Interstate Medical Licensure Compact
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**PHYSICIAN'S CORE DATA SHEET**

(*Must be the physician's accurate information to avoid delay or rejection*)

Full Legal Name **Tamer , Yvette , Middleton ,** __

Other names used (maiden, birth) ____, __, __

Residential address_____, _____, _ __, _____,

Office address **1874 Piedmont Avenue, NE Suite 585E , Atlanta , GEORGIA , 30324 ,**

Where do you wish to receive mail. Residential

Physician's cellular or alternative telephone number _____

Physician's office or practice telephone number of public record **(770) 212 - 9660**

Date of Birth **__/__/1963** Gender: Prefer not to say

Applicants personal email address _____

Email address delegated by applicant to receive correspondence _____ _____

Social Security Number: _____ _____

Physician's National Provider Identifier Number _____

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Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes

Medical School **Morehouse School Of Medicine** Date of Degree Issued **5/20/2000** Medical Degree Received: M.D.

Have you passed each component or step of the USMLE, or the COMLEX-USA within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes (if in question contact your SPL)? Yes

Which licensing exam did you pass? **USMLE**

Have you successfully completed graduate medical education approved by the ACGME or the AOA? Yes

Residency Program **Columbus Regional Family Medicine** Completion Date **6/30/2003**

What is the specialty of the program **Family Medicine**

Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? (Board eligibility does not qualify) Yes

Name of Specialty Board Certification **American Board of Family Medicine**

Lifetime **Yes** If not lifetime, Expiration Date **11/15/2025**

Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? No

Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? No

Have you ever had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? No

Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? No

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# Application for Expedited Licensure

I have read and understood the Qualifications to practice medicine in the Compact states. I attest that I am qualified and understand that pursuant to the IMLCC's rules, all fees are non-refundable. **Yes**

If you have questions please call your State of Principle License

I understand that inaccurate or missing information may be grounds for rejection of my application.

Please carefully review the Application documents before applying. **Yes**

I have reviewed the criteria to select a State of Principal License (SPL) and confirm eligibility to designate a Compact state as my SPL. **Yes**

I have a full and unrestricted license in a Compact State **Yes**

SPL **GEORGIA COMPOSITE MEDICAL BOARD** License # **51987**

**AND** at least one of the below must APPLY (Please select all that apply)

a. Your primary residence is in the SPL (State of Principal License) No
b. At least 25% of your practice of medicine occurs in the SPL Yes
c. Your employer is located in the SPL No
d. You use the SPL as your state of residence for U.S. federal income tax purposes No

Please provide below information:

Residence Street address_____

Residence City State Zip _____, _____, _____

Please describe your practice and location in the SPL selected_____**Private Practice (co-owner)**
**Atlanta Comprehensive Wellness Clinic**
**1874 Piedmont Avenue, NE**
**Suite 585E**
**Atlanta, GA 30324**_____

Please be prepared to provide documentation to the designated SPL for further verification. If you have any question please contact your SPL.

You or your employer may be asked for additional documentation about your Employment.

Name of Employer_____ Employer Contact Phone_____

Employer Street address_____

Employer City State Zip ___, ____, __

Please provide your Tax ID # (SS#, EIN) _____ (must be most recent return)Please be prepared to provide documentation to the designated SPL for further verification.

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**AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR AN IMLC LETTER OF QUALIFICATION AND MEDICAL LICENSES IN IMLC MEMBER STATES**

I, Tamer Yvette Middleton ( full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof, furnished or to be furnished with respect to my application, are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as potential prosecution under appropriate federal and state laws.

I hereby apply to **GEORGIA COMPOSITE MEDICAL BOARD** (state) as my State of Principal License ("SPL") for a Letter of Qualification ("LOQ") to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I authorize and request every person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, to furnish to the SPL any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the SPL, or any of its agents or representatives, to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact.

I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, of any and all liability of every nature and kind, arising out of an investigation made by the SPL.

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application. Additionally, I further authorize the SPL to process and release my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind, arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application, if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a LOQ, revocation, or other disciplinary sanctions of my license(s) or permit(s) to practice medicine, in one or more Compact Member States.

