222 United States	Medical Director & Staff Physician	08/01/2016 to 10/31/2018

9. ACADEMIC FACULTY APPOINTMENTS / STAFF PRIVILEGES

- A. Do you currently hold a faculty appointment at an accredited medical school? ☐ Yes ☒ No
- B. Have you had the responsibility for graduate medical education within the last ten years? ☐ Yes ☒ No

If you responded "Yes," complete the following:

Name of Institution	City/State	Title of Appointment

- C. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? ☒ Yes ☐ No

If you responded "Yes," complete the following:

Name of Facility	City/State	Type of Privileges	From-To (MM/DD/YYYY)
Planned Parenthood Center for Choice	Houston, Texas	Active Staff	12/01/2018 to Present
			to

- D. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, 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? ☐ Yes ☒ No

If you responded "Yes," complete the following:

Name of Facility	Address	From-To (MM/DD/YYYY)	Under Appeal?
		to	<input type="checkbox"/> Y <input type="checkbox"/> N
		to	<input type="checkbox"/> Y <input type="checkbox"/> N

If you responded "Yes" to D, you must provide the following:

- ☐ A written self-explanation on a separate sheet describing in detail the circumstances
- ☐ Supporting documents from the applicable entity

10. OTHER ITEMS REQUIRED

- ☐ **National Practitioner Data Bank (NPDB) Self-Query-** All applicants are required to complete a self-query to the NPDB and upon receipt of the report, provide the board office with a copy. The NPDB charges a fee to provide the self-query. You may contact NPDB at www.npdb.hrsa.gov/ or by telephone at (800) 767-6732.

All supporting documentation not submitted with the application must be sent to the board office at
BOM_InitialApps@flhealth.gov or mailed to:

Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

This information is exempt from public records disclosure.

11. HEALTH HISTORY

The board and the department, as part of its responsibility to protect the health, safety, and welfare of the public, must assess whether an applicant manifests any physical, mental health, or substance use issue that impairs the applicant's ability to meet the eligibility requirements for a health care practitioner as defined in chapter (ch.) 456, F.S., and the applicable statutory practice acts.

The board and the department support applicants seeking treatment and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the eligibility requirements to practice a health care profession.

Seeking assistance with stress, mild anxiety, situational depression, family or marital issues will not adversely affect the outcome of a Florida health care practitioner application. The board and the department do not request that applicants disclose such assistance.

1. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or impairs your ability to practice? [REDACTED]
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or impairs your ability to practice? [REDACTED]

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

- ☐ **A letter from a licensed health care practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.
- ☐ **A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

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12. DISCIPLINE HISTORY

- A. 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?
☐ Yes ☒ No
- B. Have you ever had any application for a license to practice a regulated profession, including medicine, denied by any state board or the licensing authority of any state, territory, or country? ☐ Yes ☒ No

If you responded "Yes" in questions A-B, you must provide the following:

- ☐ A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.
- ☐ A copy of all pertinent information including **Administrative Complaint(s), Final Order(s), and current disposition.**

- C. Are you currently under investigation or prosecution in any jurisdiction for an act that would constitute a violation under s. 456.072, F.S., or s. 458.331, F.S.? ☐ Yes ☒ No

If you responded "Yes" in question C, you must provide the following:

- ☐ A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.
- ☐ A letter from the state board/entity explaining the results of the investigation.

If you responded "Yes" in questions A-C, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N

- D. Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization? ☐ Yes ☒ No
- E. Have you ever been denied, or surrendered a Drug Enforcement Agency (DEA) registration? ☐ Yes ☒ No

If you responded "Yes" in questions D or E, you must provide the following:

- ☐ A written self-explanation on a separate sheet describing in detail the circumstances
- ☐ Supporting documents from the applicable entity

13. CRIMINAL HISTORY

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☒ No

If you responded "Yes" in this section, complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N

If you responded "Yes," you must provide the following:

- ☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.
- ☐ **Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
- ☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

14. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under chapter (ch.) 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☒ No

If you responded "No" to the question above, skip to question 2.

- a. If "Yes" to 1, 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? ☐ Yes ☐ No
- b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No
- c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No
- d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes" provide supporting documentation)? ☐ Yes ☐ No

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2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☒ No

If you responded "No" to the question above, skip to question 3.

- a. If "Yes" to 2, 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? ☐ Yes ☐ No
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☒ No

If you responded "No" to the question above, skip to question 4.

- a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☒ No

If you responded "No" to the question above, skip to question 5.

- a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No
- b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No
5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☒ No
- a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No
- b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

- ☐ A written self-explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.
- ☐ Supporting documentation including court dispositions or agency orders where applicable.

Documentation for sections 11 and 12 must be sent to the board office at
BOM_InitialApps@flhealth.gov or mailed to:

Board of Medicine
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Documentation for section 13 and 14 must be sent to the Background Screening Unit at
MQA.BackgroundScreen@flhealth.gov or
mailed to:

Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

15. MALPRACTICE / LIABILITY CLAIM HISTORY

- A. Have you had a judgement entered against you for medical malpractice when the incident(s) of malpractice occurred **after November 2, 2004**? ☐ Yes ☒ No
- B. Within the last ten years have you had any liability claims or actions for damages for personal injury settled or finally adjudicated in an amount that exceeds \$100,000? ☐ Yes ☒ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

- ☐ **A written self-explanation** listing your involvement in each case
- ☐ **Completed Exhibit 1 form** for each case (found following the application)
- ☐ **A copy of the complaint and disposition for each case**
- ☐ **For judgements when the incident(s) of malpractice occurred after November 2, 2004, the entire case record must be submitted in electronic format** (either PDF or TIFF), preferably on a DVD (do not send originals). The record must include:
- Initial and/or amended complaint
 - Trial transcripts
 - Evidentiary exhibits
 - Final judgement

16. LIVESCAN PRIVACY 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 (found in the forms following this application).

The board will not receive your Livescan results if you do not confirm the above statement by checking the box.

- ☐ **Electronic Fingerprinting: (Required for ALL applicants)**

All applicants, including out-of-state applicants, are required to submit their fingerprints electronically. The Department of Health accepts electronic fingerprinting offered by Livescan service providers that are approved by the Florida Department of Law Enforcement. For a list of approved vendors, visit our website at:
<http://www.flhealthsource.gov/background-screening/>.

