ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS
and Centralized Credentials Verification Service

www.armedicalboard.org

X Medicine/Surgery ____ Osteopathic Medicine/Surgery ____ Education License

1. Name THOMAS RUSSELL HORTON JR Social Security # ___ ___ ___
(Legibly Print full Legal Name)

2. Name as listed on your Driver's License or Passport: THOMAS RUSSELL HORTON JR

Driver's License State and Number ___

3. Address TN 38120

4. Address you wish license to be mailed:
TN 38120

5. Phone (Res.) ____ (Bus.) 901 210 1194 (Fax) ____ (email) ____

6. Male X Female ☐ Birth Date ROANOKE, VA, USA Race: CAUC

If born outside of U.S., how long have you lived in U.S. ____ Years ____ Months. Are you a citizen of U.S. ___yes ___no
If yes, and foreign born, attach proof of citizenship. If no, indicate your status with U.S. Immigration
(Attach copy of Visa/Work Permit)

7. ECFMG Certificate # N/A Date Issued ___

8. Intended practice location in Arkansas ____ Give name and address of hospital, clinic, group or private:
LITTLE ROCK FAMILY PLANNING SERVICES, 4 DAVIES PARK DRIVE, LITTLE ROCK, AR 72211

9. Specialty OBSTETRICS & GYNECOLOGY Subspecialty URDGYNECOLOGY
Board Certified (Date) N/A Board Certified (Date) N/A
Recertification ____ Recertification ____

10. Drug Enforcement Administration Number BH7210329 State ____ Expiration Date ____
State Controlled Substance License Number ____ State ____ Expiration Date ____
State Controlled Substance License Number ____ State ____ Expiration Date ____
Submit a copy of your DEA Registration Card and State Controlled Substance License to this office

11. UPIN # ____ Medicaid Provider # ____ Medicare Provider # ____
Accept Medicaid Patients? ____ Yes X No Accept Medicare Patients? ____ Yes X No

12. Professional Liability Insurance (**CURRENT** Carrier Name, ____
Policy # ____ Date of Expiration ____ Amount of Coverage ____
Send enclosed form to your insurance carrier and have them return directly to this office.

13. Medical School. Date Graduate MAY Mo 16 Day 1998 Yr Degree MD

	Name of Institution	Address	Date from	Date to
1st Year	EASTERN VIRGINIA MEDICAL SCHOOL	PO BOX 1980, NORFOLK, VA 23501	AUG 1994	MAY 1995
2nd Year	EVMS	"	AUG 1995	MAY 1996
3rd Year	EVMS	"	JUNE 1996	JUNE 1997
4th Year	EVMS	"	JUNE 1997	MAY 1998

Have Verification of Medical Education Form and an official Transcript mailed directly to this office.

FOR USE OF SECRETARY ONLY

License No. E-7456
Name Thomas Russell Horton Jr MD
Application for License through endorsement by
USMLE

Application received 11/18/09
Fees 500.00 Date 11/18/09
License issued Reinstated
Application Declined ____
Fees returned ____ 20 ____

NOTE: Application must be legible and completed in INK or Typed

14. Post Graduate Training (list chronologically). **Send Enclosed Verification Form – Refer to Instruction Sheet**

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No
LEHIGH VALLEY HOSPITAL	PO BOX 689, ALLENTOWN, PA 18105-1556	OBSTETRICS / GYNECOLOGY	6/98 - 6/2002	YES

15. Fellowships (list chronologically). **Send Enclosed Verification Form – Refer to Instruction Sheet**

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No
UNIV OF TN HEALTH SCIENCE CTR	853 JEFFERSON AVE, E-102	URO GYNECOLOGY	7/02 - 6/04	YES
DEPT OF OB/GYN	MEMPHIS, TN 38103			

16. Circle which licensing exam you have taken: (USMLE) NBME FLEX NBOME COMLEX LMCC

- or -

State Board Examination – State _____ **Year** _____ **(Taken prior to 1975 only)**

17. Have you taken the SPEX exam in the last five years? _____ Yes __X__ No **If yes, have certified copies of scores mailed directly to this office.**

18. Military Service? _____ Yes __X__ No If yes, which Branch? _____

Dates of Service _____ Attach **copy of separation papers and have records sent from Military Personnel Records Center. (See Instruction Sheet and Verification form.)**

19. List all states/countries in which you have or have had a medical license. **Have verification of each license mailed directly to this office. Send enclosed verification of Licensure Form. (Form may be copied if necessary.)**

State/Country	License #	Date Issued	Active Y/N
TN	36459	05/16/2002	Y
AZ	E3656	04/04/2003	N
VA	0101237059	08/13/2004	N
WA	44133	08/19/2004	N

State/Country	License #	Date Issued	Active Y/N
PA	072728L	11/22/2000	N

20. Professional References/Recommendations: **Have three physician (M.D. or D.O.) reference/recommendation letters mailed from their offices directly to this office.** These cannot be current partners or related to you. They must have worked with you and directly observed your professional performance in the recent past. At least one of these references/ recommendations must have had organizational responsibility for supervising your performance (i.e. department chief, service chief or training program director).

Name	Address	Association
MICHAEL STACK MD	6215 HUMPHREYS BLVD, SUITE 401 MEMPHIS TN 38120	MEDICAL DIRECTOR
EDWARD STANFORD MD	UTHSC DEPT OF OB/GYN 853 JEFFERSON AVE, RM E102 MEMPHIS TN 38163	PEER
VERONICA MALLETT MD	UTHSC DEPT OF OB/GYN 853 JEFFERSON AVE, RM E102 MEMPHIS TN 38163	PEER

21. Professional Activities

List in chronological order all your professional activities, institutional affiliations or places of employment since the start of Medical School. This includes hospitals, teaching institutions, HMO's, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. Exclude Residency and Fellowship. You may attach additional sheets after completing this section, if space is not sufficient. *Do not submit curriculum vitae (CV) in lieu of completing this section.*

From	To	Status	Location & Complete Address	Position
5/2000	5/2001	INACTIVE	ALLENTOWN HEALTH BUREAU 245 NORTH SIXTH STREET ALLENTOWN, PA 18102	SEXUALLY TRANSMITTED DISEASE CLINIC STAFF
4/2001	5/2002	INACTIVE	NORTH PENN HOSPITAL / CMMC 100 MEDICAL CAMPUS DRIVE LANSDALE, PA 19446	OB/GYN COVERAGE STAFF
3/2003	7/2005	INACTIVE	CRITTENDEN MEMORIAL HOSPITAL 200 W TYLER AVE WEST MEMPHIS, AR 72301	OB/GYN COVERAGE STAFF
5/2003	3/2009	INACTIVE	MEMPHIS AREA MEDICAL CENTER FOR WOMEN 29 S. BELLEVUE BLVD MEMPHIS, TN 38104	STAFF PHYSICIAN/ MEDICAL DIRECTOR
7/2003	6/2004	INACTIVE	NEWPORT HOSPITAL 1910 MCLAIN ST NEWPORT, AR 72112	OB/GYN COVERAGE STAFF LOCUM TENENS
7/2003	6/2004	INACTIVE	HARRIS HOSPITAL 1205 MCLAIN ST NEWPORT, AR 72112	OB/GYN COVERAGE STAFF LOCUM TENENS
6/2003	PRESENT	ACTIVE	PLANNED PARENTHOOD GREATER MEMPHIS REGION 1407 UNION AVE, SUITE 300 MEMPHIS, TN 38104	STAFF PHYSICIAN
7/2005	7/2006	INACTIVE	SHENANDOAH MEMORIAL HOSPITAL 759 MAIN ST WOODSTOCK, VA 22664	OB/GYN COVERAGE STAFF LOCUM TENENS
8/2005	PRESENT	ACTIVE	MEMPHIS CENTER FOR REPRODUCTIVE HEALTH 1462 POPLAR AVE MEMPHIS, TN 38104	STAFF PHYSICIAN/ MEDICAL DIRECTOR

- Please review this list carefully. If there are gaps in your chronological history you are required to provide a brief explanation. **Send enclosed Verification Hospital/Clinic forms to each facility. (See Instruction Sheet)**
- **Complete all forms in black or blue ink ONLY.**

Attach explanation of any "yes" answers. Refer to Instruction Sheet for the following questions.	YES	NO
22. Have you ever failed any licensing exam, or any part of a licensing exam, which caused you to retake it? Which exam (USMLE, NBOME, etc.)?		X
23. Has your application for examination or licensure ever been rejected, denied or withdrawn?		X
24. Has any medical licensing board ever placed your license on probation, suspension or has it revoked a license or certificate it had granted you? If yes, list name and address of board.		X
25. Have you ever been ordered to appear before a state medical board for any reason other than licensure?		X
26. Have disciplinary procedures ever been initiated toward you by either a medical board or hospital? Explain.		X
27. Have your privileges at any hospital been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending?		X
28. Have you ever voluntarily surrendered your license in any state?		X
29. Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony? (NOTE: Applicants must answer affirmatively if records, charges, or convictions have been pardoned, expunged, plead down, released or sealed.)	X	
30. Have you ever been denied provider participation in any state or Federal Medicaid program?		X
31. Have you ever previously made application to the Arkansas State Medical Board?	X	
32. Have you ever been warned, censured by, or requested to withdraw from, any hospital in which you have trained, been a staff member or held hospital privileges? If yes, explain.		X
33. Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during an internship, residency or fellowship program? If yes, explain.		X
34. Have you ever, voluntarily or involuntarily, left a training institution program before completing it? If yes, explain.		X
35. Have you ever been reported to the National Practitioners Data Bank or subject to NPDB adverse action report?		X
36. Have you resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted?		X
37. Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending?		X
38. Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicaid programs? If yes, name state _____		X
40. Have you ever been cited by a peer review organization? Explain Give the name and address of the organization _____		X
41. Have you ever had to discontinue practice for any reason for a period longer than one month? If yes, explain.		X
42. Have you been, or are you presently, being treated for alcoholism, or substance abuse? If yes, was this voluntary or the result of a medical board action? Explain.		X
43. Do you currently, or have you had, any physical or mental health condition, including alcohol or drug dependency, which with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately?		X

	YES	NO
44. Have you ever had a DWI? How many? ONE Date(s) occurred MAY 1, 1987	X	
45. Have you ever been treated for drug or substance abuse outside a hospital setting? Explain.		X
46. Have you ever been treated for drug or substance abuse in a treatment center or hospital? Give name of institution, date and length of stay?		X
47. Are you currently being, or have you ever been, monitored by a Physician Health Committee in any state? If yes, give state(s) _____ Ask your treating physician to send documentation of your status.		X
48. Have you ever been rejected by a medical society?		X
49. Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? If yes, explain.		X
50. Have you ever defaulted on any Health Education Assistance Loan? If yes, explain.		X
51. To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? If yes, explain.		X

If, during the application process, you become aware of any such investigation, you are required to report it to this office.

