Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**161744**
Application:	**Medical Doctor Application for Licensure by Endorsement**
Application Date:	**04/26/2022**

Suitability Question(s)

Are you an osteopathic physician?(If you are an osteopathic physician, this is not the correct application for you to submit. Press "Cancel" and select "Osteopathic Medicine" from the "Choose a Board/Council" drop-down menu.)	**No**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged OR I am the spouse of a veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
Are you selecting NICA Non-Participating? - (A $250.00 fee will be included if you select this option.)	**No**
Will you qualify for "In Training" status at the approval of your licensure application?	**No**

Do you plan to dispense medicinal drugs in the state of Florida for a fee or other remuneration and wish to register as required by section 465.0276, F.S., with the understanding that the fee for dispensing is $100.00 over and above the required initial license fee?	**No**
Are you selecting NICA Exempt? - (If you are not exempt, you will be considered NICA Participating, which includes a fee of $5,000.00.)	**No**

Personal Detail

Title:	**MD**
First Name:	**Michael**
Middle/Second Name:	**James**
Last Name/Surname:	**Subit**
Birthdate:	**08/30/1976**
Gender:	**Male**
Race:	**White**
Social Security Number:	[redacted]

Addresses

Mailing Address

Address:	**3294 Middle Bellville Rd** **Out of State** **MANSFIELD, OH** **44904** **US**
Phone Number:	**304-972-6296**
E-mail Address:	**michaelsubit@gmail.com**

Physical Location

Address:	**3294 Middle Bellville Rd** **Out of State** **MANSFIELD, OH** **44904** **US**

Phone Number:	**304-972-6296**

License Attributes Selected

Qualification	**NICA Part. Physician (FEE)**

Federal Credentials Verification Services (FCVS)

Are you using FCVS to verify your core credentials?	**Yes**

Year Began Practice

Year Began Practice:	**2006**

Other State Licenses 1

Do you hold, or have you ever held a license to practice medicine or any other regulated professional license(s)?	**Yes**

List all regulated professional licenses (active, inactive, or lapsed).

License Type:	**Medicine**
License Number:	**35.095198**
State/Jurisdiction:	**OHIO**
Country:	**UNITED STATES**
Original Date Issued:	**04/23/2010**
Expiration Date:	**01/01/2024**
Status of License:	**Active**

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.

Other State Licenses 2

Do you hold, or have you ever held a license to practice medicine or any other regulated professional license(s)?	**Yes**

List all regulated professional licenses (active, inactive, or lapsed).

License Type:	**Medicine**
License Number:	**23982**
State/Jurisdiction:	**WEST VIRGINIA**
Country:	**UNITED STATES**
Original Date Issued:	**05/14/2006**

Expiration Date:	**06/30/2011**
Status of License:	**Expired.**

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.

Applicant Background

Have you practiced medicine in any jurisdiction for two of the last four years, or completed a board approved postgraduate training program within the last two years?	**Yes**

United States Military and/or Public Health

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?	**No**

Availability for 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**

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

Education History - Preprofessional / Postsecondary Education

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**

Education History - Schools Attended

School Name:	**WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE**
Street Address:	**1 Medical Center Dr**
City:	**Morgantown**
Country:	**UNITED STATES OF AMERICA**
State:	**WEST VIRGINIA**
Postal/ZIP:	**26506**
Attended From:	**08/01/2001**
Attended To:	**05/14/2006**
Date Degree Received:	**05/14/2006**

All applicants except those using FCVS must have the "Medical Degree Verification" form (found on page 16 of the paper application at https://flboardofmedicine.gov/apps/medical-doctor-app.pdf) 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.

Educational Commission for Foreign Medical Graduates

Are you currently certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?	**No**

Postgraduate Training

Program Name:	**Charleston Area Medical Center**
Mailing Address:	**800 Pennsylvania Avenue**
City:	**Charleston**
State:	**WEST VIRGINIA**
Specialty Area:	**OBG - OBSTETRICS AND GYNECOLOGY**
Attended From:	**07/01/2006**
Attended To:	**06/30/2010**
Credit Received?	**Yes**

All applicants except those using FCVS must have the "Postgraduate Training Verification" form (found on page 17 of the paper application at https://flboardofmedicine.gov/apps/medical-doctor-app.pdf) submitted directly to the board office from the Chairman/Director of each postgraduate training program attended, whether completed or not. Any information not verifiable by FCVS may require the applicant to submit it.