Typically background results submitted by Livescan are received by the board within 24-72 hours of being processed. The board's ORI number is **EDOH2014Z**. The board cannot accept hard fingerprint cards or results. All results must be submitted electronically by the Livescan service provider.

The Florida Department of Health retains fingerprints on any applicant are retained in the Care Provider Clearinghouse. One of the requirements for your Livescan to be retained in the Care Provider Clearinghouse is a photograph must be taken by the Livescan service provider at the time of fingerprinting. Your background screening results will be retained for five years. You will be notified when your retention date is approaching and will be provided instructions on how to retain your fingerprints to avoid having to submit a new background screening.

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17. APPLICANT SIGNATURE

I have carefully read the questions in the application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me are true and correct. I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, F.S.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

I 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 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, 45 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature



You may print this application and sign it or sign digitally.

Date

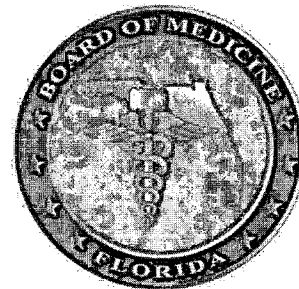
6/15/2022

MM/DD/YYYY

This form is required
for ALL applicants.

Board of Medicine
Financial Responsibility

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The Financial Responsibility options are divided into two categories: coverage and exemptions.

Choose only ONE option that best describes your situation, unless you choose **option 6** in the "Financial Responsibility Coverage" section. Not making a choice or choosing more than one option will make this form invalid. Staff is unable to advise you on which option to choose. If you have questions regarding an option, consult your legal counsel, insurance company or financial institution.

FINANCIAL RESPONSIBILITY COVERAGE

- ☐ 1. I **do not** have hospital staff privileges, I **do not** perform surgery at an ambulatory surgical center, and I have established an irrevocable letter of credit or an escrow account in an amount of \$100,000/\$300,000, in accord with ch. 675, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.
- ☐ 2. I **have** hospital staff privileges **or** I perform surgery at an ambulatory surgical center, and I have established an irrevocable letter of credit or escrow account in an amount of \$250,000/\$750,000, in accord with ch. 675, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.
- ☐ 3. I **do not** have hospital staff privileges, I **do not** perform surgery at an ambulatory surgical center, and I have obtained and maintain professional liability coverage in an amount not less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000 from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.
- ☐ 4. I **have** hospital staff privileges **or** I perform surgery at an ambulatory surgical center, and I have professional liability coverage in an amount not less than \$250,000 per claim, with a minimum annual aggregate of not less than \$750,000 from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.
- ☐ 5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F.S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F.S.
- ☒ 6. I am exempt from financial responsibility coverage *(If you choose this option you must choose one option from the exemption category on the following page.)*

Board of Medicine
Financial Responsibility
Page 2 of 2



Name: Bhavik Kumar

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE

- ☐ 1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
- ☐ 2. I hold a limited license issued pursuant to s. 458.317, F.S., and practice only under the scope of such limited license.
- ☐ 3. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents **do not** qualify for this exemption.)
- ☒ 4. I have no malpractice exposure, because I do not practice in the state of Florida. I will notify the department immediately before commencing practice in the state.
- ☐ 5. I am exempt from demonstrating financial responsibility due to meeting **all** the following criteria (If you select this option **you must also** complete the "**Financial Responsibility Affidavit of Exemption**" form that follows this page):
- a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
 - b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
 - c. I have no more than two claims resulting in an indemnity exceeding \$25,000 within the previous five-year period.
 - d. I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in ch. 458, F.S., or the medical practice act in any other state.
 - e. I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of \$500 or more for a violation of ch. 458, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See s. 458.320(5)(f), F.S., for specific notice requirements.

Section 456.067, F.S., Penalty for giving false information. - In addition to, or in lieu of, any other discipline imposed pursuant to s. 456.072, F.S., the act of knowingly giving false information in the course of applying for or obtaining a license for the department, or any board thereunder, with intent to mislead a public servant in the performance of his or her duties, or the act of attempting to obtain or obtaining a license from the department, or any board thereunder, to practice a profession by knowingly misleading statements or knowing misrepresentations constitutes a felony of the third degree, punishable in s. 775.082, F.S., s. 775.083, F.S., or s. 775.084, F.S.

Applicant Signature

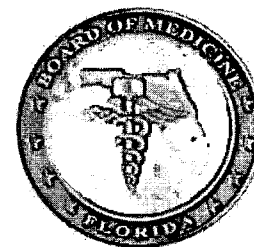
Date

6/15/2022

MM/DD/YYYY

This form is required
for ALL applicants.

Board of Medicine
Florida Birth-Related Neurological Injury
Compensation Association (NICA) Form



All applicants must choose one of the three options described below. Check **only one**.

Visit <https://www.nica.com/obgyns/index.html> for information on NICA participating, non-participating, and exempt.

☐ Exempt- \$0.00 ☒ Non-participating- \$250.00 ☐ Participating- \$5,000.00 Amount Enclosed: \$ **\$250**

For applicants who choose "**Participating**", NICA provides eligible children with lifetime benefits for catastrophic claims resulting from certain birth-related neurological injuries. In order to participate, a physician must:

1. Be licensed to practice medicine in Florida
2. Practice obstetrics or perform obstetrical services on a full or part-time basis; and
3. Have paid, or been exempted from paying, the required assessment when the incident occurred.

For applicants who choose "**Non-participating**," a mandatory annual fee of \$250.00 is paid by every physician in Florida who is not Participating or Exempt.

