SPOA 1411 (REV. 6/96)

970226 0122

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400
717-787-2381

Courier Delivery Address
STATE BOARD OF MEDICINE
124 PINE STREET, 1st FLOOR
HARRISBURG, PA 17101

OFFICIAL USE ONLY

MD-061164-L

ROIZIN APPL

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION

For Graduates of ACCREDITED Medical Schools

Official Use Only
Amount 200
Date 12/2/96

11/163/96

Application Fee: $20.00 *not refundable.*
Make check payable to the "Commonwealth of Pennsylvania."

Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment

Please print or type.

NAME: ROIZIN (Last) JOHN (First) DENNIS (Middle)

Permanent Address: [redacted]

Date of Birth: [redacted] Social Security Number: [redacted]

If your medical/licensure records are listed under another name or names list below:

LIST MEDICAL SCHOOL(S) ATTENDED: DATES OF ATTENDANCE

Universite Laval (Medical School) From: Sept 86 (Mo. & Yr.) to Dec '91 (Mo. & Yr.)

McGill University (Residency) From: Dec '91 (Mo.& Yr.) to NOV '96 (Mo. & Yr.)

Date of Graduation: _____

List all states, territories and countries in which you have ever possessed a license without restriction to practice medicine and surgery (active or inactive, current or expired). **If you never possessed a license, write "NONE."**

NONE

( ) FLEX - indicate state where taken:_____ Date taken:_____
( ) FLEX COMPONENT 1 - indicate state where taken:_____ Date taken:_____
( ) FLEX COMPONENT 2 - indicate state where taken:_____ Date taken:_____
( ) NATIONAL BOARD - PART I _____ PART II _____ PART III _____
( ) USMLE - STEP 1 _____ STEP 2 _____ STEP 3 _____
(✓) LMCC - Canadian
( ) STATE BOARD - indicate state where taken:_____

Post Graduate Education:

PGY1 Hospital: Royal Victoria Hospital From: Dec/01/91 to: Nov/30/92

PGY2 Hospital: Royal Victoria Hospital From: Dec/01/92 to: Nov/30/93

Answer the following questions, if **"YES"** to any of them, provide complete details on a separate sheet as well as certified copies of relevant documents. **Sign and date below.**

		YES	NO
1.	Has any disciplinary action been taken against your license in another state, territory or country?		✓
2.	Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?		✓
3.	Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?		✓
4.	Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
5.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **(Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Health Monitoring Program.)**	[redacted]	

****

VERIFICATION STATEMENT

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

[redacted] RECEIVED 1996 | Oct | 30

LICANT DATE

DEC 0 2 1996

P.O. Box 2649
Harrisburg, PA 17105-2649

970226 0122

Certification of Moral Character

To be completed by **two** physicians with a license without restriction in good standing in the United States or Canada.

Name of Applicant: JOHN ROIZIN

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 5 year(s) 0 month(s).

SIGNATURE: [redacted] Date: NOV. 26th 1996

Print or type name as signed above: ALICE BENJAMIN MD FRCS & FACS

State in which licensed: Quebec Canada License Number: 177 3258

Name of Applicant: JOHN ROIZIN

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 5 year(s) 0 month(s).

SIGNATURE: [redacted] Date: 11/26/96

Print or type name as signed above: A. F. ASSWAD

State in which licensed: Quebec Canada License Number: 68358

Return Completed form to Applicant

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

(61)

Courier Delivery Address
State Board of Medicine
124 Pine Street, 1st floor
Harrisburg, PA 17101

97 DR 26 DR 23
11/16/96

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING

Accredited Medical School Graduates

TO BE COMPLETED BY APPLICANT

NAME: ROIZIN (Last) JOHN (First) DENNIS (Middle)

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty. See listing on back.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

To be completed by the program director at the hospital where the graduate training occurred. If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

Name of Hospital: Royal Victoria Hospital

Located: Montreal (City) Quebec (State)

1st Year from 11/26/91 To 11/25/92 Specialty Obs & Gyn Level(PGY) 1

2nd Year from 11/26/92 To 11/25/93 Specialty Obs & Gyn Level(PGY) 2

→ "I certify that JOHN ROIZIN (Name of Applicant) successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified."

→ ***"I further certify that the above program was ACGME accredited at the time*** JOHN ROIZIN (Name of Applicant) ***completed the training."***

[Seal of Hospital]

Signature of Program Director: [signature]

Date: 96/11/14

If the hospital has no seal complete the following section **and have this form notarized**:

I hereby certify that this hospital has no seal or stamp and that this form was completed by this hospital.

Program Director's Signature: _____

Date: _____ [notary seal]

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE.

State Board of Medicine
717-783-1400
717-787-2381

970226 D122
D6116 4
Sh

VERIFICATION OF MEDICAL EDUCATION
For Graduates of Accredited Medical Schools.

SECTION 1: To be completed by applicant:

Name: ROIZIN (Last) JOHN (First) DENNIS (Middle)

Name of medical school: Université Laval

Location: Quebec City, Quebec Canada

SUBMIT THIS VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL SCHOOL ENVELOPE.