AFFIDAVIT OF APPLICANT

I, T RUSSELL HORTON, JR, certify after being sworn, that all of the information supplied in the foregoing application is true, correct, current and complete to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation or denial of any license to practice medicine granted to me, and criminal prosecution to the fullest extent of the law.

Photograph

Thomas Russell Horton, Jr.
Applicant's Signature (in INK)

NOV 16, 2009
Date Signed

Sworn to and subscribed before me this 16
day of NOVEMBER, 20 09.
My Commission Expires: 4/26/2011

Signature of Notary Public

DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

Douglas Amart

Rev 5/2/06 ljm
Form cannot be copied.

lrfps™ Little Rock
Family Planning Services

4 Office Park Drive
Little Rock, Arkansas 72211
(501) 225-3836
*Fax (501) 225-8705
Toll Free (800) 272-2183
www.lrfps.com

December 22, 2009

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, AR 72202

RE: T Russell Horton

Dear Sirs and Madams:

I am writing to confirm that I have offered Dr Horton employment in my practice in Little Rock.

My previous letter was written my personal letterhead because I was at home and used my home computer to compose the correspondence.

Sincerely,

Louis J Edwards, M.D., FACOG
Arkansas License E-2099

T. Russell Horton, Jr., M.D.

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, Arkansas 72202-1435

November 5, 2009

To Whom It May Concern:

Response to *Application for Medical Licensure in Arkansas*,

Items 29 and 44:
On May 1, 1987, in Faquier County, Virginia, I was charged with Driving While Intoxicated, and, on June 15, 1987, answered with a plea of nolo condendere in General District Court. I addition to imposing fines and a 10-day jail sentence (all days suspended conditioned on good behavior), the court suspended my drivers license for a period of six months, but allowed restricted use for travel to/from work. I agreed to attend Alcohol Safety Action Program meetings and completed that program as prescribed.

This is my only offense.

Item 31:
In April, 2003, my application to practice medicine in Arkansas was approved (license E-3656).

Sincerely,

T. Russell Horton, Jr, M.D.

T. Russell Horton, Jr., M.D.

Germantown, TN 38139

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, Arkansas 72202-1435

January 20, 2003

To Whom It May Concern:

Response to *Application for Medical Licensure in Arkansas*, **Items 36 and 52**:

On May 1, 1987, in Faquier County, Virginia, I was charged with Driving While Intoxicated, and, on June 15, 1987, answered with a plea of nolo condendere in General District Court. I addition to imposing fines, the court suspended my drivers license for a period of six months, but allowed restricted use for travel to/from work. I agreed to attend Alcohol Safety Action Program meetings and completed that program as prescribed.

This is my only offense.

Sincerely,

T. Russell Horton, Jr, M.D.

WARRANT OF ARREST

Fauquier COUNTY

General District Court ☒ Criminal ☒ Traffic
☐ Juvenile and Domestic Relations District Court

TO ANY AUTHORIZED OFFICER:

You are hereby commanded in the name of the Commonwealth of Virginia forthwith to arrest and bring the Accused before this Court to answer the charge that the Accused, within this city or county, on or about May 1, 1987 DATE did unlawfully in violation of Section 00.00 18.2-266 Code of Virginia operate a motor vehicle while under the influence of alcohol or other self-administered narcotic drug, drug or intoxicant

00.00

I, the undersigned, have found probable cause to believe that the Accused committed the offense charged, based on the sworn statements of Trooper B. Rogers, Jr. Complainant.

Execution by summons ☐ permitted at officer's discretion ☐ not permitted.

May 1, 1987 1:33am
DATE AND TIME ISSUED

CLERK OF MAGISTRATE OR JUDGE

SUMMONS (If authorized above and by serving officer)

You are hereby commanded to appear before this court located at

DATE

on 00.00 at AM/PM

I promise to appear in accordance with this Summons.

OSP# 87-21-0

ACCUSED

WARNING TO ACCUSED: You may be tried and convicted in your absence if you fail to appear in response to this Summons. Willful failure to appear is a separate offense. SIGNING THIS NOTICE DOES NOT CONSTITUTE AN ADMISSION OF GUILT.

HEARING DATE
June 15, 1987 2:00pm

Thomas Russell Sheeron
ACCUSED

ADDRESS/LOCATION
Falls Church, Va. 22042

COMPLETE DATA BELOW IF KNOWN

RACE	SEX	WGT.	HT. FT.	HT. IN.	EYES	HAIR	BORN MO.	DAY	YR.
W	M	190	5	11	BR	BR			

SSN

Commonwealth of Virginia

WARRANT OF ARREST

CLASS 1 MISDEMEANOR

☒ EXECUTED by arresting the Accused named above on this day.

☐ EXECUTED by summoning the Accused named above on this day.

5-1-87 1:34 AM
DATE AND TIME

J B Rogers
ARRESTING OFFICER

1580 VA. STATE POLICE
BADGE NO., AGENCY AND JURISDICTION

for SHERIFF

Attorney for the Accused:

Blood

Jail suspended + a LOL. To be issued on condition he pay all fees + costs/fines - email in ASAP w/in 10 days + complete successfully.

6-29-87 - DMV - SLK
license sent
DC265

TESTE:
SANDRA K. RAMEY, CLERK
BY: Teresa A. Rogers
~~CLERK~~/DEPUTY CLERK
DATE: 4/21/98

Motion to Change Bond:
☐ changed to $ .....
☐ no change

The Accused
☐ ~~tried in~~
☑ present

The Accused PLEADED:
☐ not guilty
☐ nolo contendere
☑ guilty

And was TRIED and FOUND by me
☐ not guilty
☑ guilty as charged
☐ guilty of .....

☐ I ORDER the charge dismissed
☐ I ORDER a nolle prosequi on Commonwealth's motion

I impose the following Sentence:
☑ fine of $ 200.00 with $ ....0.. suspended;
☑ * jail sentence of .10... days .....
~~months~~ with 10 ..... suspended conditioned upon being of good behavior and keeping the peace.
☐ on probation for .....
☑ * driver's license suspended ...6. months. (SUS)
.....
Restitution of .....
Payable to .....
By .....
as condition of suspended sentence.
Bond: .....
.....
Other: .....
.....
Appeal Bond $ .....
☐ appeal noted on .....

6-15-87
DATE

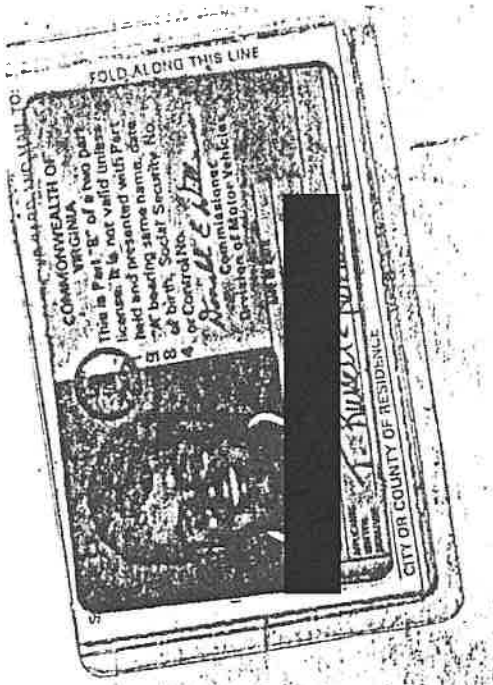
Charles B. Foley
JUDGE

FINE	$ 200.00
126 LIQUIDATED DAMAGES	$ .....
COSTS	
112 PROCESSING FEE	$ 20.00
121 TIA FEE	.....
133 BLOOD TEST FEE	35.00
132 CICF	.....
120 CT. APPT. ATTY.	.....
113 WITNESS FEE	.....
125 WEIGHING FEE	.....
OTHER (SPECIFY):	.....
TOTAL	$ 255.00

DATE PAID	RECEIPT NO.
6-15-87	#9920

ATTORNEY(S) PRESENT:
☐ COMMONWEALTH ☐ DEFENSE

DC 314 (REVERSE) 12/84



0001606379 **VIRGINIA UNIFORM SUMMONS**

DEPARTMENT OF STATE POLICE

HEARING DATE: 6-15-87 FILE NO. T87-

YOU ARE SUMMONED TO APPEAR IN THE FAUQUIER CITY/COUNTY

☒ GENERAL DISTRICT COURT (TRAFFIC)
☐ GENERAL DISTRICT COURT (CRIMINAL)
☐ JUVENILE & DOMESTIC RELATIONS DISTRICT COURT

6th COURT ST WARRENTON VA
ADDRESS

ON JUNE 15, 1987 AT 2:00 ☐ A.M. ☒ P.M.

FOR VIOLATION OF ☒ STATE ☐ COUNTY ☐ CITY ☐ TOWN

LAW SECTION 18.2-266 DESCRIBE CHARGE: DUI

I PROMISE TO APPEAR AT THE TIME AND PLACE SHOWN ABOVE. SIGNING THIS SUMMONS IS NOT AN ADMISSION OF GUILT.

ARRESTED
SIGNATURE

YOU MUST APPEAR AT TRIAL (JUVENILES MUST APPEAR WITH PARENT/LEGAL GUARDIAN).

~~YOU MAY AVOID COMING TO COURT ONLY IF INSTRUCTIONS ON DEFENDANT'S COPY ARE FOLLOWED.~~

ONLY CALL 703-347-8600 IF MORE HELP IS NEEDED.

ABSTRACT OF CONVICTION
D.M.V. DRIVER IMPROVEMENT DEPT. P.O. BOX 27412, RICHMOND, VA 23261-7412

TESTE:
SANDRA K. RAMEY, CLERK
BY: Teresa C. Rogers
~~CLERK~~/DEPUTY CLERK
DATE: 4/21/98

NAME: LAST HORTON, FIRST RUSSELL THOM

ADDRESS: 2970 MONTICELLO DR.