☐ **Participating and Non-participating applicants** must complete and attach this form and appropriate fees to the application or submit to the Board of Medicine at:

Board of Medicine

P.O. Box 6330

Tallahassee, FL 32314-6330

☐ **Applicants claiming exemption** must complete this form, and return it with proof of qualification for the exemption to:

Board of Medicine

4052 Bald Cypress Way Bin C-03

Tallahassee, FL 32399-3253

NICA

2360 Christopher Place

Tallahassee, FL 32308

Exemptions Include:

1. Resident physicians, assistant resident physicians and interns in postgraduate training programs approved by the Board of Medicine (documentation of the dates of your program signed by the chair of your department must be provided to NICA).
2. Retired physicians who maintain an active license, but who have withdrawn from employment in any medically related field, as evidenced by an affidavit filed with NICA (a copy of this affidavit must be provided to the Department of Health).
3. Physicians who hold a limited license, as defined by ch. 458, F.S., who do not receive any compensation for medical services (an affidavit must be provided to NICA stating that no compensation is received for medical services).
4. Physicians employed full-time by the Veterans Administration whose practices are confined to Veterans Administration hospitals (a letter from your employer stating you are a full-time employee as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
5. Any licensed physician on active duty with the Armed Forces of the United States; (a letter from your commanding officer stating that you are on active duty in the Armed Forces as well as an affidavit from you stating you are not engaged in the private practice of medicine must be provided to NICA).
6. Physicians who are full-time state of Florida employees whose practice is confined to state owned correctional facilities, mental health or developmental services facilities, or the Department of Health or County Health Department (a letter from state government documenting your employment status as well as an affidavit from you stating you are not engaged in outside employment must be provided to NICA).

It is each physician's obligation to notify NICA of a subsequent change in status with regard to a claimed exemption. For questions about NICA or this form, contact NICA at www.nica.com or (850) 488-8191.

Applicant Name: Bhavik Kumar

Address: 3262 Westheimer Road #901 Houston, Texas 77098

Street and Number

City

State

ZIP

I have read the information provided by NICA at www.nica.com and I have selected the option above.

Applicant Signature [Signature]

Date 6/15/2022

MM/DD/YYYY

LIMITED POWER OF ATTORNEY

Physician Medical Licensing Service, Inc.

1331 East Lafayette Street, Suite D

Tallahassee, FL 32301

(850) 325-1400 fax (850) 877-6417

I, Bhavik Kumar, hereby name and appoint KATIE BERTOLDI, KRISTY ROWAN, KAITLIN SENDAR, LAUREN COURTNEY, DALIANNI FROMETA, ALEXANDRA ROMANELLO and/or any other representatives of PHYSICIAN MEDICAL LICENSING SERVICE, to represent my interests and to assist me in the administrative proceeding of my application for medical licensure with your Medical Board, Board of Registration in Medicine, by which I am governed and regulated. This Power of Attorney extends to authorize Mrs. Bertoldi, et al., to access all of my records and information contained within my application/credential, access necessary documents from other governmental agencies, access correspondence to/from the Medical Board regarding my application/credential, have authority to serve as my agent for delivery and collection of fees, receipts, and licenses; perform all required activities to obtain proper licensure (initial and/or renewal). If done so in writing, this Power of Attorney may be revoked, at my discretion, at any point in time.

In addition to the appointment of Mrs. Bertoldi, et al., with this Power of Attorney, I request that the Medical Board grant the same courtesy and cooperation as you have and would show to me.

6/1/2022
DATE

[Signature]
SIGNATURE

The foregoing was acknowledged before me this 1st day of June, 2022.

by Bhavik Kumar, who is not personally known to me and did take an oath.

Notary Public

Nina Tiana Nguyen

State of

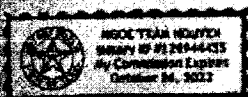
FL

Commission Number

15694458

Commission Expiration

December 16, 2022



Mrs. Katie Bertoldi / FL Medical Licensing Service

From: Registrations <Registrations@tmb.state.tx.us>
Sent: Wednesday, June 15, 2022 5:13 PM
To: Mrs. Katie Bertoldi / FL Medical Licensing Service
Cc: BOM_InitialApps@flhealth.gov
Subject: RE: TX License Verification Request to the FL Medical Board - Dr. Bhavik Kumar
Attachments: KUMAR, BHAVIK-Q2321.pdf

Good Afternoon,

Attached please find the verification request to Florida Medical fulfilled.

Sincerely,

Registrations Department - CM
Texas Medical Board
(512) 305-7030
Registrations@tmb.state.tx.us
www.tmb.state.tx.us

DISCLAIMER

Any and all statements herein should not be construed as official policy or positions of the Texas Medical Board and are merely provided by Board staff for general guidance. No individual staff member is authorized to provide a binding opinion or statement for the full Board. Nothing herein should be construed as legal advice for any particular situation.

From: Mrs. Katie Bertoldi / FL Medical Licensing Service <katie@floridamedlicense.com>
Sent: Monday, June 13, 2022 11:02 AM
To: Registrations <Registrations@tmb.state.tx.us>; Verifications-CIC <Verification.CIC@tmb.state.tx.us>
Subject: TX License Verification Request to the FL Medical Board - Dr. Bhavik Kumar
Importance: High



Hi Texas Board!

Please find attached a license verification request to be sent to the Florida Medical Board for Dr. Bhavik Kumar.

Thank you,

Mrs. Katie Bertoldi

Vice President
Florida Medical Licensing Service, Inc.



Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

FLORIDA DEPARTMENT OF HEALTH - BOARD OF MEDICINE
4052 BALD CYPRESS WAY #C-03
TALLAHASSEE, FL 32399-3253

June 15, 2022

For: FLORIDA DEPARTMENT OF HEALTH - BOARD OF MEDICINE

In response to a recent request, we verify the following information:

Physician: BHAVIK KUMAR, MD
License: Q2321
Date Issued: 11/07/2014
Licensed by:
Date of Birth: 1985
Medical School: TEXAS TECH UNIV HLTH SCI CTR, LUBBOCK, TX
Graduation Year: 2010
Permit Expires: 11/30/2023

Registration Status:

This is to certify that the above-named physician is licensed to practice medicine in Texas.

Disciplinary Status:

The board has not filed any formal complaints or statements of charges against this physician.

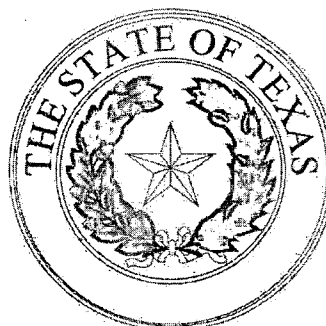
Investigation Status:

Not applicable.