SECTION 2: To be completed by Dean or Registrar of medical school:

Name of medical student: John ROIZIN

Date student began to attend this medical school: September 1986
Month/Day/Year

Date of graduation: June 30th, 1991
Month/Day/Year

[Seal of School]

I certify that all of the above information is correct.
Signature of
~~Dean or Registrar:~~ [redacted]
Lucie Rondeau-Rivard, md
→Secretary of the Faculty of Medicine
Date: November 27, 1996

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in official school envelope. DO NOT RETURN TO APPLICANT.

****

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
U.S.A

Courier Delivery Address
State Board of Medicine
124 Pine Street, 1st Floor
Harrisburg, PA 17101
U.S.A.

970226 0122 6116 VL

The Medical Council of Canada
Le Conseil médical du Canada

Suite 300, 2283 boul. St. Laurent Blvd.
Ottawa, Ontario, Canada K1G 5A2

W. DALE DAUPHINEE, M.D., FRCPC
Executive Director/Directeur général

17 December 1996

"CONFIDENTIAL"

Pennsylvania State Board of Medicine
PO Box 2649
Harrisburg PA 17105-2649
USA

SUBJECT: **Dr. John Dennis ROIZIN**

D.O.B. [redacted]
L.M.C.C. No. 77250

The enclosed certificate is submitted to you on behalf of the person named. I hope that this will provide a satisfactory statement of this Licentiate's registration with this Council.

The above-named physician wrote the examination in English.

Sincerely

P. Boendale

Noreen Nolan
Director
Credentials and Registrations

NN/pb

Encl.

Mailing Address: P.O. Box/CP 8234, Station 'T', Ottawa, Ontario, Canada K1G 3H7
Telephone (613) 521-6012 FAX (613) 521-9417

THE MEDICAL COUNCIL OF CANADA

P.O. Box 8234, Ottawa, Ontario, Canada, K1G 3H7

STATEMENT OF REGISTRATION

PRIVATE AND CONFIDENTIAL

N.B. - This statement is issued subject to the following explanation:

(1) Licensure of medical practitioners in Canada is the responsibility of the medical licensing authorities of Canada, on whose behalf the Medical Council of Canada holds professional examinations leading to enrolment in the Canadian Medical Register as Licentiate of the Medical Council of Canada (L.M.C.C.). A person so qualified may obtain a license to practice if considered otherwise suitable by the medical licensing authority.

(2) This Statement of Registration pertains to licentiates awarded standing upon success in the examination conducted after January 1, 1988, and whose names are entered in the Canadian Medical Register. This comprehensive examination includes an objective, multiple choice portion and a Patient Management Problems portion. The former assesses medical knowledge in the subjects of Medicine, Obstetrics and Gynaecology, Paediatrics, Preventive Medicine and Community Health, Psychiatry and Surgery. It may include questions on the basic medical sciences as pertain to these subjects. The Patient Management Problems portion contains questions in the subjects listed, presented in interdisciplinary form and is designed to assess the candidate's ability to solve and manage clinical problems.

(3) Results are reported as standardized scores with a mean of 500. The standardized score required to pass the examination concerned is shown below. The average performance of each candidate in each of the six subjects and in the Patient Management Problems is expressed as a ratio of the candidate's raw score to the average obtained by all the candidates in these seven components, which is shown as 1.

(4) The information obtained by the Medical Council of Canada does not enable it to certify reliably concerning a licentiate's character or habits, nationality or citizenship, educational record or standing, or provincial registration or license as a practitioner. This information should be obtained from the Canadian medical licensing authority where the physician is licensed to practice.

(5) This statement is not evidence of the identity of its holder with the person named herein, and must not be used as such.

I hereby certify that **Dr. John Dennis ROIZIN** having passed the required examination, was registered on the Canadian Medical Register as Licentiate of the Medical Council of Canada under the registration number **7 7 2 5 0** on **13 October 1994**. I further certify that the examination results of this licentiate are as follows:

The standardized passing score for the examination written in **May 1991** was **330**

Final standardized score obtained by this candidate **357**

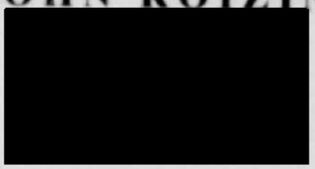
Subjects

Medicine	.80	Preventive Medicine & Community Health	.84
Obstetrics & Gynaecology	.95	Psychiatry	.98
Paediatrics	.82	Surgery	.85
		Patient Management Problems	.95

Date **18 December 1996**

P. Bourdeau, Registrar

JOHN ROIZIN



EDUCATION:

McGill University, Montreal, Quebec — 1991 - 1996
Obstetrics & Gynecology Residency Program
Chief Resident: 1994 - 1996
Research in apoptosis of granulosa cells, 1996