Applicant Signature

Type Applicant's Name Tamer Y Middleton
Applicant's NPI _____
Date 7/3/2022

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# Letter of Qualification

Date: 7/19/2022

Name: Tamer Yvette Middleton

Address:

CityStZip:

Dear Dr.: Tamer Yvette Middleton

RE: Your application for IMLC Letter of Qualification

The GEORGIA COMPOSITE MEDICAL BOARD ("Board"), on behalf of the State of Principal Licensure ("SPL") you selected, has received and reviewed your application for a Letter of Qualification ("LOQ") for licensure through the Interstate Medical Licensure Compact ("IMLC").

Based upon the information you submitted with your application, data in the Board's files regarding your licensure by the Board, verifications of your credentials, and the results of the check of national databases, the Board has determined that you are ELIGIBLE to be licensed through the IMLC. Therefore, this notice will serve as your LOQ for licensure in IMLC Member States through the IMLC, and will remain in effect for 365 days from date of issuance, set out above.

An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license in by each.

All medical licenses issued by Member Boards through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions including, but not limited to, each Member Board's continuing medical education requirements. It is also your obligation to keep your SPL, the Member Boards which have licensed you, and the IMLC Commission informed of any changes in your contact information or qualifications and eligibility for licensure through the IMLC.

Authorized Signature from SPL David Harris

Type Name David Harris
Title of Authorized SPL Licensure Manager
Date 7/19/2022

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# MEDICAL LICENSE ISSUANCE INFORMATION

**Physician's Name** Tamer (First) Yvette (Middle) Middleton (Last)

Please fill in your respective Member Board's information for the qualified Physician named above.

National Provider Identifier Number _____

Medical Board Name NEVADA STATE BOARD OF MEDICAL EXAMINERS

Member Board License Number 22702

Date License Issued 8/19/2022 (mm/dd/yyyy)

Date of Expiration 6/30/2023 (mm/dd/yyyy)

Member Board Signature Leah Hall

Name Leah Hall
Date 8/19/2022

**NEVADA STATE BOARD OF MEDICAL EXAMINERS**
9600 Gateway Drive Reno, Nevada 89521 Phone (775) 688-2559

Licensee Name: Tamer Yvette Middleton
(Please indicate your FULL legal name)

Licensee Public Address: Po Box 14968

City, State, Zip: Atlanta GA 30324

Public Telephone Number: 770 212 9623

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Mailing Address (if different than Public Address): same as above

City, State, Zip: same as above

Direct Contact Telephone Number (Not Public): _____

Direct Contact Electronic Mail Address (Not Public): _____

## Attestations/Affirmations:

1. CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this question is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

**Please place a check mark next to one of the following statements:**

✓ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

2. ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. ✓ Yes ____ No

http://www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

RECEIVED
SEP 08 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS

## 3. SAFE INJECTION PRACTICE ATTESTATION

**ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS**

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. ✓ Yes ____ No

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

## 4. COMMUNICATIONS AFFIRMATION

**Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada or via telemedicine and whose physical presence exists outside the state of Nevada or the United States.**

I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change.

Printed Name of Applicant/Licensee: Tamer Middleton

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

## 5. MILITARY SERVICE ATTESTATION

1-Have you ever served in the United States Military (to include National Guard or Reserves)? ____ Yes ✓ No

*If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.*

2-If yes, which branch of service did you serve?
- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard

3-Military occupation specialty or specialties?
- ☐ Administration or Personnel
- ☐ Logistics or Supply
- ☐ Aviation
- ☐ Maintenance
- ☐ Civil Engineering
- ☐ Medical Services
- ☐ Communications
- ☐ Security Forces Military Police
- ☐ Infantry or Armor
- ☐ Legal or Chaplin Corps
- ☐ Other

4&5-Dates of service in the Military: 4-From: ____/____/____ (DD/MM/YYYY) 5-To: ____/____/____ (DD/MM/YYYY)

6-Are you still serving? ____Yes ____No

7-Have you ever served on active duty in the Armed Forces of the United States? _____Yes _____No

8-Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States? _____Yes _____No

9-Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States? _____Yes _____No

10-If the answer to question(s) 7, 8 and/or 9 is "yes," did you separate from such service under conditions other than dishonorable? (Unless you were dishonorably discharged, your answer should be "yes.") _____Yes _____No _____N/A

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## 6. LICENSEE PHOTOGRAPH

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

9-5-2022

**Signature of Licensee** **Date**