If you have any further questions, please contact the Hearings division

Sincerely,

C. Morell
Customer Information Center
BOARD SEAL



Mrs. Katie Bertoldi / FL Medical Licensing Service

From: noreply@fsmb.org
Sent: Wednesday, June 15, 2022 6:01 AM
To: katie@floridamedlicense.com
Subject: FSMB Credentials Verification Survey Request

Dear Bhavik Kumar,

FCVS has completed the verification process. As requested, a copy of your profile has been provided to each of the following:

- Florida Board of Medicine

Medical boards may require additional time to complete the licensure process after receiving your FCVS profile. Processing times vary by medical board.

If you ordered a 'Self' profile (will display in the list above) it will be available electronically; Log In to download from the Submitted Applications page.

Now that your request has been completed we would like to ask you about your overall experience. Please take a few moments to complete this online survey about the credentials verification process by using the link below.

<http://FCVS-Satisfaction-Survey.com/cgi-bin/ciwweb.pl?studyname=cvs2&pid=215574898>

All of the feedback you provide to us will be examined by our team to help us with evaluating and prioritizing improvements to our application. We appreciate your time and participation.

Thank you,

FCVS Staff
Federation of State Medical Boards

Need Help? Have a Question? Please Contact Us.

When contacting customer support, reference your Federation ID: 215574898

Office of the Professions

License Certification and Verification

Thank You

✓ Thank you for completing a certification request. Your payment has been successfully processed.

Payment Date: 06/13/2022
Payment Amount: \$20.00
Transaction ID: 43455053505

Certification/Verification Requests

A Certification of a NYS professional license is official documentation that provides the basis of licensure and disciplinary information, if applicable, which is required for licensing purposes in another state or jurisdiction.

A written Verification of a NYS professional license is an official letter that states the licensure and registration status and disciplinary information, if applicable.

Note that in NYS the terms "Certification" and "Verification" may differ from those utilized in other states or jurisdictions. Your response to the question(s) below will direct you to the correct form.

* Do you require official documentation be sent to another person, jurisdiction or organization that provides the basis of your NYS licensure/permit to obtain a license/permit in another state or jurisdiction?

Yes

Certification

A Certification can only be requested by the NYS licensee or permit holder being certified and contains the following information, as applicable to the profession and licensee:

- professional education
- professional examination results
- professional experience
- disciplinary information, if applicable

* Do you have a Social Security Number?

Yes

* Last 4 digits of Social Security Number (SSN) if applicable

* Date of Birth 01/19/1985

* First Name Bhavik

Middle Name No response provided.

* Last Name Kumar

What is your mailing address? 3262 Westheimer Road

#901

Houston, TX 32399

Phone (850) 245-4131

Please type whole numbers and they will be auto-formatted for you.

* E-mail Address: katie@floridamedilicense.com

* Profession Medicine

* Is this request for a license or a permit (select one)?

License

* License Number 269339

Name originally licensed under (if different from above) No response provided.

Certification - Name and Address

Name and address to whom the certification is to be sent.

* Name *Florida Board of Medicine*

Organization *Florida Board of Medicine*

* Address

*4052 Bald Cypress Way, Bin #C-03
Tallahassee, FL 32399*

* Licensee's Signature *Bhavik Kumar*

Attestation

☒ * I attest, under penalty of perjury and/or falsification of government documents, that I am the licensee described in this request.

NYSED Home (<http://www.nysed.gov>) | Professions Home (<http://www.op.nysed.gov/prof>) | Accessibility (<http://www.nysed.gov/terms-of-use#Accessibility>)
| Terms of Use (<http://www.nysed.gov/terms-of-use>) | Privacy Policy (<http://www.nysed.gov/privacy-policy>)

FIRMLY TO SEAL

PRESS FIRMLY TO SEAL



PRIORITY MAIL

Rate of delivery specified *
US TRACKING™ included to many major national destinations.
Insured international insurance.
Insurance up available. *
Insurance supplies online. *
Insurance used internationally, a customs declaration label may be required.

Domestic only



EP14F Oct 2018

FROM:

Physician Med Licensing Services
1331 E Lafayette St Ste. D
Tallahassee, FL 32301

TO:

FL. Board of Health
P.O. Box 6330
Tallahassee, FL 32314-8330

Label 400 Jan 2013
7680-16-000-7948



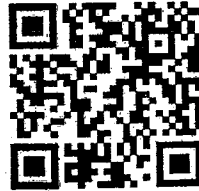
USPS TRACKING #

9114 9023 0722 4930 6348 41

UNITED STATES
POSTAL SERVICE®



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scan the QR code.



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AC#

COPY

**STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE**

DATE	LICENSE NO.	CONTROL NO.
07/06/2022	ME 157907	806848

THE MEDICAL DOCTOR

NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.

Expiration Date: **JANUARY 31, 2024**

BHAVIK KUMAR
4600 GULF FREEWAY
HOUSTON, TX 77053

STATE OF FLORIDA

DEPARTMENT OF HEALTH

DIVISION OF MEDICAL QUALITY ASSURANCE

AC#

DATE

LICENSE NO.

CONTROL NO.

07/06/2022

ME 157907

806848

THE MEDICAL DOCTOR

NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.

Expiration Date: **JANUARY 31, 2024****BHAVIK KUMAR****COPY - NOT A VALID LICENSE - COPY**

LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR

State Surgeon General

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **JANUARY 31, 2024**

Your license number is ME 157907. Please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the Department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please visit www.FLHealthSource.gov and click "Renew A License" to renew online.

The Medical Quality Assurance Online Services Portal gives you the ability to manage your license to perform address updates, name changes, request duplicate licenses and much more.

It's simple. Log onto your MQA Online Services account today at <http://flhealthsource.gov/>. Select the "Account Login" button to access your account. For changes to your name, address or to request duplicate licenses, choose your selection from the dropdown list under "Manage My License". Your profession will open for renewal 90 days prior to your expiration date. When the renewal cycle opens for your profession, the "Renew My License" header will automatically display on your license Dashboard.

IMPORTANT ANNOUNCEMENTS**ARE YOU RENEWAL READY?**

The Department of Health will now review
your continuing education records at the
time of license renewal.