CITY/TOWN FALLS CHURCH STATE VA 220

RACE	SEX	D.O.B. MO.	DA.	YR.	HT. FT. IN.	WGT.	EYE
W	M				1	190	BR

OL/CL # (IF CRIMINAL OFFENSE USE SSN #)

VEH	YEAR	MAKE	TYPE	LICENSE NO.	YR.
	85	FORD	5DRHB	HAB-911	88

JURIS. OF OFF.	DATE OF OFF.	DAY OF WK.
030	5-1-87	FRI

DIRECTION	ACCIDENT YES	ACCIDENT NO	WEA.	ROUTE NO./STREET
W		X	CLR	I-66

LOCATION OF OFFENSE: MM 38 1/2 M. E RT 245

ARREST DATE: SAME ARREST LOCATION:

OFFICER: TROOPER JB Rogers COD 35

CONVICTED ON 6-15-87 OF ☐ SAME AS CHARGED DWI 18.2-266 (VASAP)

PLEA	JAIL/DETENTION	COMMUNITY SERVICE	FINE	COST	FINE AND COST SATISFIED?
☒ G ☐ NG ☐ NC ☐ TA		☐ YES ☒ NO	200	55	☒ YES – PAID ☐ COMMUNITY SERVICE ORDERED ☐ NO – COURT SUSPENDED OL/CL ☐ NO – DMV SHALL SUSPEND OL/CL

OL/CL SURRENDERED	OL/CL SUSPENDED/REVOKED	DMV ASSIGN TO DRIVER IMPROVEMENT CLINIC
☒ YES ☐ NO	☒ YES VASAP R.D.L. ☐ NO (AMOUNT OF TIME)	☐ YES ☒ NO

I CERTIFY THIS AS A TRUE ABSTRACT OF THE RECORDS OF COURT AS IT RELATES TO THE CHARGE, JUDGMENT AND PENALT

S. K. Ramey Dep Clerk 6.29
AUTHORIZED SIGNATURE DA

61 - 64	65 - 69	70 - 71	72 - 75	70 - 72
CONV. CODE	CONV. CODE	CT SUSP	COURT	JURIS. FOR RESID

To enroll in VASAP yes

Fine & cost 200 + e

Fine suspended No

O. L. Suspended 6 months

Suspend the suspension No

O. L. surrendered yes

Restricted O.L. yes

To & from work + community employment

To attend ASAP meetings ✓

Hold O. L. until fine/cost/fees paid

Jail 10 days Jail cost

Jail suspended 10 days

COMMUNITY SERVICE HOU

DC-220 Notice of Suspension

Indicates he can pay

Thomas Russell Horton

00 099 1 9920 3061137

FULL PAYMENT
DEFENDANT NAME
04/HORTON
05/THOMAS R
TRIAL DATE
12/061587
CASE NUMBER
01/T87-3197

110 STATE FINES	1		200.00
112 PROCESS FEES	1		20.00
133 BLOOD TEST	1		35.00
AMOUNT TENDERED			255.00
CHANGE			.00
TOTAL			255.00

FAUQUIER GEN DIST COURT

06/15/87 14:16

TESTE:
SANDRA K. RAMEY, CLERK
BY: Teresa A. Rogers
~~CLERK~~/DEPUTY CLERK
DATE: 4/21/98

T. Russell Horton, Jr., M.D.

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, Arkansas 72202-1435

December 1, 2009

Re: *Licensure in Washington State without work history*

To Whom It May Concern:

During the spring of 2004, I began negotiations with a prospective employer in Tacoma, Washington. During the period of negotiation I proceeded with application for license to practice medicine which was issued in August, 2004.

Although I was offered an employment contract, I ultimately made the decision to decline the offer and never did any work in Washington.

Sincerely,

T. Russell Horton, Jr, M.D.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www armedicalboard org

VERIFICATION OF MEDICAL EDUCATION

EASTERN VIRGINIA MEDICAL SCHOOL
Name of Institution

PO BOX 1980
Street

NORFOLK VA 23501
City State Zip

I, THOMAS RUSSELL HORTON JR (Print full name), M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the application process, the Arkansas State Medical Board requires verification of my **Medical Education.**

I hereby authorize EASTERN VIRGINIA MEDICAL SCHOOL (Name of medical / osteopathic school or college), its staff, or representative to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand completed forms returned to me will not be accepted for verification purposes.

Sincerely, T. Russell Horton. (Signature of Applicant)

Date or Birth ___ / ___ / ___ (MO / DAY / YR)

Social Security Number _____

Date of Graduation 05 / 16 / 98 (MO / DAY / YR)

For verification of MEDICAL EDUCATION ONLY Please provide exact date.

The following section must be completed by the dean or registrar of the medical or osteopathic school and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted.** *Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.*

This certifies that Thomas Russell Horton, Jr. (Full name of applicant)

Enrolled in Doctor of Medicine (Name of medical or osteopathic school)

on 08 / 12 / 94 (MO / DAY / YR) graduated 05 / 16 / 98 (MO / DAY / YR) with a degree in Medicine

Further, the records of this institution indicate that the attached photograph (Check one)
☒ Represents a true likeness of the above named applicant.
☐ Does not represent a true likeness of the above named applicant.

AN OFFICIAL SCHOOL TRANSCRIPT MUST BE RETURNED WITH THIS FORM

By _____
Signature of the dean or registrar **(NO STAMPED SIGNATURES ACCEPTED)**

Print or Type Name of dean/registrar Robert M. McCombs, Ph.D.

Signed and the college Seal affixed on 02 / 10 / 03 (MO / DAY / YR)

Phone (757) 446-5805 Fax ( ) 757 446-5817

Rev. 12/01amm Form may be copied.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF MEDICAL EDUCATION

EASTERN VIRGINIA MEDICAL SCHOOL
Name of Institution

PO BOX 1980
Street

NORFOLK VA 23501
City State Zip

I, THOMAS RUSSELL HORTON JR (Print full name), M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the application process, the Arkansas State Medical Board requires verification of my **Medical Education.**

I hereby authorize EVMS (Name of medical / osteopathic school or college), its staff, or representative to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand completed forms returned to me will not be accepted for verification purposes.

Sincerely, T. Russell Horton (Signature of Applicant)

Date or Birth ___ / ___ / ___ (MO / DAY / YR)

Social Security Number ___

Date of Graduation 05 / 16 / 98 (MO / DAY / YR)

For verification of MEDICAL EDUCATION ONLY Please provide exact date.

The following section must be completed by the dean or registrar of the medical or osteopathic school and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted.** *Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.*

This certifies that Thomas Russell Horton, Jr. (Full name of applicant)

Enrolled in Eastern Virginia Medical School (Name of medical or osteopathic school)

on 08 / 12 / 94 graduated 05 / 16 / 98 (MO / DAY / YR) with a degree in MD

Further, the records of this institution indicate that the attached photograph **(Check one)**

☑ Represents a true likeness of the above named applicant.

☐ Does not represent a true likeness of the above named applicant.

AN OFFICIAL SCHOOL TRANSCRIPT MUST BE RETURNED WITH THIS FORM

SEAL

By Jennifer Gray
Signature of the dean or registrar **(NO STAMPED SIGNATURES ACCEPTED)**

Print or Type Name of dean/registrar Jennifer Gray

Signed and the college Seal affixed on 11 / 23 / 09 (MO / DAY / YR)

Phone (___) ___ Fax (___) ___

Medical school seal MUST be imprinted partially on photograph.

Rev 12/01anm Form may be copied.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF POSTGRADUATE TRAINING

DR CRAIG J SOBOLEWSKI
Name of Program Director

LEHIGH VALLEY HOSPITAL
Name of Institution

PO BOX 7017
Street

ALLENTOWN PA 18105-7017
City State Zip

I, T. RUSSELL HORTON (Print full name), have applied for a license to practice medicine in the State of Arkansas. As part of the application process, the Arkansas State Medical Board requires a reference from the program director of each ACGME accredited **Postgraduate Training** program to which I have been appointed.

I hereby authorize LEHIGH VALLEY HOSPITAL (Name of Institution), its staff, or representative to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and /or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, T. Russell Horton
(Applicant)

Date of Birth ___ MO ___ DAY ___ YR Social Security Number: _____

For verification of POSTGRADUATE TRAINING Please provide exact date(s).

The following section must be completed by the Program Director or his/her representative and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted. DO NOT USE SIGNATURE STAMPS.**

This is to certify that T. RUSSELL HORTON (Name of applicant), a graduate of EASTERN VIRGINIA MEDICAL SCHOOL (Medical School)

commenced postgraduate training (*internship/residence/clinical fellowship) in OB/GYN RESIDENCY - LEHIGH VALLEY (Legibly Print or Type Name and address of training program)

HOSPITAL, 17TH + CHEW STS., PO BOX 7017, ALLENTOWN PA 18105-7017

on 06 / 24 / 98 (MO / DAY / YR) and completed **(check one)** ☑ successfully ☐ **unsuccessfully such training on 06 / 23 / 02 (MO / DAY / YR),

or anticipated graduation date on ___/___/___.

☑ Internship- Name of Dept./Dates OB/GYN 1998

☑ Residency- Name of Dept./Dates OB/GYN 1999 - 2002

☐ Fellowship-Name of Dept./Dates _____ ☐ Clinical ☐ Research

Type or Legibly Print Name CRAIG SOBOLEWSKI MD Signature: [signature] MD

Date Signed 01.27.03

Title OB/GYN RESIDENCY PROGRAM DIRECTOR

Tel. No. (610) 402 9515 Fax No. (610) 402 9688

COMMENTS: _____
(Attach additional sheet if needed.)

***List the reason for unsuccessful completion in Comments or attach a letter of explanation.**

*Circle one.

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THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

COLLEGE of MEDICINE

Department of Obstetrics & Gynecology
853 Jefferson Avenue
Memphis, TN 38163
Phone: (901) 448-5771
Fax: (901) 448-4701

January 7, 2010

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, AR 72202

RE: Dr. Rusty Horton

To the Board,

This is an addendum and explanation for the attached verification of Postgraduate training form. The previous letter dated December 29, 2009 had some errors. I hope to clarify with this letter.

Dr. Horton was in a fellowship in Urogynecology at the University of Tennessee Department of Obstetrics and Gynecology from July 1, 2002- June 30, 2004. This 3-year fellowship was accredited by the American Board of Obstetricians and Gynecologists but was not an ACGME-accredited fellowship. However, the fellowship director, Dr. Val Vogt, and the other Urogynecologist, Dr. Robert Summitt, left the department to a private practice prior to Dr. Horton completing his training.

Therefore, Dr. Horton successfully completed 2 of 3 years his fellowship training at the University of Tennessee.

If you have any questions, please do not hesitate to contact me. ophillip@uthsc.edu. I was interim department chair at the time.

Sincerely,

Owen Phillips, MD
Professor
Department of Obstetrics and Gynecology

BUREAU OF HEALTH
245 North 6th Street
Allentown, PA 18102-4128

Alliance Hall
(610) 437-7702
FAX (610) 437-8799

City of Allentown

March 7, 2003

Pat Fisher
Arkansas State Medical Board
2100 River Front Drive
Little Rock, Ark 72202-1435

RE: Russell Horton Jr, MD

Dear Ms. Fisher:

I am writing this letter on behalf of Dr. Russell Horton Jr, MD to verify his clinic employment here at the Allentown Health Bureau. Dr. Horton had staff privileges at our clinic from 5/1/00 - 6/6/01. The scope of his clinical privileges was as our sexually transmitted disease clinic physician. During this stated period of time, the clinical privileges of this individual were not denied, revoked, suspended or relinquished. Dr. Horton was an excellent physician, who was liked by both the staff and the patients. He was very competent and knowledgeable in the areas of OB/GYN, as well as the treatment of STD's. Based on his performance here, we would recommend him for staff appointment in your state.

If you have any further questions or concerns, please don't hesitate to contact me.