University of Laval, Quebec City, Quebec — 1986 - 1991
Medical Doctor
Research in androgen resistance, 1989

University of Waterloo, Waterloo, Ontario — 1985 - 1986
M.Sc. Program
Molecular and Cellular Biology
Research in heat shock proteins

University of Waterloo, Waterloo, Ontario — 1981 - 1985
Honours B.Sc. in Biology

PROFESSIONAL MEMBERSHIPS:

Royal College and American Board Eligible, Obstetrics and Gynecology

American College of Obstetrics and Gynecology (ACOG) Junior Fellow
District I, Quebec Regional Chair

Society of Obstetrics and Gynecology of Canada (SOGC) Junior Member

LANGUAGES:

Fluent in English and French
Some Spanish

PERSONAL INTERESTS:

Soccer, cooking, skiing and Scrabble

REFERENCES:

Upon Request

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

March 21, 2007

JOHN DENNIS ROIZIN
[redacted]

RE: ERICA MICHELE HARTZELL

Dear Doctor:

This is in response to your application to supervise a physician assistant. To the degree that the documents you submitted indicate that you intend for the physician assistant to perform services not specifically authorized by the Board's regulations, you are reminded of the following:

The Board's regulations at 49 Pa. Code §18.151 define the role of a physician assistant. A copy of the regulations is enclosed.

The regulations authorize the physician assistant under appropriate direction and supervision by a physician assistant supervisor, to augment the physician's data gathering abilities in order to assist the physician in reaching decisions and instituting care plans for the physician's patients. The regulations identify specific procedures which physician assistants are authorized to perform. Although the list of procedures is not all inclusive, it identifies those procedures which may be considered pre-approved.

If you desire your physician assistant to provide services beyond those included in the regulations you must adhere to the statutory provisions which address delegation of medical services. Sections 17 and 21 of the Medical Practice Act, 63 P.S. §§422.17 and 422.21, address the use of non-physician in the performance of medical services. A copy of the Act is enclosed.

The Board is unable to pre-approve procedures which are not contained in the regulation. As a government agency the Board's activities are limited to that authorized by the Medical Practice Act of 1985, 63 P.S. §§422.1 - 422.45. The act does not confer authority on the Board to issue advisory opinions or pre-approve specific conduct. This issue has been addressed by the

Pennsylvania Commonwealth Court, which is the Court having review authority over decisions of the Board. That Court has held that where the legislature has not provided authority for a licensing board to pre-approve conduct of its licensees, such pre-approval decisions are in the nature of an advisory opinion and thus a nullity. See Avis Rent A Car Systems v. Commonwealth Department of State, 548 A.2d 402 (Pa. Cmwlth. Ct. 1988).

The Court has also held specific to the State Board of Medicine that the Medical Practice Act does not confer pre-approval authority to the Board. Such actions by the Board are outside the scope of power granted by the legislature. The Board's authority to decide issues concerning accepted ethical and quality standards of conduct arises in the context of promulgating regulations or in the context of a disciplinary action. See Morrison v. State Board of Medicine, 618 A.2d 1098 (Pa. Cmwlth. Ct. 1992). Outside the context of its regulations the Board lacks authority to provide you the pre-approval you seek.

In assessing whether the particular service is one which is appropriate for delegation under those regulations, the physician must comply with the Board's delegation regulations contained at 49 PA Code; Section 18.401 - 18.402 (copy enclosed). The physician retains responsibility for the medical service performed, whether performed personally or delegated to another person. Determine the level of skill and knowledge necessary to the safe performance of the procedure. Research the medical community's accepted practices, review the medical literature, and review the practice with experts in the field. Assess the competency of the individual who will provide the service. Ascertain whether performing the procedure on the particular patient creates any special risk. Provide supervision and monitoring appropriate to the difficulty of the procedure, the skill of the delegatee, and the risk to the particular patient.

We trust this information will assist you in exercising professional judgment regarding this matter.

Sincerely,

State Board of Medicine

MX0060118

49-106 (REV. 11/06)

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone 717-783-1400 717-787-2381 **email** st-medicine@state.pa.us

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

APPLICATION FOR REGISTRATION AS A SUPERVISING PHYSICIAN

INSTRUCTIONS - Print or type all information. If the written agreement is identical for all supervisors, submit one application for each physician assistant. Attach the fee and written agreement.

FEE - $35.00 for each application with one primary and one substitute physician assistant supervisor. An additional $5.00 fee is due for each additional substitute supervisor. NOTE: A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR FINANCIAL INSTITUTION. REGARDLESS OF REASON FOR NON-PAYMENT. MAKE CHECK PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA." THE FEE CANNOT BE REFUNDED OR TRANSFERRED TO ANOTHER APPLICATION.

Upon approval of the application, the Board will issue an approval letter for the primary supervisor and provide a list of all substitute supervisors. These documents will be sent to the primary supervisor at the address provided on page one of the application.