To learn more, please visit
www.FLHealthSource.gov/AYRR

GROUND FOR DISCIPLINE

You should be familiar with the Grounds for
Discipline found in Section 456.072(1),
Florida Statutes, and in the practice act for
the profession in which you are licensed.
Florida Statutes can be accessed at
www.leg.state.fl.us/Statutes

**DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SUPPORT SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260**



PRSRT. FIRST-CLASS
U.S. POSTAGE

PAID

TALLAHASSEE, FL-32301
PERMIT NO. 552

***** AUTO *****

BHAVIK KUMAR
3262 WESTHEIMER ROAD
APT #901
HOUSTON, TX - 77098-1002

8_3_00002592

2.0.7.4



Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts .



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the Healthiest State in the Nation

July 1, 2022

Bhavik Kumar , M.D.
3262 Westheimer Road
Apt #901
Houston, TX 77098

Dear Dr. Kumar:
File: 162876

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Elizabeth.Riser@flhealth.gov or call 850-617-1902.

Sincerely,

Elizabeth Riser
Regulatory Specialist II

Enclosure(s)

Florida Department of Health

Division of Medical Quality Assurance • Bureau of HCPR
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253
PHONE: (850)245-4131 • FAX : (850) 488-0596



Accredited Health Department
Public Health Accreditation Board

Riser, Elizabeth

From: Mrs. Katie Bertoldi / FL Medical Licensing Service <katie@floridamedlicense.com>
Sent: Tuesday, July 5, 2022 9:41 AM
To: Riser, Elizabeth
Subject: RE: FL Board of Medicine-F#162876 - Dr. Bhavik Kumar
Attachments: Employment History Continued.pdf; FDLE Criminal History Information on the Internet_TCN Response.pdf

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Hi Elizabeth,
Thanks for the update. Please see attached for Dr. Kumar's file. Please note a page of his continued employment history was mistakenly left out of his application submitted.

Please find that attached as well as his livescan.

I am hoping his LA license verification could be pulled since that would be the last remaining item.

Thanks!

Mrs. Katie Bertoldi

Vice President
Florida Medical Licensing Service, Inc.
1331 E. Lafayette Street, Suite D.
Tallahassee, FL 32301
850-942-0080
850-877-6417 Fax

From: Riser, Elizabeth [mailto:Elizabeth.Riser@flhealth.gov]
Sent: Friday, July 01, 2022 4:49 PM
To: Bhavik.Kumar@ppgulfcoast.org
Cc: Mrs. Katie Bertoldi / FL Medical Licensing Service
Subject: FL Board of Medicine-F#162876

Hello,

Please see the attached notices towards your full unrestricted medical license. These items must be completed before we can proceed with final review and issuance of your medical license. Should you come across any questions or concerns, please do not hesitate to contact me 😊

See below for instructions and tips for a speedy licensure (Please note: Not all will be applicable to your application, this is just a guide. Please refer to your deficiency letter to assist you.):

- Applicants must contact the correlating agencies to request the verifications to clear deficiencies.

- Please note that any official verifications must be sent to the Florida Board of Medicine directly from the corresponding school or program. Official verifications that are uploaded or sent to the Board by the applicant will **NOT** be accepted to clear the deficiency. If supporting documentation has been mailed, please allow **5** business days for arrival in light of COVID-19. **Note:** This does **NOT** include your National Practitioner Data Bank (NPDB) which can be sent to me via email once received.
- If you opted to use **FCVS**, the following information will be included in your FCVS packet below. You can learn more about the service by visiting <https://www.fsmb.org/fcvs/>. If you have any questions specific to the process, please contact FCVS at **817-868-5000** or by email at fcvs@fsmb.org. (Note: Applicants are **NOT** required to use this service).
 - Medical School Verification
 - ECFMG Status Report/5th Pathways Verification
 - Exam Scores
 - Board Certifications
 - Postgraduate Training Verifications

******In the event that FCVS is unable to provide verification of your program, you may be required to request verification yourself******

- If you are **NOT** using FCVS, and you need the correct forms for your **Medical School and Postgraduate Training Verification**, visit <https://flboardofmedicine.gov/resources/>, click PDF applications and then Medical Doctor application. Forms can be found on pages 16 & 17.
- See below for **background screening** inquiries. If any questions arise, the BSU can be reached at **850-488-0595** or by email at mqa.backgroundscreen@flhealth.gov.
 - The ORI number for the appointment can be found by visiting: <https://www.flhealthsource.gov/bgs-requirements>
 - For applicants that **ARE** currently in the state of Florida visit <https://www.flhealthsource.gov/bgs-providers> for providers within the state of Florida, if you are unable to locate one near you then call the providers to see if they have a substation near you. They will walk you through the process.
 - For applicants that are **NOT** in the state of Florida visit <https://www.flhealthsource.gov/out-of-state-providers> to locate a provider near you, if you do not see you state/area contact the providers to see if they have a substation near you. They will walk you through the process.
- **Additional Contact Information for supporting documents.** (**Note:** if you are using FCVS, some of these items may already be covered in the packet. Please see the above).

○ **License Verifications:**

- **Submit a License Verification** form (Page 27) to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority or www.veridoc.org regardless of the status of the license. Check www.veridoc.org for states that use the online verification service. Applicants educated outside the U.S. may be required to request international license verification(s). You will be notified in writing if international license verification is required.

○ **ECFMG Status Report**

ECFMG

3624 Market Street

Philadelphia, PA 19104-2685 USA

Phone: (215) 386-5900 (*Mon-Fri, 9:00 AM to 5:00 PM EST*)

Fax: (215) 386-9196

www.ecfm.org

○ **Exam Score Reports**

National Board score report

National Board of Medical Examiners Inc.

3750 Market Street

Philadelphia, PA 19104-3190

(215)590-9500

www.nbme.org

SPEX, FLEX, or USMLE score report

Federation of State Medical Boards

400 Fuller Wiser Rd., Suite 300

Eules, TX 76039-3855

(817)868-4000

www.fsmb.org

○ **National Practitioner Data Bank (NPDB)**

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- No extensions will be offered to applicants whose application has Expired.
- One application is not accelerated at the expense of another, particularly if there is a premature commitment to start practicing medicine.

Sincerely,

Elizabeth Riser

Regulatory Specialist II

Department of Health | Division of Medical Quality Assurance

Board of Medicine

4052 Bald Cypress Way

Tallahassee, Florida

Phone: (850) 617-1902

Please Note: *Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.*

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the Healthiest State in the Nation

Bhavik Kumar, M.D.