Sincerely,

Michelle S. Maron

Michelle S. Maron, BSN, RN
Clinical Services Manager
Allentown Health Bureau
245 N 6th Street
Allentown, Pa 18102
(610)437-7526
(610)437-8799 Fax
maron@allentowncity.org

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802
www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

CENTRAL MONTGOMERY MEDICAL CENTER (NORTH PENN HOSPITAL)
Name of Institution
100 MEDICAL CAMPUS DRIVE
Street
LANSDALE PA 19446
City State Zip

I, T RUSSELL HORTON (Print Full Name), M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize NORTH PENN HOSP / CMMC (Name of Hospital), its staff, or representative to provide the Arkansas Sate Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, T. Russell Horton.

Date of Birth: ___ (MO) ___ (DAY) ___ (YR) Social Security Number ___

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section **must be completed** by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

Courtesy 2/4/03

I, Diane Huntoon (Print Full Name) state that the above named physician has/had the following staff privileges (Circle One): Courtesy - Active Staff - Temporary - Other Courtesy at our hospital/clinic from 5/17/01 (MO DAY YR) to 7/17/02 (MO DAY YR)

Indicate the scope of Clinical Privileges, if any: OB-GYN

Data accepted by Board

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

*Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.

Diane Huntoon
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Diane Huntoon
Signature

Asst. Adm.
Title

2/3/03
Enter Date Signed (MO DAY YR)

215 361-4570 (215) 412-5002
Telephone Number Fax Number

Rev. 12/01anm Form may be copied.

2100 Riverfront Drive
Little Rock, AR 72202
Phone: (501) 296-1802
Fax: (501) 296-1972
E-mail: pkf@armedicalboard.org

Arkansas State Medical Board

TO:	Carmen Ward Medical Staff Manager North Penn Hospital/Central Montgomery Med Ctr	**From:**	Pat Fisher Licensing Coordinator
Fax	215-412-5002	**Date**	12/14/2009
Phone:	215-361-4590	**Pages**	3
RE:	Thomas Russell Horton, Jr., M.D.	**CC:**	

URGENT REQUEST

Enclosed is a copy of the verification you provided for Dr. Horton. Also, enclosed is another verification that we received when Dr. Horton initially received a license in Arkansas.

- **Both of these verifications have different dates for Dr. Horton's affiliation. Please review his file and provide our Board with an explanation and new verification if applicable.**
- **This can be faxed back to our office at 501-296-1972.**

Thank you in advance for your help and if you have any questions please let me know.

Pat Fisher
Licensing Coordinator

Pat

The file is no longer available. The dates I provided you were in a computer database. Sometimes the actual date was entered when approved instead of a temporary privilege date. Also, the end date was entered as the date by Board acceptance & not the date the physician actually resigned.

Carmen

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

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VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

NORTH PENN HOSPITAL / CENTRAL MONTGOMERY MEDICAL CENTER
Name of Institution

100 MEDICAL CAMPUS DRIVE
Street

LANSDALE, PA 19446
City State Zip

I, THOMAS RUSSELL HORTON, JR, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)

the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize NORTH PENN HOSPITAL / CMMC, its staff, or representative to provide the Arkansas Sate Medical Board
(Name of Hospital)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, T. Russell Horton

Date of Birth ___ ___ ___ (MO DAY YR) Social Security Number _____

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Carmen Ward state that the above named physician has/had the following staff privileges
(Print Full Name)

(Circle One): Courtesy - Active Staff –Temporary - Other Coverage, at our hospital/clinic from 6 / 13 / 01 (MO/DAY/YR) to 6 / 14 / 02 (MO/DAY/YR)

Indicate the scope of Clinical Privileges, if any: OB-GYN

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Carmen Ward
Type or Legibly Print Name **(DO NOT USE SIGNATURE STAMPS)**

Carmen Ward
Signature

Medical Staff Manager
Title

11 / 24 / 09 Email address: CWard@ahlansdale.org
Date Signed (MO/DAY/YR)

(215) 361-4590 (215) 412-4002
Telephone Number Fax Number

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ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

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VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

MEMPHIS AREA MEDICAL CENTER FOR WOMEN
Name of Institution

1 5 BELLEVUE BLVD
Street

MEMPHIS TN 38104
City State Zip

I, THOMAS RUSSELL HORTON, JR (Print Full Name), M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize MEMPHIS AREA MEDICAL CENTER (Name of Hospital), its staff, or representative to provide the Arkansas Sate Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, T. Russell Horton

Date of Birth ___ MO ___ DAY ___ YR Social Security Number ___

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Valarie Morrow (Print Full Name) state that the above named physician has/had the following staff privileges

(Circle One): Courtesy - (Active Staff) - Temporary - Other ___, at our hospital/clinic from 04 MO / 02 DAY / 03 YR to 03 MO / 16 DAY / 09 YR.

Indicate the scope of Clinical Privileges, if any: ___

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Type or Legibly Print Name **(DO NOT USE SIGNATURE STAMPS)**

Valarie Morrow
Signature

Administrator
Title

02 / 12 / 09 Email address: reginam1958@yahoo.com
Date Signed (MO/DAY/YR)

(901) 722-9050 (901) 278-5040
Telephone Number Fax Number

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ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

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VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

WOMENS CLINIC OF WEST MEMPHIS / DR JAMES DEROSSITT
Name of Institution

210 SOUTH RHODES STREET
Street

WEST MEMPHIS AR 72301-4212
City State Zip

I, THOMAS RUSSELL HORTON JR, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)

the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize DR JAMES DEROSSITT, its staff, or representative to provide the Arkansas Sate Medical Board
(Name of Hospital)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, T. Russell Horton.

Date of Birth 1 . MO DAY YR Social Security Number

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, JAMES PRENTICE DEROSSITT state that the above named physician has/had the following staff privileges
(Print Full Name)

(Circle One): Courtesy - Active Staff –Temporary - Other locum tenens at our hospital/clinic from 04 / 03 / 2004 to 01 / 03 / 2005
MO DAY YR MO DAY YR

Indicate the scope of Clinical Privileges, if any: Full OB-GYN Privileges.

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

JAMES PRENTICE DEROSSITT.
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

James P. DeRossitt
Signature

OWNER THE Women's Clinic
Title

12 / 22 / 2009 Email address: wmemobgyn@aol.com
Date Signed (MO/DAY/YR)

(870) 732-5445 (870) 732-1734
Telephone Number Fax Number

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ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

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VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

CRITTENDEN MEMORIAL HOSPITAL
Name of Institution

200 W TYLER AVE
Street

WEST MEMPHIS AR 72301
City State Zip

I, THOMAS RUSSELL HORTON, JR, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)
the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize CRITTENDEN MEMORIAL HOSPITAL, its staff, or representative to provide the Arkansas Sate Medical Board
(Name of Hospital)
any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, T. Russell Horton

Date of Birth ___ / ___ / ___ (MO / DAY / YR) Social Security Number _____

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Angela K. Dickey state that the above named physician has/had the following staff privileges
(Print Full Name)
(Circle One): Courtesy - Active Staff –Temporary - Other LT, at our hospital/clinic from 5 / 28 / 03 (MO / DAY / YR) to 11 / 9 / 05 (MO / DAY / YR)

Indicate the scope of Clinical Privileges, if any: OB/GYN

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Angela Dickey
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Angela Dickey
Signature

Medical Staff Coordinator
Title

11 / 18 / 09 Email address: angie_dickey@crhwm.org
Date Signed (MO/DAY/YR)

870 735-1500 ext. 1003 870-733-3861
Telephone Number Fax Number

Rev. 8/18/06 ljm Form may be copied.

T. Russell Horton, Jr., M.D.

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, Arkansas 72202-1435

November 5, 2009

Re: Verification of affiliation from Newport Hospital

To Whom It May Concern:

On November 16, 2009 I mailed the *Verification of Affiliation* form to Newport Hospital for completion and inclusion in my application for licensure. It was returned to me on November 23 by USPS marked "not deliverable/unable to forward".

I have since been informed that Newport Hospital is no longer in operation. I have been unable to find where their staff records are kept or who is in custody of them.

Please let me know if you need further information regarding my affiliation with Newport Hospital.

Sincerely,

T. Russell Horton, Jr, M.D.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

HARRIS HOSPITAL
Name of Institution

1105 McLAIN ST
Street

NEWPORT AR 72112.
City State Zip

I, THOMAS RUSSELL MORTON, JR (Print Full Name), M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize HARRIS HOSPITAL (Name of Hospital), its staff, or representative to provide the Arkansas Sate Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, T. Russell Morton

Date of Birth MO DAY YR Social Security Numbe

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Ashley Boreani (Print Full Name) state that the above named physician has/had the following staff privileges (Circle One): Courtesy - Active Staff –Temporary - Other locum, at our hospital/clinic from *see attached MO DAY YR to MO DAY YR.

Indicate the scope of Clinical Privileges, if any: OB/GYN

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Ashley Boreani
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Ashley Boreani
Signature

HR/MS Asst
Title

12, 01, 09 Email address: Ashley_Boreani@chs.net
Date Signed (MO/DAY/YR)

(870) 512-3377 (870) 523-0135
Telephone Number Fax Number

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ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

PLANNED PARENTHOOD, GREATER MEMPHIS REGION
Name of Institution

1407 UNION AVE, SUITE 300
Street

MEMPHIS TN 38104
City State Zip

I, THOMAS RUSSELL HORTON, JR, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)

the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize PPGMR, its staff, or representative to provide the Arkansas Sate Medical Board
(Name of Hospital)

any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named Institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, T. Russell Horton

Date of Birth ___ / ___ / ___ (MO / DAY / YR) ,Social Security Number _____

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Barry Chase, state that the above named physician has/had the following staff privileges
(Print Full Name)

(Circle One): Courtesy - (Active Staff) - Temporary - Other _____, at our hospital/clinic from 8 / 3 / 2003 (MO / DAY / YR) to (MO / DAY / YR) Present

Indicate the scope of Clinical Privileges, if any: _____.

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☒ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☒ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Barry Chase
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Barry Chase
Signature

CEO
Title

11, 18, 2009 Email address: bchase@ppms.org
Date Signed (MO/DAY/YR)

(901) 725-1717 (901) 274-1660
Telephone Number Fax Number

Rev 8/18/06 ljm Form may be copied.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

SHENANDOAH MEMORIAL HOSPITAL
Name of Institution

759 MAIN ST
Street

WOODSTOCK VA 22664
City State Zip

I, THOMAS RUSSELL HORTON JR, M.D./D.O., have applied for a license to practice medicine in
(Print Full Name)
the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize SHENANDOAH MEMORIAL HOSPITAL, its staff, or representative to provide the Arkansas Sate Medical Board
(Name of Hospital)
any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely, T. Russell Horton.