***NOTE, PENNSYLVANIA LAW REQUIRES THAT YOU MAINTAIN A COPY OF THIS APPLICATION AND ALL ATTACHMENTS.**

***REGARDLESS OF THE FILING DATE, A PHYSICIAN ASSISTANT CANNOT PRACTICE PRIOR TO THE BOARD'S APPROVAL OF THIS APPLICATION.**

PRIMARY SUPERVISING PHYSICIAN NAME/LICENSE NUMBER:

Roizin (LAST) John (FIRST) D (MIDDLE) MD- 061165-L (LIC NO)

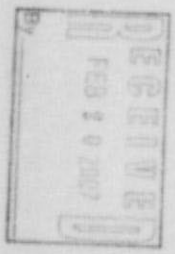
PHYSICIAN ASSISTANT NAME/LICENSE NUMBER:

Hamzell (LAST) Erica (FIRST) M (MIDDLE) MA- 051475 (LIC NO)

PRACTICE ADDRESS 1409 Union Blvd, Rear (STREET)

Allentown (CITY) PA (STATE) 18109 (ZIP CODE)

PRACTICE TELEPHONE (610) 770-9077



49-106 (REV. (11/06)

Primary supervising physician must complete this section:

List your specialties obstetrics and gynecology

Do you hold a membership in any American Boards of Medical Specialties
YES ✓ NO

If yes, list Board(s) American Board of Obstetrics & Gynecology (ABOG)

Do you hold hospital staff privileges?
YES ✓ NO

If you have hospital staff privileges, indicate the hospital name(s)
Carlisle Regional Medical Center

VERIFICATION

I will direct and exercise supervision over the named physician assistant in accordance with the rules and regulations of the State Board of Medicine. I verify that I have reviewed the Medical Practice Act and Regulations of the State Board of Medicine. I recognize that I am obligated to comply with all the provisions of the Act and Regulations **including those provisions that require me to notify the Board of the termination of my agreement to supervise the physician assistant**. I recognize that I retain full professional and legal responsibility for the performance of the physician assistant and the care and treatment of the physician assistant's patients. I verify that I will not provide primary supervision to more than two physician assistants.

I verify that the statements in this application and written agreement are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my registration.

The physician assistant identified in this application will only work with the primary supervising physician and substitute physician assistant supervisor(s) listed in this application. This physician assistant will only provide medical services to [redacted] the primary and substitute supervisor(s) named in [redacted]

[redacted] 2/17/07

[redacted] 2/9/07
Date

Name of S[redacted]ervisor Sherwood Samet, MD

Signature [redacted] 2-13-07 MD# MD 024786L

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

Name of Substitute Physician Assistant Supervisor _____

Signature _____ Date _____ MD# _____

(Attach 8 1/2 x 11 sheets with additional names if needed.)

49-106 (REV. 11/06)

WRITTEN AGREEMENT

Dr John Fortin MD — NAME OF PRIMARY SUPERVISING PHYSICIAN

Erica Hartzell PA C — NAME OF PHYSICIAN ASSISTANT

INSTRUCTIONS: Please provide the following information for questions 1 and 2 on 8 1/2 x 11 sheets and attach to this form. Number each section on the attachment. The information on this agreement must be identical for all supervisors listed on page 2.

1. Describe the functions/tasks to be delegated to the physician assistant.

2. Provide details regarding the time, place and manner of supervision and direction you will provide the physician assistant.

3. List the name, address, and practice setting(i.e. hospital, private practice, group practice, etc.) where the physician assistant will serve.

   Allentown Women's Center, 1469 Union Blvd, Rear, Allentown PA 18109, office

4. Will the physician assistant prescribe and dispense drugs/therapeutic devices?

   YES ✓ NO _____

   If yes, list below any categories that the physician assistant **will not** be permitted to prescribe/dispense.

   If yes, will Schedule II, III, IV and/or V controlled substances be prescribed and dispensed?

   YES ✓ NO _____

NOTE: The Regulations of the State Board of Osteopathic Medicine do not permit a physician assistant to prescribe or dispense drugs when practicing under the supervision of an osteopathic physician.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105

Telephone: (717) 787-2381
(717) 783-1400

Fax: (717) 787-7769
www.dos.state.pa.us

3/5

February 26, 2007

JOHN ROIZIN
[redacted]

RE: ERICA M HARTZELL, PA-C

Dear Doctor:

The Board is in receipt of your physician assistant supervisor application. The following is required so your application can be re-evaluated.

Submit a job description listing the specific duties, treatments and procedures that will be performed by the physician assistant. A physician assistant is permitted to perform only those duties, treatments and procedures specifically listed in the written agreement.

Please answer question two regarding the time, place and manner of supervision and direction you will provide the physician assistant.

EVALUATOR: TERRY

NOTE: PLEASE RETURN A COPY OF THIS LETTER WHEN SUBMITTING THE ABOVE INFORMATION. THE PHYSICIAN ASSISTANT MAY NOT BEGIN WORKING UNDER YOUR EMPLOY UNTIL YOUR SUPERVISOR APPLICATION HAS BEEN APPROVED.