Date: July 1, 2022

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS June 30, 2023

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24-72 hours for receipt of your results. You can find more information on this process, including how to find a provider in your area and your ORI number, by visiting the Background Screening Website at <http://www.flhealthsource.gov/background-screening/>. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website (Click on 'General FAQs'). Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address: Attn: Background Screening Unit Florida Department of Health 4052 Bald Cypress Way, Bin BSU-01 Tallahassee, FL, 32399

An official verification of your medical license from the state of LA has not been received

The employment/non-employment section of your application was not completed. Submit your employment/non-employment activities to our office for 10/31/2018-present

Please note the following: Pursuant to Chapter 458.313 of the Florida Statutes, that an applicant applying for licensure via endorsement must have submitted evidence of the active licensed practice of medicine in another jurisdiction, for at least 2 of the immediately preceding 4 years, or evidence of successful completion of either a board-approved postgraduate training program within 2 years preceding filing of an application or a board-approved clinical competency examination within the year preceding the filing of an application for licensure. For purposes of this paragraph, "active licensed practice of medicine" means that practice of medicine by physicians, including those employed by any governmental entity in community or public health, as defined by this chapter, medical directors under s. 641.495(11) who are practicing medicine, and those on the active teaching faculty of an accredited medical school.

If you have any questions, please contact me at Elizabeth.Riser@flhealth.gov or call 850-617-1902. The Florida Board of Medicine has assigned **162876** as your **tracking number**. Please

Florida Department of Health

Division of Medical Quality Assurance • Bureau of HCPR
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253
PHONE: (850)245-4131 • FAX : (850) 488-0596



Accredited Health Department
Public Health Accreditation Board

indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Riser, Elizabeth

From: Mrs. Katie Bertoldi / FL Medical Licensing Service <katie@floridamedlicense.com>
Sent: Tuesday, July 5, 2022 9:55 AM
To: Riser, Elizabeth
Cc: Bhavik.Kumar@ppgulfcoast.org
Subject: RE: FL Board of Medicine-F#162876 - Dr. Bhavik Kumar

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

Hi Elizabeth,

They are different office locations hence the reason we listed them all separately and provided the full mailing addresses. These were not listed in error.

Also yes his position as medical director and staff physician most definitely requires him to hold an active Texas medical license.

Thanks,

Mrs. Katie Bertoldi

Vice President
Florida Medical Licensing Service, Inc.
1331 E. Lafayette Street, Suite D.
Tallahassee, FL 32301
850-942-0080
850-877-6417 Fax

From: Riser, Elizabeth [mailto:Elizabeth.Riser@flhealth.gov]
Sent: Tuesday, July 05, 2022 9:48 AM
To: Mrs. Katie Bertoldi / FL Medical Licensing Service
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Name of Employer	Employer Address	Position Title	Employment Dates From-To (MM/DD/YYYY)
Whole Woman's Health	3256 Lackland Rd Fort Worth, Texas 76116 United States	Medical Director & Staff Physician	08/01/2016 to 10/31/2016
Whole Woman's Health	4100 Duval Road Building 2, Suite 201 Austin, Texas 78759 United States	Medical Director & Staff Physician	08/01/2016 to 10/31/2016
Whole Woman's Health	802 S Main St McAllen, Texas 78501 United States	Medical Director & Staff Physician	08/01/2016 to 10/31/2016
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In addition, please indicate if the position as Medical Director and Staff Physician at Planned Parenthood GulfCoast in Houston TX required an active full medical doctor license in TX in order to perform the job duties.

Sincerely,

Elizabeth Riser

Regulatory Specialist II
Department of Health | Division of Medical Quality Assurance
Board of Medicine
4052 Bald Cypress Way
Tallahassee, Florida
Phone: (850) 617-1902

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From: Mrs. Katie Bertoldi / FL Medical Licensing Service <katie@floridamedlicense.com>

Sent: Tuesday, July 5, 2022 9:41 AM

To: Riser, Elizabeth <Elizabeth.Riser@flhealth.gov>

Subject: RE: FL Board of Medicine-F#162876 - Dr. Bhavik Kumar

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Florida Medical Licensing Service, Inc.
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Tallahassee, FL 32301
850-942-0080

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Subject: FL Board of Medicine-F#162876

Hello,

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See below for instructions and tips for a speedy licensure (Please note: Not all will be applicable to your application, **this is just a guide**. Please refer to your deficiency letter to assist you.):

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- If you opted to use **FCVS**, the following information will be included in your FCVS packet below. You can learn more about the service by visiting <https://www.fsmb.org/fcvs/>. If you have any questions specific to the process, please contact FCVS at **817-868-5000** or by email at fcvs@fsmb.org. (Note: Applicants are **NOT** required to use this service).
 - Medical School Verification
 - ECFMG Status Report/5th Pathways Verification
 - Exam Scores
 - Board Certifications
 - Postgraduate Training Verifications

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- **Additional Contact Information for supporting documents.** (**Note:** if you are using FCVS, some of these items may already be covered in the packet. Please see the above).
 - **License Verifications:**
 - **Submit a License Verification** form (Page 27) to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority or www.veridoc.org regardless of the status of the license. Check www.veridoc.org for states that use the online verification service. Applicants educated outside the U.S. may be required to request international license verification(s). You will be notified in writing if international license verification is required.
 - **ECFMG Status Report**

ECFMG
3624 Market Street
Philadelphia, PA 19104-2685 USA
Phone: (215) 386-5900 (*Mon-Fri, 9:00 AM to 5:00 PM EST*)
Fax: (215) 386-9196
www.ecfm.org
 - **Exam Score Reports**

National Board score report National Board of Medical Examiners Inc. 3750 Market Street Philadelphia, PA 19104-3190 (215)590-9500 www.nbme.org	SPEX, FLEX, or USMLE score report Federation of State Medical Boards 400 Fuller Wiser Rd., Suite 300 Euless, TX 76039-3855 (817)868-4000 www.fsmb.org
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Sincerely,

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Board of Medicine
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Riser, Elizabeth

From: Mrs. Katie Bertoldi / FL Medical Licensing Service <katie@floridamedlicense.com>
Sent: Tuesday, July 5, 2022 10:14 AM
To: Riser, Elizabeth
Cc: Bhavik.Kumar@ppgulfcoast.org
Subject: RE: FL Board of Medicine-F#162876 - Dr. Bhavik Kumar

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The positions of medical director and staff Physician with Planned Parenthood Gulfcoast in Houston requires him to hold a full TX medical license.