Date of Birth ___ / ___ / ___ Social Security Number ___ - ___ - ___
MO DAY YR

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. **Form must be signed.**

I, Donald Jansen, MD state that the above named physician has/had the following staff privileges
(Print Full Name)
(Circle One): Courtesy - Active Staff –Temporary - Other Locum, at our hospital/clinic from 07 / 27 / 05 to 07 / 27 / 06
MO DAY YR MO DAY YR

Indicate the scope of Clinical Privileges, if any: Obstetrics + Gynecology

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☑ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☑ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Donald Jansen, M.D.
Type or Legibly Print Name **(DO NOT USE SIGNATURE STAMPS)**

Signature

Vice President Medical Affairs
Title

11 / 23 / 09 Email address: djansen@valleyhealthlink.com
Date Signed (MO/DAY/YR)

(540) 459-1166 (540) 459-1186
Telephone Number Fax Number

Rev. 8/18/06 ljm Form may be copied.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202 (501) 296-1802
www.armedicalboard.org

VERIFICATION OF HOSPITAL/CLINIC AFFILIATION

MEMPHIS CENTER FOR REPRODUCTIVE HEALTH
Name of Institution
1462 POPLAR AVE
Street
MEMPHIS, TN 38104
City State Zip

I, THOMAS RUSSELL HORTON JR (Print Full Name), M.D./D.O., have applied for a license to practice medicine in the state of Arkansas. As part of the process, the Arkansas State Medical Board requires verification from each hospital/clinic in which I have or have had Hospital/Clinic Privileges or Employment.

I hereby authorize MEMPHIS CENTER FOR REPRODUCTIVE HEALTH (Name of Hospital), its staff, or representative to provide the Arkansas Sate Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, AR, 72202. Completed forms returned to me will not be accepted for verification purposes. They must be mailed directly to the Arkansas State Medical Board office.

Sincerely: T. Russell Horton.

Date of Birth ___ MO ___ DAY ___ YR Social Security Number _

For verification of HOSPITAL, CLINIC or EMPLOYMENT AFFILIATION. Please provide exact dates.

The following section must be completed by the hospital administrator or his/her representative and returned directly to the Arkansas State Medical Board. Any substitution must contain the same information and be mailed directly to the state board or it will not be accepted for verification purposes. Form must be signed.

I, Rebecca Terrell (Print Full Name) state that the above named physician has/had the following staff privileges

(Circle One): Courtesy - Active Staff - Temporary - Other _____, at our hospital/clinic from 08/20/2005 (MO/DAY/YR) to 12/09/2009 (MO/DAY/YR) present

Indicate the scope of Clinical Privileges, if any: Gynecology

During the stated period of time, the clinical privileges of this individual (check one) ☐ Were ☑ Were not denied, revoked, suspended, limited, reduced, not renewed or relinquished (whether by resignation or expiration, voluntarily or involuntarily).

Based on his/her performance, he/she (check one) ☑ Would ☐ Would not be recommended for medical staff reappointment at this facility.

If for any reason the requested data regarding the above physician cannot be verified, please briefly explain or attach additional sheet.

***Note: Breaks in privileges should be listed as separate entries. If the physician was there on/off as a locum tenens, contract physician or was moonlighting, a listing of each time period the physician had privileges at your facility should be listed or a separate sheet detailing to/from dates should be attached to this document, or copies of this form should be copied for each.**

Rebecca L. Terrell
Type or Legibly Print Name (DO NOT USE SIGNATURE STAMPS)

Signature

Executive Director
Title

12/19/09 Email address: rterrell@mcrh-tn.org
Date Signed (MO/DAY/YR)

(901) 274 3550 (901) 274 3551
Telephone Number Fax Number

Rev. 8/18/06 ljm Form may be copied.

Planned Parenthood®
Greater Memphis Region

1407 Union Avenue
Suite 300
Memphis, TN 3 8104
(901) 725-1717
Fax (901) 274-1660
www.ppgmr.org

December 2, 2009

To: Arkansas State Medical Board

From : Dr. Michael Stack, Medical Director Greater Memphis Region Planned Parenthood M_S

Re: Recommendation for Dr. Thomas Russell Horton, Jr.

I have worked with Dr. Horton in my capacity as a Medical Director at Memphis Planned Parenthood for 7 years. He is a competent physician with a broad knowledge base and a superior work ethic. He takes great care of our patients and goes the extra mile to make sure they are comfortable and informed. I think he would be a great asset to your physicians in Arkansas and I recommend him for licensure.

MS MD

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

COLLEGE of MEDICINE

Department of Obstetrics & Gynecology
853 Jefferson Avenue
Memphis, TN 38163
Phone: (901) 448-5771
Fax: (901) 448-4701

December 30, 2009

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, Arkansas 72202

RE: Thomas Russell Horton, Jr., M.D.

Dear Sir or Madam:

It is with pleasure that I recommend Dr. Rusty Horton for licensure in Arkansas. I have worked with Dr. Horton and find him to be of good moral character who consistently practices within the accepted standard of care.

You may contact me at anytime if you need further information.

Sincerely,

Edward Stanford MD MS FACOG FACS
Professor, Obstetrics and Gynecology
Division Head, Gynecologic Specialties
Chief, Urogynecology/Female Pelvic Medicine
Fellowship Director, Minimally Invasive Gynecologic Surgery
University of Tennessee, Memphis

THE UNIVERSITY OF TENNESSEE
Health Science Center

College of Medicine
Department of Obstetrics and Gynecology
853 Jefferson Avenue
Memphis, TN 38163
Tel: (901) 448-5771 • Fax: (901) 448-4701

November 25, 2009

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, AR 72202

To Whom It May Concern:

I am writing to recommend Dr. Rusty Horton for licensure in Arkansas. Dr. Horton known as Dr. Thomas Russell Horton, Jr. has been a colleague since prior to 2004. I met Dr. Horton at the American Urogynecology Society during his training as a fellow in Urogynecology. Subsequently, Dr. Horton has been a provider in the Memphis community. I am aware of his reputation of having an excellent character, providing quality medical care, and empathy for the patient population that he serves. Dr. Horton provides a valuable service to the women in the Shelby County community as I am sure he will do in the eastern Arkansas community.

If you have any questions regarding Dr. Horton, I can attest to his overall competency and character. If you have any questions regarding Dr. Thomas Russell Horton please feel free to contact me.

Sincerely,

, M.D.

Veronica T. Mallett, M.D.
Professor and Medical Director Health Care Excellence
Director of Centering Pregnancy
UT Medical Group Chair of Excellence
University of Tennessee Health Science Center
Memphis, Tennessee
Phone: (901) 448-4775 / Fax: (901) 448-4701 / Email: vmallett@utmem.edu

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
tennessee.gov/health

TENNESSEE BOARD OF MEDICAL EXAMINERS
1-800-778-4123

November 17, 2009

T RUSSELL HORTON, MD
1462 POPLAR AVENUE
MEMPHIS TN 38104

TO WHOM IT MAY CONCERN:

The Tennessee Board of Medical Examiners is pleased to furnish the following information from our files:

PROFESSION:	Medical Doctor
NAME:	T RUSSELL HORTON
LICENSE NUMBER:	MD36459
ISSUE DATE:	05/16/2002
EXPIRATION DATE:	09/30/2011
CURRENT STATUS:	Licensed
STATUS DATE:	05/16/2002

COMMENTS: There is no derogatory information in our files concerning this individual. The State of Tennessee only provides the above information. Any other information needed must be obtained from the licensee.

Sincerely,

Board Administrator
Tennessee Board of Medical Examiners

MD/LV1

To expedite the verification process, the above is the standard format used by the Medical Board of Tennessee.

COMMONWEALTH of VIRGINIA

VERIFICATION

Re: **T. Russell Horton**

From: Virginia Board of Medicine

Subj: Licensure Verification

Date: November 13, 2009

This is to certify that the above named individual was issued a license to practice by the Virginia Board of Medicine:

Licensed in/as a:	**Medicine & Surgery**
License:	**0101237059**
Issued on:	**08/13/2004**
Expires:	**09/30/2008**

This license has not been the subject of an administrative proceeding. If you have any questions, please call 804-367-4451.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this board.

Verifications may also be obtained from our website at www.dhp.virginia.gov or our interactive phone system at 804-270-6836 with fax back option.

Sincerely,

M. Ola Powers

Deputy Executive Director, Licensing
Virginia Board of Medicine

NOTE: The Board of Medicine no longer provides a raised seal on this document.

N14EZ

COMMONWEALTH of VIRGINIA

VERIFICATION

Re: **T. Russell Horton**

From: Virginia Board of Medicine

Subj: Licensure Verification

Date: November 17, 2009

This is to certify that the above named individual was issued a license to practice by the Virginia Board of Medicine:

Licensed in/as a:	**Medicine & Surgery**
License:	**0101237059**
Issued on:	**08/13/2004**
Expires:	**09/30/2008**

This license has not been the subject of an administrative proceeding. If you have any questions, please call 804-367-4451.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this board.

Verifications may also be obtained from our website at www.dhp.virginia.gov or our interactive phone system at 804-270-6836 with fax back option.

Sincerely,

M. Ola Powers

Deputy Executive Director, Licensing
Virginia Board of Medicine

NOTE: The Board of Medicine no longer provides a raised seal on this document.

N14EZ

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

MEDICAL QUALITY ASSURANCE COMMISSION

November 18, 2009 *P.O. Box 47866, Olympia, Washington 98504-7866*

State of Arkansas
2100 Riverfront Dr
Littlerock AR 72202

Subject: Credential Verification

To Whom It May Concern:

This will verify the status of the Physician And Surgeon License for Dr. T HORTON.

Sections may be blank because the information is not in our database or is not applicable for this credential type.

Year of Birth:	
Credential Number:	MD.MD.00044133
Credential Type:	Physician And Surgeon License
Current Credential Status:	EXPIRED CREDENTIAL NOT RENEWED
First Credential Date:	08/19/2004
Expiration Date:	09/24/2005
Last Renewal Date:	
Examination:	
Exam Level:	
Score:	

Our records above show that the licensee has not been disciplined, the licensee is considered in good standing

Please call me at (360) 236-2766 if you have questions or visit our Online Provider Credential Search at www.doh.wa.gov.

Betty Elliott

Betty Elliott, Customer Service Specialist 2

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

November 17, 2009

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	THOMAS RUSSELL HORTON JR
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD072728L
ORIGINAL LICENSURE DATE:	11/22/2000
EXPIRATION DATE:	12/31/2002
STATUS:	Inactive

The license is in good standing and the records indicate no derogatory information.