PHYSICIAN ASSISTANT
DELINEATION OF CLINICAL RESPONSIBILITIES

Name of PA-C: Erica Michele Hartzell

Name of Supervising Physician: John Roizin, MD

Location: Allentown Women's Center, Allentown, PA

Role of the Physician Assistant:

The physician assistant shall, under the appropriate direction and supervision by a physician assistant supervisor, augment the physician's data gathering abilities in order to assist the physician in reaching decisions and instituting care plans for the physician's patients.

Duties to be performed include:

1. Screen patients to determine need for medical attention including performing urine pregnancy tests.
2. Review patient records to determine health status.
3. Take a patient history including gynecologic, obstetric and psycho- social history.
4. Perform a physical examination including head, eyes, ears, nose, and throat, heart, lung, and abdominal exam; musculoskeletal exam, neurological exam; a clinical breast exam; pelvic exam to include speculum examination of vagina and cervix, pap smear, cervical cultures, and wet mount of vaginal discharge; bimanual examination; rectal exam with stool testing for occult blood.
5. Record pertinent data.
6. Make decisions regarding data gathering and appropriate management and treatment of patients being seen for initial evaluation of a problem or the follow-up evaluation of a previously diagnosed and stabilized condition.
7. Prepare patient summaries.
8. Initiate requests for commonly performed initial laboratory studies including urinalysis, hematological studies, endocrine function, metabolic profiles, HIV, syphilis, hepatitis, and herpes testing.
9. Collect specimens for and carry out commonly performed blood, urine, and stool analysis and cultures.
10. Identify normal and abnormal findings on history, physical examination, and commonly performed laboratory studies
11. Initiate appropriate evaluation and emergency management for emergency situations including, but not limited to abnormal vaginal bleeding/vaginal hemorrhage.
12. Perform clinical procedures, such as:
    a. Venipuncture.
    b. Assesment of vital signs including temperature, height, weight, blood pressure, respiratory rate, and heart rate.

c. Obtain endocervical and ectocervical specimens for pap smear.
d. Evaluate vaginal discharge via wet mount preparation in order to evaluate vaginal infection such as candidiasis, bacterial vaginosis, and trichomoniasis.
e. Obtain cervical cultures in order to test for gonorrhea and Chlamydia.
f. Removal of vaginal foreign bodies such as retained tampons or condoms.
g. Carry out aseptic and isolation techniques.
h. Perform intradermal tests.
i. Perform administration of medications and immunizations except as specified in 18.158 (relating to prescribing and dispensing drugs)
j. Removal of superficial foreign bodies.
k. Perform CPR/ACLS

13. Provide counseling and instruction regarding common patient problems including prevention of pregnancy and sexually transmitted diseases, birth control methods, and their proper use, management of peri-menopausal and menopausal symptoms including hot flushes and irregular vaginal bleeding and vaginal dryness, HIV, diabetes, heart disease, cancer prevention, and screening.
14. Work with supervising physician for education in performing office procedures such as endometrial biopsy, paraguard IUD and Mirena insertions, and vulvar biopsy. Upon completion of education, perform these procedures in office.
15. Complete course in colposcopy and work with supervising physician for education in performing office colposcopy. Following education and proper certification perform colposcopy.
16. Prescribe medications as specified on page 4 of the "Application for registration as a physician assistant supervisor" under "Prescribing and dispensing drugs by a physician assistant.

Manner of supervision:

During office hours, supervising physican or substitute supervising physician will be available via telecommunications at all times to discuss the management and treatment plan for patients. At times supervising physician will be present in office to discuss patient care and treatment plans.

Manner of Record Review:

Charts will be reviewed by supervising physician or substitute supervising physician within 10 working days following patient visits.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105

Telephone: (717) 787-2381
(717) 783-1400

Fax: (717) 787-7769
www.dos.state.pa.us

March 9, 2007

JOHN ROIZIN
[redacted]

RE: ERICA M HARTZELL, PA-C

Dear Doctor:

The Board is in receipt of your physician assistant supervisor application. The following is required so your application can be re-evaluated.

The answer provided to question one indicates in item 16 that the physician assistant will 'prescribe medications as specified on page 4 of the 'Application for registration….' The Application for Registration as a Physician Assistant Supervisor is the old application that is no longer accepted. You submitted the new Application for Registration as a Supervising Physician and it does not have a page four. Please update your written agreement to correlate with the new application that was submitted.

EVALUATOR: TERRY

NOTE: PLEASE RETURN A COPY OF THIS LETTER WHEN SUBMITTING THE ABOVE INFORMATION. THE PHYSICIAN ASSISTANT MAY NOT BEGIN WORKING UNDER YOUR EMPLOY UNTIL YOUR SUPERVISOR APPLICATION HAS BEEN APPROVED.

Allentown
Women's
Center

March 16, 2007

Dear Terry,

I received your letter dated March 9, 2007 regarding Erica M Hartzel, PA-C (enclosed). I have revised the written agreement with the changes made as requested. Please contact me at [redacted] if you have any additional questions.