Thanks,

Mrs. Katie Bertoldi

Vice President
Florida Medical Licensing Service, Inc.
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Tallahassee, FL 32301
850-942-0080
850-877-6417 Fax

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Sent: Tuesday, July 05, 2022 10:09 AM
To: Mrs. Katie Bertoldi / FL Medical Licensing Service
Cc: Bhavik.Kumar@ppgulfcoast.org
Subject: RE: FL Board of Medicine-F#162876 - Dr. Bhavik Kumar

Hi Katie,

Thank you for confirming. Regarding the below, can you please include the position and employer in your response:

- In addition, please indicate if the position as Medical Director and Staff Physician at Planned Parenthood GulfCoast in Houston TX required an active full medical doctor license in TX in order to perform the job duties.

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American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

July 5, 2022

To Whom It May Concern:

This letter verifies Bhavik Kumar, M.D. (NPI: 1003197641) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 01, 2013 - *

Certification Number: 1022146751

* Certification is continuous as long as Family Medicine Certification Requirements are maintained.

Family Medicine Certification Requirements:

Current Status:



Meeting Requirements

Current Clinical Status:

Clinically Active

Clinical Status History:

Jun 28, 2018 -

Clinically Active

Initial display of clinical status began June 2018 and history is only shown for certified periods.

Beginning in 2011 certification by the American Board of Family Medicine is maintained through successful completion of the Family Medicine Certification process. The Family Medicine Certification process is a continuous process that requires being in compliance with Guidelines for Professionalism Licensure and Personal Conduct including maintaining a currently valid, full, and unrestricted license to practice medicine in the United States or Canada, completing certification activities in a timely fashion, and performing successfully on the examination every ten years. Failure to maintain any of these requirements will result in the loss of certification status with the ABFM. Based upon the continuous nature of Family Medicine Certification, no end date for certification is presented above.

The ABFM website serves as primary source verification. Details of the Family Medicine Certification process are available online at www.theabfm.org.

Sincerely,

Salena C. Nelson

Verifications Coordinator and Professionalism Coordinator

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

July 5, 2022

Bhavik Kumar, M.D.
3262 Westheimer Road
Apt #901
Houston, TX 77098

Dear Dr. Kumar:

Congratulations! You have completed the application process for licensure as a Medical Doctor in the State of Florida. Your license number is ME 157907. You will receive your printed license within two weeks. Within 24 hours, you can verify your license online at www.FLHealthSource.gov.

The current license biennium expires 01/31/2024. It is your obligation to complete any continuing education (CE) that is required. You must have completed the required CEs prior to renewing your license. Visit www.FLHealthSource.gov/AYRR and become familiar with the renewal process. Your CE requirements can be found at www.FLHealthSource.gov/requirements.

Licenses are renewed on a biennial basis. Approximately 90 days prior to the expiration date shown on your license, a postcard reminder will be mailed to the last known address on file for you. The U.S. Post Office does NOT forward state mail. Address changes may be submitted electronically through your MQA Online Services Portal account. If you have not registered for an account in the new system, go to www.FLHealthSource.gov/mqa-services and select "No" to get started. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User.

Practitioner Profile – Section 456.041, Florida Statutes, requires specific information be complied and published online about you. In carrying out this legislative mandate to publish practitioner profiles, we want to ensure the information that we publish is accurate. You should receive your license within two weeks. You can review your practitioner profile by accessing your MQA Online Services Account at <http://www.flhealthsource.gov/>. Please select "Account Login" from the top of the page. In order to use the online services portal, you will need to complete a one-time registration process if you have not done so already. Once you have gained entry onto your account, please select "Review, Update & Confirm Profile" under "Manage My License". You are **required to review** and confirm or make changes to the information that will be published in your practitioner profile. If you see the statement "The practitioner did not provide this mandatory information," you are **required to provide** the missing information. We cannot accept curriculum vitae or resumes in place of your providing specific information. Changes, excluding education and training, year began practicing, and liability claims, can be made to your profile electronically. You may also submit changes by mail to the Department of Health, Licensure Support Services, 4052 Bald Cypress Way Bin #C10, Tallahassee, Florida 32399-3260. If you have questions, please call (850) 488-0595, option 3, Monday through Friday, 8:00 a.m. to 6:00 p.m., EST. You may also email us at MQAOnlineService@flhealth.gov.

According to section 456.041(8), Florida Statutes, you have thirty (30) days from receipt of this letter to submit changes to the department. If you do not make changes within thirty (30) days, your profile will

Florida Department of Health

Division of Medical Quality Assurance • Bureau of HCPR
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253
PHONE: (850)245-4131 • FAX : (850) 488-0596



Accredited Health Department
Public Health Accreditation Board

be automatically published.

Thank you for applying for licensure in Florida. If you have additional questions, you may contact the board office at (850) 245-4131 or at the address listed below

Welcome to Florida,

Board of Medicine Staff

Employment History Continued

Name of Employer	Employer Address	Position Title	Employment Dates: From-To
N/A	Houston, Texas	Time-off between positions	11/01/2018- 11/30/2018
Planned Parenthood Gulf Coast	4600 Gulf Freeway Houston, TX 77023	Medical Director & Staff Physician	12/01/2018-Present

Louisiana State Board of Medical Examiners

License Verification

Licensee Information

Name	Public Address
BHAVIK KUMAR	4600 GULF FREEWAY, , HOUSTON, TX 77023

Credential Information

Credential Number	Practitioner Type	Current Status	Discipline Status	Issue Date	Expiration Date	Reinstatement Date
312179	PHYSICIAN & SURGEON	Active	None	04/03/2019	01/31/2023	

Specialities

Speciality 1	Speciality 2	Speciality 3	Speciality 4
Family Medicine			

Discipline History

If Discipline Status is Conditional, Limited, Probation, Reprimanded, Revoked, Suspended, Past Disciplinary Action or Voluntary Surrender of License, a Board issued order can be found on our Disciplinary Actions page

Credential Number	Discipline Status	Public Document
-------------------	-------------------	-----------------

PRIMARY SOURCE VERIFICATION STATEMENT: Verification service provides data extracted by the LSBME from its own database. The data in this web site is provided by and controlled entirely by the LSBME and therefore constitutes a primary source verification as authentic as a direct inquiry to the LSBME. The information provided through the verification service is all of the information pertinent and available in that field of information in the LSBME database.