Basil L. Merenda

SEAL

Commissioner
Bureau of Professional and Occupational Affairs

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

THOMAS RUSSELL HORTON MD

MEMPHIS TN 38120-3428

Primary Office Address:

MEMPHIS CENTER FOR REPRODUCTIV
HEALTH
1462 POPLAR AVE
MEMPHIS TN 38104-2948
Phone: 1-901-274-3550

Birthdate:
Birthplace: ROANOKE, VA UNITED STATES OF AMERICA

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: GYNECOLOGY
Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

E VA MED SCH OF M C OF HAMPTON RDS, NORFOLK VA 23501
Degree Awarded: Yes
Degree Year: 1998

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

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

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: LEHIGH VALLEY HOSP
Specialty : OBSTETRICS & GYNECOLOGY

State: PENNSYLVANIA
06/1998 - 06/2002
(VERIFIED)

Note: **If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.**

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
WASHINGTON	MD	08/19/2004	09/24/2005	INACTIVE	UNLIMITED	10/16/2009
VIRGINIA	MD	08/13/2004	09/30/2008	INACTIVE	UNLIMITED	10/15/2008
ARKANSAS	MD	04/04/2003	09/30/2006	INACTIVE	UNLIMITED	11/02/2009
TENNESSEE	MD	05/16/2002	09/30/2011	ACTIVE	UNLIMITED	11/02/2009
PENNSYLVANIA	MD	11/22/2000	12/31/2002	INACTIVE	UNLIMITED	10/20/2009

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

ECFMG Certfication:

Applicant Number:

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

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Federal Drug Enforcement Administration:

* *Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
	22N 33N 4 5	10/31/2012	10/08/2009

Address: Memphis Center For Reproductiv, Health, 1462 Poplar Ave, Memphis, TN 38104-2948

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

Specialty Board Certification(s)*:

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

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission and National Committee for Quality Assurance (NCQA).

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:

Duration	Effective	Expiration	Occurrence	Last Reported

Note: For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

Medicare/Medicaid Sanction(s):

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

Other Federal Sanction(s):

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

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Additional Information:

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

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site (http://www.ama-assn.org/go/amaprofiles) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

ARKANSAS RULES AND REGULATIONS AFFIDAVIT

I, THOMAS RUSSELL HOLDEN JR (Type or Print Name) on this date, NOV 1, 2005

do affirm that I have read the Medical Practices Act, Arkansas Code 17-95-101, *et seq.*, and the Rules and Regulations of the Arkansas State Medical Board.

Signed: T. Russell Holden (Physician's Signature)

Date: NOV 01, 2005

THIS IS A REQUIREMENT FOR LICENSURE. YOU MUST COMPLETE THIS FORM AND RETURN IT TO:
ARKANSAS STATE MEDICAL BOARD
ATTN: LICENSING
2100 RIVERFRONT DRIVE
LITTLE ROCK, AR 72202-1435

Rev. 01/01 anm

T. RUSSELL HORTON, JR., M.D.

March 6, 2003

Ms. Pat Fisher
Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, AR 72202-1435

To Whom It May Concern:

I have made application for Arkansas medical license so that I can provide coverage for Dr. James DeRossitt, an obstetrician/gynecologist, practicing in West Memphis, Arkansas. This coverage will be provided at Crittenden Memorial Hospital and at his practice, The Women's Clinic of West Memphis.

Additionally, two breaks in my training exist for which explanation has been requested:

1) May 17, 1998 to June 23, 1998: This 38-day period was a break between graduation from medical school and beginning of residency. During this period, I was "off not training" and preparing for moving my household and family.

2) June 21, 2002 to June 30, 2002: This 9-day period was a break between completion of residency and beginning of fellowship training. During this period of time I was "off not training", preparing and sitting for written ABOG examination and moving my household and family.

Please contact me should further explanation be necessary.

Sincerely,

T. Russell Horton

T. Russell Horton, Jr, M.D.

2381 REDBUD TRAIL DRIVE • GERMANTOWN, TENNESSEE • 38139
PHONE: 901-751 0321 • FAX: 901-347 8345

T. Russell Horton, MD

Experience

Medical Director/Laboratory Director, August 2005 to Present
Memphis Center for Reproductive Health, Memphis, Tennessee
- Responsible for direction and coordination of medical program.
- Maintain medical standards and guidelines, develop protocols and implement new services.
- Responsible for technical and scientific operation of laboratory.
- Responsible for training, credentialing, and scheduling of medical staff.
- Provide consultation to medical and nursing staff.
- Provide services to clients according to institutional guidelines.

Staff Physician, August 2003 to Present
Planned Parenthood, Greater Memphis Region, Memphis, Tennessee
- Provide services to clients according to institutional standards and guidelines.
- Provide consultation to medical and nursing staff.

Medical Director/Laboratory Director, August 2005 to March 2009
Memphis Area Medical Center for Women, Memphis, Tennessee
- Responsible for direction and coordination of medical program.
- Maintain medical standards and guidelines and develop new protocols.
- Responsible for technical and scientific operation of laboratory.
- Responsible for training, credentialing, and scheduling of medical staff.
- Provide consultation to medical and nursing staff.
- Provide services to clients according to institutional guidelines.

Locums Tenens Physician, August 2005 to October 2005
Weatherby Locums, Fort Lauderdale, Florida
Shenandoah Memorial Hospital, Woodstock, Virginia
- Provide locums tenens in-office and on-call coverage for a two-physician Ob/Gyn practice located in rural northern Virginia.

Staff Physician, May 2003 to August 2005
Memphis Area Medical Center for Women, Memphis, Tennessee
- Provide services to clients on an outpatient basis according to institutional standards and guidelines.

Education/Training

Fellowship – Urogynecology and Reconstructive Pelvic Surgery, July, 2002 to June, 2004
University of Tennessee Health Science Center, Memphis, Tennessee

Residency – Obstetrics and Gynecology, July, 1998 to June, 2002
Lehigh Valley Hospital, Allentown, Pennsylvania

MD – May, 1998
Eastern Virginia Medical School, Norfolk, Virginia

BS in Biology, May, 1993
George Mason University, Fairfax, Virginia

Board Certification

American Board of Obstetrics and Gynecology, Written Examination, June, 2002

Medical Licensure

Tennessee:	36459	May 2002
Virginia:	0101237059	Aug 2004 – Sept 2006 (Inactive)
Arkansas:	E-3656	April 2003 – Sept 2006 (Inactive)
Washington:	MD00044133	Aug 2004 – Aug 2006 (Inactive)
Pennsylvania:	MD-072728-L	June 2001 – Dec 2002 (Inactive)

Society Membership

Junior Fellow, American College of Obstetricians and Gynecologists
National Abortion Federation
Association of Reproductive Health Professionals

University Appointments

Instructor and Fellow, Division of Urogynecology
Department of Obstetrics and Gynecology, University of Tennessee at Memphis
Memphis, Tennessee, July 2002 – June 2004

Teaching Experience

Urogynecology lecture series. Presented every three months to residents in Obstetrics and Gynecology, University of Tennessee, Memphis, 2002 – 2004.

Videotapes

Horton TR, Sobolewski C, Lucente V: Laparoscopic Burch Colposuspension. Presented at the 22nd Annual Clinical Meeting, The American Urogynecologic Society, Chicago, IL, October, 2001.

Academic Presentations: National and International Meetings, Published In Abstract Form

1. Horton TR, Druckenmiller J, Lucente V: Concomitant Vaginal Surgery With Tension-Free Vaginal Tape Pubovaginal Sling For Treatment Of Female Stress Urinary Incontinence And Pelvic Support Defects. The Society of Gynecologic Surgeons Twenty-Seventh Annual Scientific Meeting, Lake Buena Vista, FL, March 3-7, 2001

2. Horton TR, Druckenmiller J, Lucente V: Pubovaginal Sling Using Tension-Free Vaginal Tape In Advanced Elderly Women. Twenty-second Annual Clinical Meeting. The American Urogynecologic Society, Chicago, IL, October, 2001

3. Horton TR, Sobolewski CJ, Lucente V: Laparoscopic Burch Colposuspension: Technical Tricks. The American Urogynecologic Society, Chicago, IL, October, 2001

4. Murphy M, Horton TR, Druckenmiller J, Lucente V: Tension-Free Vaginal Tape for Treatment of Stress Urinary Incontinence Refractory to Periurethral Collagen Injections. Twenty-second Annual Clinical Meeting. The American Urogynecologic Society, Chicago, IL, October, 2001

5. Porter WE, Horton TR, Vogt VY, Summitt RL Jr: Genital Prolapse Symptoms and Quality of Life Parameters Associated with Pessary Use. American College of Obstetrics and Gynecology, Annual Clinical Meeting, New Orleans, LA April 2003.

6. Porter WE, Horton TR, Vogt VY, Summitt RL Jr: Historical and Physical Factors Predictive of Successful Pessary Use: American College of Obstetrics and Gynecology, Annual Clinical Meeting, New Orleans, LA April 2003.

7. Horton TR, Vogt VY, Summitt RL Jr: A Hands-On Model to Teach the Pelvic Organ Prolapse Quantification System. CREOG & APGO Annual Meeting, Lake Buena Vista, FL March 2004.

8. Horton, TR, Gettings NA, Marshall J: Integration of HIV Prevention Services and Abortion Care. National Abortion Federation, 33rd Annual Meeting, Portland, OR April 2009.

9. Horton, TR, Gettings NA, Marshall J: Integration of HIV Prevention Services and Reproductive Health Services. Association of Reproductive Health Professionals, Reproductive Health 2009, Los Angeles, CA October 2009.

Research and Other External Support

Agency: Pharmacia
Title: Assessment of the Efficacy of Tolterodine ER versus Placebo for the Symptom of Urgency and the Improvement in Bladder Condition (DETAOD-0084-047)
Staff: Vogt V, Summitt RL, Porter W, Horton TR

Agency: Eli Lilly and Co.
Title: Long Term Monitoring of Safety in Subjects Treated with Duloxitine for Bladder Overactivity (F1J-MC-SBBX)
Staff: Summitt RL, Vogt V, Porter W, Horton TR

Agency: Alza Pharmaceuticals and University of California, San Diego
Identifying bladder origin pelvic pain/interstitial cystitis in gynecologic patients and their treatment with pentosan polysulfate vs. placebo
Principal Investigator: Val Vogt, MD
Collaborating Investigators: Frank W. Ling, MD, Robert L. Summitt, Jr., MD, Williams E. Porter, MD, T. Russell Horton, MD

Agency: Eli Lilly & Company
Efficacy and Safety of Duloxetine Compared with Placebo in Subjects with Symptoms of Bladder Overactivity due to Pure Detrusor Instability or Sensory Urgency (Incorporating Protocol Amendments a and b) (F1J-MC-SBBL)
Principal Investigator: Robert L. Summitt, Jr., MD
Co-Investigator: Val Y. Vogt, MD, William Porter, MD, T. Russell Horton, MD

Agency: Johnson & Johnson/Gynecare
A Comparison of Gynecare MoniTorr and Multi-channel Urodynamics: Correlation of Measurement, Relationship to Incontinence Severity and Preference (CT-MONT-001-02)
Principle Investigator: T. Russell Horton, MD
Co-investigators: Robert L. Summitt, MD, Val Y. Vogt, MD

Agency: Johnson & Johnson/Gynecare
Gynecare MoniTorr Urethral Retro-resistance Pressure in Women without Symptoms of Urinary Incontinence (2003-005)
Principle Investigator: T. Russell Horton, MD
Co-investigators: Robert L. Summitt, MD, Val Y. Vogt, MD