Sincerely,

[redacted]

John D. Kolzin, MD

OK

c. Obtain endocervical and ectocervical specimens for pap smear.
d. Evaluate vaginal discharge via wet mount preparation in order to evaluate vaginal infection such as candidiasis, bacterial vaginosis, and trichomoniasis.
e. Obtain cervical cultures in order to test for gonorrhea and Chlamydia.
f. Removal of vaginal foreign bodies such as retained tampons or condoms.
g. Carry out aseptic and isolation techniques.
h. Perform intradermal tests.
i. Perform administration of medications and immunizations except as specified in 18.158 (relating to prescribing and dispensing drugs)
j. Removal of superficial foreign bodies.
k. Perform CPR/ACLS

13. Provide counseling and instruction regarding common patient problems including prevention of pregnancy and sexually transmitted diseases, birth control methods, and their proper use, management of peri-menopausal and menopausal symptoms including hot flushes and irregular vaginal bleeding and vaginal dryness, HIV, diabetes, heart disease, cancer prevention, and screening.
14. Work with supervising physician for education in performing office procedures such as endometrial biopsy, paraguard IUD and Mirena insertions, and vulvar biopsy. Upon completion of education, perform these procedures in office.
15. Complete course in colposcopy and work with supervising physician for education in performing office colposcopy. Following education and proper certification perform colposcopy.
16. Prescribe medications as specified on page 3 of the "Application for registration as a supervising physician."

Manner of supervision:

During office hours, supervising physican or substitute supervising physician will be available via telecommunications at all times to discuss the management and treatment plan for patients. At times supervising physician will be present in office to discuss patient care and treatment plans.

Manner of Record Review:

Charts will be reviewed by supervising physician or substitute supervising physician within 10 working days following patient visits.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105

Telephone: (717) 787-2381
(717) 783-1400

Fax: (717) 787-7769
www.dos.state.pa.us

March 9, 2007

JOHN ROIZIN
[redacted]

RE: ERICA M HARTZELL, PA-C

Dear Doctor:

The Board is in receipt of your physician assistant supervisor application. The following is required so your application can be re-evaluated.

The answer provided to question one indicates in item 16 that the physician assistant will 'prescribe medications as specified on page 4 of the 'Application for registration….' The Application for Registration as a Physician Assistant Supervisor is the old application that is no longer accepted. You submitted the new Application for Registration as a Supervising Physician and it does not have a page four. Please update your written agreement to correlate with the new application that was submitted.

EVALUATOR: TERRY

NOTE: PLEASE RETURN A COPY OF THIS LETTER WHEN SUBMITTING THE ABOVE INFORMATION. THE PHYSICIAN ASSISTANT MAY NOT BEGIN WORKING UNDER YOUR EMPLOY UNTIL YOUR SUPERVISOR APPLICATION HAS BEEN APPROVED.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105

Telephone: (717) 787-2381
(717) 783-1400

Fax: (717) 787-7769
www.dos.state.pa.us

February 26, 2007

JOHN ROIZIN
[redacted]

RE: ERICA M HARTZELL, PA-C

Dear Doctor:

The Board is in receipt of your physician assistant supervisor application. The following is required so your application can be re-evaluated.

Submit a job description listing the specific duties, treatments and procedures that will be performed by the physician assistant. A physician assistant is permitted to perform only those duties, treatments and procedures specifically listed in the written agreement.

Please answer question two regarding the time, place and manner of supervision and direction you will provide the physician assistant.

EVALUATOR: TERRY

NOTE: PLEASE RETURN A COPY OF THIS LETTER WHEN SUBMITTING THE ABOVE INFORMATION. THE PHYSICIAN ASSISTANT MAY NOT BEGIN WORKING UNDER YOUR EMPLOY UNTIL YOUR SUPERVISOR APPLICATION HAS BEEN APPROVED.

*NLA - no longer Accessable

PHYSICIAN ASSISTANT Hartzell Erica

WA in AS400 - access NLA
WA in L2K Patrina Hess

PRIMARY PHYSICIAN Roizin John

WA in AS400 - access NLW
WA in L2K 0

SUBSTITUTE PHYSICIAN 1

	APPROVED	PENDING
FEE	Ok	35 —
APPLICATION	Ok	
WRITTEN AGREEMENT	Legal	~~Q1 & 2~~ Q: refer to page 4 of appl which no longer exist. w/new appl sent
DRUG LIST	no exclusions	

Prescription (Y) N
Hosp. Tel Y (N)
(Y) OR N SCHED 2, 3, 4, 6/OR 5

APPROVAL LTR ISSUED 3-21-07

License # MX006118

Medicine- Medical Physician and Surgeon- Application

AA0000876129

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649

APPLICANT INFORMATION

PERSONAL INFORMATION

Last Name	ROIZIN			**First Name**	JOHN		
Middle Name	DENNIS			**Suffix**			
Full Name	JOHN DENNIS ROIZIN						
SSN	[redacted]	**Date Of Birth**	[redacted]	**Age**	[redacted]	**Gender**	MALE