Specialty Board Certifications

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**

If you responded "Yes," complete the following:

Board Name:	**AMERICAN BOARD OF OBSTETRICS & GYNECOLOG**
Certification/Specialty/Subspecialty:	**OBG - OBSTETRICS AND GYNECOLOGY**
Date of Certification:	**11/06/2015**

Fifth Pathway Certificate Holders Only

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or university?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**No**

Did you complete all of the formal requirements 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?	**No**
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?	**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

Examination History

Examination Taken:	**National Examination (NBME, FLEX, or USMLE III)**
Examination Date:	**12/01/2006**

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

Employment History

Name of Employer:	**Womens Care Of Mansfield**
Address:	**500 S Trimble Rd**
City:	**Mansfield**

State: **OH**

Position Title: **Physician Owner**

Employed From: **01/03/2013**

Employed To: **04/26/2022**

If still employed, enter today's date in the "Employed To" field.

Academic Faculty Appointments

Do you currently hold a faculty appointment at an accredited medical school? **No**

Graduate Medical Education

Have you had the responsibility for graduate medical education within the last 10 years? **No**

Staff Privileges 1

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

If you responded "Yes," complete the following:If your privileges are for a facility in another state, select "Out of State" from the "Name of Facility" drop-down menu.

Name of Facility: **OUT OF STATE**

Out of State Facility: **Ohio Health Mansfield**

City: **Mansfield**

State: **OHIO**

Type of Privileges: **Active, unrestricted**

Privileges Held From: **01/03/2013**

Privileges Held To: **04/26/2022**

Staff Privileges 2

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

If you responded "Yes," complete the following:If your privileges are for a facility in another state, select "Out of State" from the "Name of Facility" drop-down menu.

Name of Facility: **OUT OF STATE**

Out of State Facility: **Avita Health System - Galion**

City: **Galion**

State: **OHIO**

Type of Privileges: **Courtesy (Surgery)**

Privileges Held From:	**08/01/2019**
Privileges Held To:	**04/26/2022**

Staff Privileges 3

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

If you responded "Yes," complete the following:If your privileges are for a facility in another state, select "Out of State" from the "Name of Facility" drop-down menu.

Name of Facility:	**OUT OF STATE**
Out of State Facility:	**Avita Ontario Hospital**
City:	**Ontario**
State:	**OHIO**
Type of Privileges:	**Active - unrestricted**
Privileges Held From:	**10/01/2020**
Privileges Held To:	**04/26/2022**

Staff Privileges History

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?	**No**

Health History

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?	■
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	■

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.

Discipline History - Disciplinary Action

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?	**No**
Discipline History - Denied	
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?	**No**
Discipline History - Investigation	
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.?	**No**
Discipline History - Specialty Board	
Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**
Discipline History - DEA	
Have you ever been denied, or surrendered a Drug Enforcement Agency (DEA) registration?	**No**
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 (DWLSR) driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.	**No**
Criminal and Medicaid / Medicare Fraud Questions	
1. Have you been convicted of, or entered a plea of guilty or nolo contendere, 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?	**No**
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)?	**No**

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s.409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. 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 (LEIE)?	**No**
5b. Is the student loan default or delinquency the only reason you are listed on the LEIE?	**N/A**

Medical Malpractice

Have you had a judgement entered against you for medical malpractice when the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 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?	**No**

Electronic Fingerprinting

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.	**Yes**
Enter today's date:	**04/26/2022**

The board will not receive your Livescan results if you do not confirm the above statement by selecting "Yes."

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.

Financial Responsibility

Financial Responsibility: **Financial Exemption**

I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
I hold a limited license issued pursuant to s. 458.317, F.S., and practice only under the scope of such limited license.
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).
I have no malpractice exposure because I do not practice medicine in the state of Florida. I will notify the department immediately before commencing practice in the state.
I am exempt from demonstrating financial responsibility due to meeting all of the following criteria (if you select this option you must also complete the "Financial Responsibility Affidavit of Exemption" form found on page 20 of the paper application at https://flboardofmedicine.gov/apps/medical-doctor-app.pdf):
(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 part-time practice of no more than 1,000 patient contact hours per year. (c) I have had 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 chapter 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 chapter 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 section 458.320(5)(f), F.S., for specific notice requirements.

Financial Exemption: **9. NOT PRACTICING IN FLORIDA**

Fees

Application	**$350.00**
Unlicensed Activity	**$5.00**
NICA Part. Phys. Fee	**$4750.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$5705.00**

Attestation

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

Attestation Answer: Yes