Agency: National Institute of Child and Human Development (NICHD)
Grant # U10-HD41261
Colpopexy and Urinary Reduction Efforts (The CARE Study)
Summitt RL, Vogt VY, Lipscomb GH, Horton TR (Subcontracted to Pelvic Floor Disorders Network, PFDN, University of Alabama, Birmingham)

Agency: National Institute of Child and Human Development (NICHD)
Childbirth and Pelvic Symptoms (CAPS) Study
Summitt RL, Vogt VY, Lipscomb GH, Horton TR (Subcontracted to Pelvic Floor Disorders Network, PFDN, University of Alabama, Birmingham)

Previous Employment

Sexually Transmitted Disease Clinic – Staff Physician
Allentown Health Bureau
Allentown, Pennsylvania
5/2000 – 5/2001

Obstetrics and Gynecology Coverage Staff
North Penn Hospital
Lansdale, Pennsylvania
4/2001 – 7/2002

Locum Tenens - Obstetrics and Gynecology Coverage Staff
Crittenden Memorial Hospital
West Memphis, Arkansas
4/2003 – 1/2005

Locum Tenens – Obstetrics and Gynecology Coverage Staff
Newport Hospital

Newport, Arkansas
7/2003 - 7/2004

Locum Tenens - Obstetrics and Gynecology Coverage Staff
Harris Hospital
Newport, Arkansas
7/2003 - 7/2004

Locum Tenens - Obstetrics and Gynecology Coverage Staff
Shenandoah Memorial Hospital
Woodstock, VA
7/2005 - 7/2006

Visiting Professorships and Invited Lectures

1. Thirty-sixth Annual Review Course for the Family Physician, Department of Family Medicine, University of Tennessee Health Science Center, Memphis, TN, March 17-21, 2003
    a. "Evaluation and Treatment of Female Urinary Incontinence"
2. Lupus Foundation of America, Memphis Area Chapter, Weekly Lecture Series, Memphis, TN, Feb 9, 2003
    a. "Female Urinary Incontinence: Facts for Every Woman"

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS
and Centralized Credentials Verification Service

www.armedicalboard.org

✓ Medicine/Surgery ____ Osteopathic Medicine/Surgery

1. Name THOMAS RUSSELL HORTON JR Social Security # _____
(Legibly Print full Legal Name) (APPLICATION MUST BE COMPLETED IN INK)

2. Address 2381 REDBUD TRAIL DRIVE GERMANTOWN, TN 38139

3. Address you wish license to be mailed
2381 REDBUD TRAIL DRIVE GERMANTOWN, TN 38139

4. Phone (Res.) _____ (Work) 901 448 5819 (Fax) 901 347 8345

5. Male ☒ Female ☐ Birth Date _____ Birth Place ROANOKE, VA

If born outside of U.S., how long have you lived in U.S. ____ Years ____ Months. Are you a citizen of U.S. ✓ yes ___ no

If yes, and foreign born, attach proof of citizenship. If no, indicate your status with U.S. Immigration _____
(Attach copy of Visa/Work Permit)

6. ECFMG Certificate # _____ Date Issued _____
Have certified verification mailed directly from ECFMG to this office.

7. Intended practice location in Arkansas N/A Give name and address of hospital, clinic, group or private:
LOUMS

8. Specialty OBSTETRICS AND GYNECOLOGY Subspecialty _____
Board Certified (Date) N/A Board Certified (Date) _____
Recertification _____ Recertification _____
Have enclosed form completed by your Specialty Board and returned directly to this office.

9. Drug Enforcement Administration Number _____ State TN Expiration Date 10/31/03
Submit a copy of your DEA Registration Card to this office.

10. UPIN # _____ Medicaid Provider # _____ Medicare Provider # _____
Accept Medicaid Patients? ____Yes ____ No Accept Medicare Patients? ____ Yes ____ No

11. Professional Liability Insurance (**CURRENT** Carrier Name) _____
Policy # _____ Date of Expiration _____ Amount of Coverage _____
Send enclosed form to your insurance carrier and have them return directly to this office.

12. Medical School. Date Graduate 05 Mo 16 Day 1998 Yr Degree MD

	Name of Institution	Address	Date from	Date to
1st Year	EASTERN VIRGINIA MEDICAL SCHOOL	NORFOLK, VA	08-94	
2nd Year	EVMS			
3rd Year	EVMS			
4th Year	EVMS			05-98

Have Verification of Medical Education Form and an official Transcript mailed directly to this office.

FOR USE OF SECRETARY ONLY

License No. E-36576
Name Thomas Russell Horton, Jr., M.D.
Application for License through endorsement by
USMLE

Application received 2-20-03
Fee 450.00 Date 2-26-03
License issued 4-4-2003
Application Declined _____
Fee returned _____ 20 ____

NOTE: Application must be legible and completed in INK or Typed

13. Post Graduate Training (list chronologically). **Send Enclosed Verification Form – Refer to Instruction Sheet**

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No
LEHIGH VALLEY HOSPITAL	PO BOX 7017 ALLENTOWN PA 18105	OB/GYN	6/98-6/02	YES

14. Fellowships (list chronologically). **Send Enclosed Verification Form – Refer to Instruction Sheet**

Name of Institution	Address	Type of Program	Dates From/To	Completed? Yes/No
UNIV OF TENN, MEMPHIS	853 JEFFERSON, E 102	UROGYNECOLOGY	7/02-PRESENT	NO
	MEMPHIS TN 38103			

15. Have you taken the National Board (NBME) exams? ____ Yes __X__ No. ***If yes, have certified copy of scores mailed directly to this office.***

16. Have you taken the State Board Examination? ____ Yes __X__ No. Where? _____ When? _____
If yes, have certified copy of scores mailed directly to this office.

17. Have you taken the National Board of Osteopathic Medicine? _____ Yes __X__ No. ***If yes, have certified copy of scores mailed directly to this office.***

18. Have you taken the FLEX Exam? _____ Yes __X__ No. ***If yes, have certified copy of scores mailed directly to this office.***

19. Have you taken the United States Medical Licensing Exam (USMLE)? __X__ Yes _____ No. ***If yes, have certified copy of scores mailed directly to this office.***

20. Have you taken the LMCC Exam? _____ Yes __X__ No. ***If yes, have certified copy of scores mailed directly to this office.***

21. Have you taken the SPEX within the last five years? _____ Yes __X__ No. ***If yes, have a certified copy of scores mailed directly to this office.***

22. Indicate the name and date of your most recent written exam AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY/ JUNE 24, 2002 WRITTEN EXAM

23 Continuing Medical Education

List Continuing Medical Education for the last two years excluding Residency/Fellowship training.

Date	Description	Sponsor/Location	AMA Cat. 1 Hours	Cat. Other Hours
	N/A			

If you have trained in additional procedures, submit certificates of training or other documentation.

24. Professional Activities

List in chronological order all your professional activities, institutional affiliations or places of employment since graduation from Medical School. This includes hospitals, teaching institutions, HMO's, private practice, corporations, military assignments, government agencies, and Locum Tenens assignments. Exclude Residency and Fellowship. You may attach additional sheets after completing this section, if space is not sufficient. *Do not submit curriculum vitae (CV) in lieu of completing this section.*

From	To	Status	Location & Complete Address	Position
6-00	5-01	RESIGNED	ALLENTOWN HEALTH BUREAU 245 N 6TH STREET ALLENTOWN, PA 18102	SEXUALLY TRANSMITTED DISEASE CLINIC PHYSICIAN STAFF
5-01	5-02	RESIGNED	CENTRAL MONTGOMERY MEDICAL CENTER 100 MEDICAL CAMPUS DRIVE LANSDALE, PA 19446	OBSTETRICS AND GYNECOLOGY COVERAGE STAFF

- Please review this list carefully. If there are gaps in your chronological history you are required to provide a brief explanation. **Send enclosed Verification Hospital/Clinic forms to each facility. (See Instruction Sheet)**
- **Complete all forms in black or blue ink ONLY.**

25. Military Service? _____ Yes X No If yes, which Branch? _____

Dates of Service _____ Attach copy of separation papers and have records sent from Military Personnel Records Center. (See Instruction Sheet and Verification form.)

26. Medical Societies and Professional Organizations: **Send enclosed Verification of Medical Society Membership Form to State or County Medical Society.**

Organization	Address	From	To
N/A			

27. List all states/countries in which you have or have had a medical license. **Have verification of each license mailed directly to this office. Send enclosed verification of Licensure Form.** (Form may be copied if necessary.)

State/Country	License #	Date Issued	Active Y/N
PA/USA	MD072728L		N
TN/USA	36459	5/16/02	Y

State/Country	License #	Date Issued	Active Y/N

28. Professional References/Recommendations: **Have three reference/recommendation letters mailed from their offices directly to this office.** These cannot be current partners or related to you. They must have worked with you and directly observed your professional performance in the recent past. At least one of these references/recommendations must have had organizational responsibility for supervising your performance (i.e. department chief, service chief or training program director).

Name	Address	Association
DR CRAIG J SOBOLEWSKI	LEHIGH VALLEY HOSPITAL - DEPT OF OB/GYN PO BOX 7017 ALLENTOWN PA 18105-7017	RESIDENCY TRAINING PROGRAM DIRECTOR
DR ROBERT L SUMMITT	UT-MEMPHIS DEPT OF OB/GYN 853 JEFFERSON RM E-102 MEMPHIS TN 38103	FELLOWSHIP DIRECTOR UROGYNECOLOGY
DR FRANK W LING	UT-MEMPHIS DEPT OF OB/GYN - CHAIRMAN 853 JEFFERSON RM E-102 MEMPHIS TN ~~38139~~ 38103	CHAIRMAN.

Attach explanation of any "yes" answers. Refer to Instruction Sheet for the following questions.