ADDRESS DETAILS

Street Address	[redacted]		
City/State/Zip	EASTON PA 18042		
County	Northampton	**Country**	United States

CONTACT DETAILS

Phone number	[redacted]	**Mobile Phone number**	
Primary Email Address	[redacted]	**Secondary Email Address**	[redacted]

CHECKLIST ITEMS

Checklist name	Status	Submitted Date	Expiration Date
Application	Pending Review	10/10/2018	
Application Fee	Completed	10/10/2018	
Child Abuse CE	Not Received	10/10/2018	

LEGAL QUESTIONS

	Questions	Answer	Document Uploaded	File Name
1	Are you submitting a name change with this renewal?	N	No	
2	First Name		No	
3	Middle Name		No	
4	Last Name		No	
5	You must submit a copy of a legal document verifying the name (s). The following are acceptable name change verification documents: (1) Marriage Certificate: (2) Divorce decree which indicates the retaking of your maiden name: (3) Other "legal" document indicating the retaking of a maiden name: (4) For a "legal" name change, a copy of the court document must be provided.		No	
6	With the exception of the one you are currently renewing, do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y	No	

7	Please provide the profession and state or jurisdiction.	Physician-North Carolina	No	
8	Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N	No	
9	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
10	Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
11	Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N	No	
12	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N	No	
13	Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N	No	
14	Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N	No	
15	Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N	No	
16	Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N	No	
17	Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]		
18	Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N	No	
19	Have you previously reported the complaint to the Board?		No	
20	Provide the docket number:		No	
21	Upload a copy of the entire Civil Complaint, which must include the filing date and the date you were served.		No	
22	Have you completed at least 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids?	Y	No	
23	Do you hold a DEA number or use the registration number of another person or entity to prescribe controlled substances?		No	
24	Have you registered with the Pennsylvania Prescription Drug Monitoring Program?	Y	No	

25	I will be retiring from practice but desire to place my license on active-retired status which will allow me to treat immediate family members. I am exempt from the CME requirements, except for completion of the 2 hours of Board-approved continuing education in child abuse recognition and reporting and 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids. Renewal must be completed and fee required.	N	No	
26	Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y	No	
27	Upload an explanation or reason for an exemption request.		No	
28	Have you met your continuing education requirements? Please review the continuing education requirements posted on the Board's website at www.dos.pa.gov/med. Click on General Board Information. If you qualify for an exemption of the continuing education requirements, answer yes to the question. You are required to retain your official continuing education certificates of completion earned for this license renewal period until December 31, 2020.	Y	No	

Licenses/Certificates/Permits/Registrations in Any State/Jurisdiction

Profession	State/Jurisdiction
Physician	North Carolina

CONFIRMATION

☑ All fees are non-refundable. Please check to continue with your transaction. (10/10/2018 14:45:17)

Medicine- Medical Physician and Surgeon-Application
Renewal (MD061164L)
AA0002623949

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649

APPLICANT INFORMATION

PERSONAL INFORMATION

Last Name	ROIZIN			**First Name**	JOHN		
Middle Name	DENNIS			**Suffix**			
Full Name	JOHN DENNIS ROIZIN						
SSN	[redacted]	**Date Of Birth**	[redacted]	**Age**	[redacted]	**Gender**	MALE

ADDRESS DETAILS

Street Address	[redacted]		
City/State/Zip	EASTON PA 18042		
County	Northampton	**Country**	United States

CONTACT DETAILS

Phone number	[redacted]	**Mobile Phone number**	[redacted]
Primary Email Address		**Secondary Email Address**	

CHECKLIST ITEMS

Checklist name	Status	Submitted Date	Expiration Date
Application	Pending Review	10/22/2020	
Application Fee	Completed	10/22/2020	
Child Abuse CE	Not Received	10/22/2020	

LEGAL QUESTIONS

	Questions	Answer	Document Uploaded	File Name
1	Are you submitting a name change with this renewal?	N	No	
2	First Name		No	
3	Middle Name		No	
4	Last Name		No	
5	You must submit a copy of a legal document verifying the name (s). The following are acceptable name change verification documents: (1) Marriage Certificate: (2) Divorce decree which indicates the retaking of your maiden name: (3) Other "legal" document indicating the retaking of a maiden name: (4) For a "legal" name change, a copy of the court document must be provided.		No	
6	With the exception of the one you are currently renewing, do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y	No	