3762468



Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

MEDICINE BOARD
2022 JUN 16 AM 7:49

FLORIDA DEPARTMENT OF HEALTH - BOARD OF MEDICINE
4052 BALD CYPRESS WAY #C-03
TALLAHASSEE, FL 32399-3253

June 15, 2022

For: FLORIDA DEPARTMENT OF HEALTH - BOARD OF MEDICINE

In response to a recent request, we verify the following information:

Physician: BHAVIK KUMAR, MD
License: Q2321
Date Issued: 11/07/2014
Licensed by:
Date of Birth: 1985
Medical School: TEXAS TECH UNIV HLTH SCI CTR, LUBBOCK, TX
Graduation Year: 2010
Permit Expires: 11/30/2023

Registration Status:

This is to certify that the above-named physician is licensed to practice medicine in Texas.

Disciplinary Status:

The board has not filed any formal complaints or statements of charges against this physician.

Investigation Status:

Not applicable.

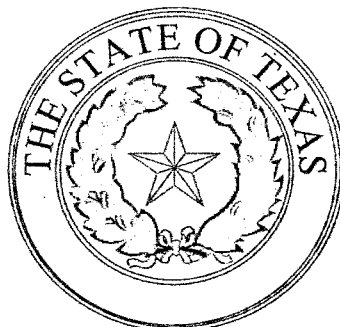
If you have any further questions, please contact the Hearings division

Sincerely,

C. Morell

Customer Information Center

BOARD SEAL



142874

License Verification

ORIGINAL

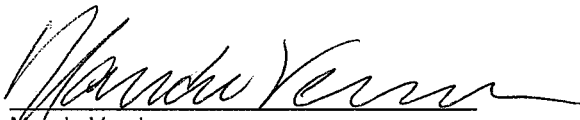
07/08/2022

Dear Sir/Madam:

This is to certify that the records of the Louisiana State Board of Medical Examiners indicate the following information regarding:

Name:	BHAVIK KUMAR		
Professional School Information:	School	City	State
	Texas Tech University Health Sciences Center School of Medicine	Lubbock	TX
Credential Definition:	PHYSICIAN & SURGEON		
License Number:	312179		
Date Issued:	04/03/2019		
Expiration Date:	01/31/2023		
Discipline Status:	None		

To expedite the verification/endorsement process, the above is the standard format for all professions regulated by this Board.


Maude Varela

2022 JUL 15 AM 10:43
MAUDE VARELA

In compliance with Act 2018-655, the Board gives notice to its licensees and applicants of their opportunity to file a complaint about board actions and board procedures. You may submit such complaints to one or more of the following organizations:

1. Louisiana State Board of Medical Examiners; 630 Camp Street, New Orleans, LA, 70130; (504) 568-6820; lsbme@lsbme.la.gov
2. Committee on House & Governmental Affairs; La. House of Representatives; PO Box 94062, Baton Rouge, LA 70804; (225) 342-2403; h&ga@legis.la.gov
3. Committee on Senate & Governmental Affairs; La. Senate; PO Box 94183, Baton Rouge, LA 70804; (225) 342-9845; s&g@legis.la.gov

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THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, KUMAR BHAVIK was issued license/certificate number 269339 for the practice of MEDICINE on 03/22/2013.

Our records also indicate the following information:

Date of birth: 01/19/1985
School attended: TEXAS TECH UNIVERSITY
Date of graduation: 05/22/10
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
11/11									
07/09									
06/08									

EXMS TAKEN=03

A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: NO
Address: 360 E 193RD ST

Last reg period ended: 12/31/16

BRONX

NY 10458-0000

Disciplinary information: No charges have been preferred against this licensee

Comments:

I, Sandra Barsallo, Education Credentials Specialist, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Education Credentials Specialist of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL



Sandra Barsallo

Sandra Beth Barsallo 06/15/22
Education Credentials Specialist

Physician-in-Training Permit

NAME: BHAVIK KUMAR

LICENSE: BP10045440

INFORMATION CURRENT AS OF: 7/5/2022

CURRENT STATUS: PERMIT TERMINATED

[Click here for a detailed information on what each section below contains.](#)

THE INFORMATION IN THIS BOX HAS BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Verified Information

Year of Birth: 1985

License Number: BP10045440 Physician-in-Training Permit

Begin Date: 03/20/2013

Expiration Date: 04/08/2013

Current Status: PERMIT TERMINATED as of 04/08/2013

Disciplinary Restrictions: NONE

Non-Disciplinary Restrictions: NONE

Specialties:

Visiting Physician Temporary Permit

NAME: BHAVIK KUMAR

LICENSE: 44193

INFORMATION CURRENT AS OF: 7/5/2022

CURRENT STATUS:

[Click here for a detailed information on what each section below contains.](#)

THE INFORMATION IN THIS BOX HAS BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Verified Information

Year of Birth: 1985

License Number: 44193 Visiting Physician Temporary Permit

Begin Date: 01/01/1900

Expiration Date:

Current Status: as of 02/05/2013

Disciplinary Restrictions: NONE

Non-Disciplinary Restrictions: NONE

Specialties:

Physician License

NAME: BHAVIK KUMAR, MD

LICENSE: Q2321

INFORMATION CURRENT AS OF: 7/5/2022

CURRENT STATUS: ACTIVE

[Click here for a detailed information on what each section below contains.](#)

THE INFORMATION IN THIS BOX HAS BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Verified Information

Year of Birth: 1985

License Number: Q2321 Physician License

Issuance Date: 11/07/2014

Expiration Date: 11/30/2023

Current Status: ACTIVE as of 11/13/2014

Disciplinary Restrictions: NONE

Non-Disciplinary Restrictions: NONE

Specialties:

School of Graduation:

TEXAS TECH UNIV HLTH SCI CTR, LUBBOCK, TX 2010