	YES	NO
29. Have you ever failed a licensing exam? Where? _____ Explain.		✓
30. Has your application for examination or licensure ever been rejected, denied or withdrawn?		✓
31. Has any medical licensing board ever placed your license on probation, suspension or has it revoked a license or certificate it had granted you? If yes, list name and address of board.		✓
32. Have you ever been ordered to appear before a state medical board for any reason other than licensure?		✓
33. Have disciplinary procedures ever been initiated toward you by either a medical board or hospital? Explain.		✓
34. Have your privileges at any hospital been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending?		✓
35. Have you ever voluntarily surrendered your license in any state?		✓
36. Have you ever been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony ?	✓	
37. Have you ever been denied provider participation in any state or Federal Medicaid program?		✓
38. Have you ever previously made application to the Arkansas State Medical Board?		✓
39. Have you ever been warned, censured by, or requested to withdraw from, any hospital in which you have trained, been a staff member or held hospital privileges? If yes, explain.		✓

	YES	NO
40. Have you ever been disciplined or dismissed from any professional activity or training program? If yes, explain.		✓
41. Have you ever, voluntarily or involuntarily, left a training institution program before completing it? If yes, explain.		✓
42. Have you ever been reported to the National Practitioners Data Bank or subject to NPDB adverse action report?		✓
43. Have you resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted?		✓
44. Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending?		✓
45. Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicaid programs? If yes, name state _____		✓
47. Have you ever been cited by a peer review organization? Explain Give the name and address of the organization _____		✓
48. Have you ever had to discontinue practice for any reason for a period longer than one month? If yes, explain.		✓
49. Have you been, or are you presently, being treated for alcoholism, or substance abuse? If yes, was this voluntary or the result of a medical board action? Explain.		✓
50. Have you been, or are you presently, being treated for a mental health condition? If "Yes", was this voluntary or the result of a medical board action? Explain.		✓
51. Do you currently, or have you had, any physical or mental health condition, including alcohol or drug dependency, which with or without accommodation, affects or is reasonably likely to affect your ability to practice medicine or to perform professional or medical staff duties appropriately?		✓
52. Have you ever had a DWI? How many? ONE Date(s) occurred _____	✓	
53. Have you ever been treated for drug or substance abuse outside a hospital setting? Explain.		✓
54. Have you ever been treated for drug or substance abuse in a treatment center or hospital? Give name of institution, date and length of stay? _____		✓
55. Are you currently being, or have you ever been, monitored by a Physician Health Committee in any state? If yes, give state(s) _____ Ask your treating physician to send documentation of your status.		✓
56. Have you ever been rejected by a medical society?		✓
57. Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? If yes, explain.		✓
58. Have you ever defaulted on any Health Education Assistance Loan? If yes, explain.		✓
59. To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? If yes, explain.		✓

If, during the application process, you become aware of any such investigation, you are required to report it to this office.

AFFIDAVIT OF APPLICANT

I, THOMAS RUSSELL HORTON JR., certify after being sworn, that all of the information supplied in the foregoing application is true, correct, current and complete to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation or denial of any license to practice medicine granted to me, and criminal prosecution to the fullest extent of the law.

T. Russell Horton

Applicant's Signature (in INK)

01/17/2003

Date Signed

Sworn to and subscribed before me this 17th

day of January, 20 03.

My Commission Expires: June 07, 2006

Brenda J. Jansen

Signature of Notary Public

DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

VERIFICATION OF POSTGRADUATE TRAINING

DR ROBERT L SUMMITT
Name of Program Director

UNIVERSITY OF TENNESSEE, MEMPHIS
Name of Institution

853 JEFFERSON, RM E102
Street

MEMPHIS TN 38103
City State Zip

I, T. RUSSELL HORTON (Print full name), have applied for a license to practice medicine in the State of Arkansas. As part of the application process, the Arkansas State Medical Board requires a reference from the program director of each ACGME accredited **Postgraduate Training** program to which I have been appointed.

I hereby authorize UNIVERSITY OF TENNESSEE (Name of Institution), its staff, or representative to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named institution and /or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the Arkansas State Medical Board, 2100 Riverfront Drive, Little Rock, Arkansas 72202. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, T. Russell Horton (Signature of Applicant)

Date of Birth ___ (MO) ___ (DAY) ___ (YR) Social Security Number: _____

For verification of POSTGRADUATE TRAINING Please provide exact date(s).

The following section must be completed by the Program Director or his/her representative and returned directly to the Arkansas State Medical Board. **Verifications returned to the applicant will not be accepted. DO NOT USE SIGNATURE STAMPS.**

This is to certify that T. Russell Horton, M.D. (Name of applicant), a graduate of Eastern Virginia Medical School (Medical School)

commenced postgraduate training (*internship/residence/clinical fellowship) in University of Tennessee, 853 Jefferson (Legibly Print or Type Name and address of training program)

Avenue, RM E102, Memphis, TN 38103

on 07 (MO) / 01 (DAY) / 02 (YR) and completed **(check one)** ☐ successfully ☐ **unsuccessfully such training on ___ (MO) / ___ (DAY) / ___ (YR),

or anticipated graduation date on 06 / 30 / 05.

☐ Internship- Name of Dept./Dates _____

☐ Residency- Name of Dept./Dates _____

☒ Fellowship-Name of Dept./Dates Obstetrics & Gynecology; Urogynecology 7-1-02 to 6-30-05 ☒ Clinical ☐ Research

Type or Legibly Print Name: Robert L. Summitt, JR., M.D. Signature: R. L. Summitt

Date Signed _____

Title Professor & Chief, Section of Urogynecology

Tel. No. (901) 448-5393 Fax No. (901) 448-7075

COMMENTS: _____ (Attach additional sheet if needed.)

***List the reason for unsuccessful completion in Comments or attach a letter of explanation.*

*Circle one.

THE UNIVERSITY OF TENNESSEE
Health Science Center

College of Medicine
Department of Obstetrics and Gynecology
853 Jefferson Avenue
Memphis, TN 38163
Tel: (901) 448-5771 • Fax: (901) 448-4701

January 21, 2003

Arkansas State Medical Board
Credentialing/ Pat Fisher
2100 Riverfront Drive
Little Rock, AR 72202-1435

Re: T. Russell Horton, M.D.

It is my pleasure to support Dr. Horton in his application for licensure by the State of Arkansas. Dr. Horton is currently undertaking subspecialty training in Pelvic Reconstructive Surgery and Urogynecology here in the Department of Obstetrics and Gynecology at the University of Tennessee Health Science Center at Memphis. It is anticipated that he will successfully complete this endeavor in June, 2005.

His clinical skills are excellent and his interactions with others have always been highly professional. He works well with not only other physicians, but also nursing staff and trainees. His ethical standards and integrity are of the highest caliber. I support Dr. Horton's application without hesitation, and recommend him to you at the highest level.

Should there be any questions, please let me know.

Sincerely,

Frank W. Ling, M.D.
UT Medical Group Professor and Chair
Department of Obstetrics and Gynecology
University of Tennessee, Memphis

FWL/mjm

Craig J. Sobolewski, M.D.
Chief, Division of Gynecology
Director, OB/GYN Residency Program
Director, Chronic Pelvic Pain Program
Obstetrics & Gynecology

17th & Chew Streets
Post Office Box 7017
Allentown, Pennsylvania 18105-7017
Residency Program 610-402-2890
Appointments 610-402-1600
Fax 610-402-9688
Email craig.sobolewski@lvh.com

LEHIGH VALLEY

PHYSICIAN GROUP

Affiliated with Lehigh Valley Hospital & Health Network

January 20, 2003

Arkansas State Medical Board
2100 Riverfront Drive
Little Rock, AR 72202-1435

RE: T. Russell Horton, M.D.

To Whom It May Concern:

I am pleased to write this letter of recommendation for Dr. Rusty Horton. I am privileged to have had the opportunity to work with Rusty during his entire residency training here at Lehigh Valley Hospital. I have worked with him on several levels, including as his attending physician, as well as in my role as Associate Residency Program Director for the Obstetrics and Gynecology Residency Program.

Rusty has performed well throughout his residency. He has a good medical knowledge base and excels technically in both the obstetric and gynecologic arenas. Rusty has established excellent relationships with his patients and his co-residents, as well as the ancillary hospital personnel involved in the care of his patients.

In summary, I am quite confident that Rusty will be an active positive asset to any hospital. I welcome the opportunity to discuss his performance here at Lehigh Valley Hospital with you at any time in the future if you deem it necessary.

Sincerely,

Craig J. Sobolewski, M.D., F.A.C.O.G.

CJS/tfb

THE UNIVERSITY OF TENNESSEE
Health Science Center

College of Medicine
Department of Obstetrics and Gynecology
853 Jefferson Avenue
Memphis, TN 38163
Tel: (901) 448-5771 • Fax: (901) 448-4701

March 3, 2003

Arkansas State Medical Board
Credentialing/Pat Fisher
2100 Riverfront Drive
Little Rock, AR 72202-1435

RE: T. Russell Horton, M.D.

Dear Ms. Fisher:

This letter is written in support of Dr. T. Russell Horton, who is applying for Arkansas medical licensure. Dr. Horton is currently functioning as a fellow and instructor in the Department of Obstetrics and Gynecology at the University of Tennessee, Memphis. He completed his residency training in obstetrics and gynecology at Lehigh Valley Hospital, Allentown, Pennsylvania in June 2002. Dr. Horton has demonstrated excellent clinical and surgical skills. His medical knowledge is above average and his responsibility to clinical duties is excellent. Dr. Horton's professional conduct and interaction with staff and patients is unquestionable.

In summary, I strongly support Dr. Horton for licensure in your state. If I can provide any further information to you, please do not hesitate to contact me.

Sincerely,

Robert L. Summitt, Jr., M.D.
Professor and Chief
Section of Urogynecology
Director, Residency Training Program

RLS/ltt

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
FIRST FLOOR, CORDELL HULL BUILDING
425 FIFTH AVENUE NORTH
NASHVILLE, TENNESSEE 37247-1010
www.tennesseeanytime.com
TENNESSEE BOARD OF MEDICAL EXAMINERS

January 27, 2003

T RUSSELL HORTON, MD
2381 REDBUD TRAIL DRIVE
GERMANTOWN TN 38139

TO WHOM IT MAY CONCERN:

The Tennessee Board of Medical Examiners is pleased to furnish the following information from our files:

PROFESSION: Medical Doctor

NAME: T RUSSELL HORTON

LICENSE NUMBER: MD36459

ISSUE DATE: 05/16/2002

EXPIRATION DATE: 09/30/2003

CURRENT STATUS: Licensed

STATUS DATE: 05/16/2002

COMMENTS: There is no derogatory information in our files concerning this individual. The State of Tennessee only provides the above information. Any other information needed must be obtained from the licensee.

Sincerely,
Nick Pentecost

Board Administrator
Tennessee Board of Medical Examiners

MD/LV1

To expedite the verification process, the above is the standard format used by the Medical Board of Tennessee.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

February 12, 2003

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	THOMAS RUSSELL HORTON JR
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD072728L
ORIGINAL LICENSURE DATE:	11/22/2000
EXPIRATION DATE:	12/31/2002
STATUS:	Inactive

The license is in good standing and the records indicate no derogatory information.

David M. Williams

Commissioner
Bureau of Professional and Occupational Affairs

ARKANSAS STATE MEDICAL BOARD

2100 Riverfront Drive, Little Rock, Arkansas 72202-1435 (501) 296-1802

www.armedicalboard.org

ARKANSAS RULES AND REGULATIONS AFFIDAVIT

I, THOMAS RUSSELL HORTON JR (Type or Print Name) on this date, JAN 15, 2003

do affirm that I have read the Medical Practices Act, Arkansas Code 17-95-101, *et seq.*, and the Rules and Regulations of the Arkansas State Medical Board.

Signed: T. Russell Horton (Physician's Signature)

Date: Jan 15 2003

THIS IS A REQUIREMENT FOR LICENSURE. YOU MUST COMPLETE THIS FORM AND RETURN IT TO:
ARKANSAS STATE MEDICAL BOARD
ATTN: LICENSING
2100 RIVERFRONT DRIVE
LITTLE ROCK, AR 72202-1435