7	Please provide the profession and state or jurisdiction.	Medicine-North Carolina	No	
8	Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N	No	
9	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
10	Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
11	Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N	No	
12	Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N	No	
13	Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N	No	
14	Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N	No	
15	Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]		
16	Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N	No	
17	Have you previously reported the complaint to the Board?		No	
18	Provide the state:		No	
19	Provide the county:		No	
20	Provide the docket number:		No	
21	Upload a copy of the entire Civil Complaint, which must include the filing date and the date you were served.		No	
22	Have you completed at least 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids?	Y	No	
23	Do you hold a DEA number or use the registration number of another person or entity to prescribe controlled substances?		No	
24	Have you registered with the Pennsylvania Prescription Drug Monitoring Program?	Y	No	
25	I will be retiring from practice but desire to place my license on active-retired status which will allow me to treat immediate family members. I am exempt from the CME requirements, except for completion of the 2 hours of Board-approved continuing education in child abuse recognition and reporting and 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids. Renewal must be completed and fee required.	N	No	

26	Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y	No	
27	Upload an explanation or reason for an exemption request.		No	
28	Have you met your continuing education requirements? Please review the continuing education requirements posted on the Board's website at www.dos.pa.gov/med. Click on General Board Information. If you qualify for an exemption of the continuing education requirements, answer yes to the question. You are required to retain your official continuing education certificates of completion earned for this license renewal period until the end of the next renewal period.	Y	No	

Licenses/Certificates/Permits/Registrations in Any State/Jurisdiction

Profession	State/Jurisdiction
Medicine	North Carolina

PA VETERANS REGISTRY

	Questions	Answer
1	Have you served in the U.S. Armed Forces?	N
2	Thank you for your service. Would you like to register with the PA Veterans Registry? The PA Veterans Registry provides veterans with information about federal, state and local benefits, programs and services that are available to Pennsylvania veterans and links veterans with resources that can provide assistance. Registration is quick and easy, and provides the Department of Military and Veterans Affairs (DMVA) with a way to contact you regarding the benefits and services you may be eligible for. If you check "Yes," you will receive an email with instructions to assist you in registering.	

CONFIRMATION

☑	Any fees paid are non refundable. (10/22/2020 12:58:37)

Medicine- Medical Physician and Surgeon-Application
Renewal (MD061164L)
AA0004199467

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649

APPLICANT INFORMATION

PERSONAL INFORMATION

Last Name	ROIZIN	**First Name**	JOHN
Middle Name	DENNIS	**Suffix**	
Full Name	JOHN DENNIS ROIZIN		
SSN	[redacted]	**Date Of Birth**	[redacted]
Age	[redacted]	**Gender**	MALE

ADDRESS DETAILS

Street Address	[redacted]		
City/State/Zip	EASTON PA 18042		
County	Northampton	**Country**	United States

CONTACT DETAILS

Phone number	[redacted]	**Mobile Phone number**	[redacted]
Primary Email Address		**Secondary Email Address**	

CHECKLIST ITEMS

Checklist name	Status	Submitted Date	Expiration Date
Application	Pending Review	11/01/2022	
Application Fee	Completed	11/01/2022	
Child Abuse CE	Not Received	11/01/2022	

LEGAL QUESTIONS

	Questions	Answer	Document Uploaded	File Name
1	Are you submitting a name change with this renewal?	N	No	
2	First Name		No	
3	Middle Name		No	
4	Last Name		No	
5	You must submit a copy of a legal document verifying the name (s). The following are acceptable name change verification documents: (1) A birth certificate. (2) A marriage certificate (not a marriage license). (3) Divorce decree. (4) An official name change document issued by a court. (5) A passport. (6) A social security card. (7) A Pennsylvania driver's license or non-driver ID card. (8) A driver's license or official non-driver ID card issued by another state that complies with the federal REAL ID Act requirements (signified with a star on the front)		No	

6	With the exception of the one you are currently renewing, do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y	No	
7	Please provide the profession and state or jurisdiction.	Physician-North Carolina	No	
8	Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N	No	
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Licenses/Certificates/Permits/Registrations in Any State/Jurisdiction

Profession	State/Jurisdiction
Physician	North Carolina

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	Questions	Answer
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ACKNOWLEDGEMENT OF DUTY TO SELF-REPORT DISCIPLINARY CONDUCT AND CERTAIN CRIMINAL ACTIVITY

☑ **I hereby acknowledge that in addition to any existing reporting requirement required by a specific board or commission, I am REQUIRED pursuant to Act 6 of 2018 to NOTIFY the Bureau of Professional and Occupational Affairs WITHIN 30 DAYS of the occurrence of any of the following:**
(1) A disciplinary action taken against me by a licensing board or agency in another jurisdiction;
(2) A finding or verdict of guilt, an admission of guilt, a plea of nolo contendere, probation without verdict, a disposition in lieu of trial or an Accelerated Rehabilitative Disposition (ARD) of any felony or misdemeanor offense in a criminal proceeding. **I further acknowledge that failure to comply with these mandatory reporting requirements may subject me to disciplinary action by the Board.** I acknowledge my understanding that to self-report a disciplinary action or criminal matter as set forth above, I may log in to the Pennsylvania Licensing System (PALS) at www.pals.pa.gov and select "Mandatory Reporting by Licensee" under the heading "Your Licenses."

(11/01/2022 11:11:27)

CONFIRMATION

☑ Any fees paid are non refundable. (11/01/2022 11:11:27)