Medical Doctor Application for Licensure

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

Do Not Write in this Space
For Revenue Receipting Only

ME 30027

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

☐ Examination (1024) ☒ Endorsement (1021)

Select the appropriate fee based on residency/fellowship status:

Not in a residency/fellowship $705.00 + NICA fee

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

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

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

In a residency/fellowship $555.00 (NICA Exempt)

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

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

Total fee includes the following:

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

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

1. PERSONAL INFORMATION

Name: Felix (Last/Surname) Cherise (First) M. (Middle) **Date of Birth:** 09/28/1971 (MM/DD/YYYY)

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

1514 Red Oak Drive (Street/P.O. Box) — (Apt. No.) — Brentwood (City)

Tennessee (State) — 37027 (ZIP) — United States (Country) — 423 534 5817 (Home/Cell Telephone (Input without dashes))

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

7909 Concord Hills Drive (Street) (Place of Employment) — Suite 201 (Suite No.) — Brentwood (City)

Tennessee (State) — 37027 (ZIP) — United States (Country) — (Work/Cell Telephone (Input without dashes))

EQUAL OPPORTUNITY DATA:

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

Gender: ☐ Male ☒ Female

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

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

☒ Yes ☐ No Email Address: cherisefelix@gmail.com

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

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

2. **SOCIAL SECURITY DISCLOSURE** Cherise M. Felix

This information is exempt from public records disclosure.

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

Last Name: Felix

First Name: Cherise

Middle Name: M.

Social Security Number: [redacted]
(Input without dashes)

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

Name: Cherise M. Felix

3. APPLICANT BACKGROUND

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

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

B. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.
Cherise Allen

C. List the year you legally began to practice medicine *(may be the date you began your postgraduate training)*.
Year: 2004
YYYY

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

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

License Type	License #	State/Jurisdiction or Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License
MD	31061	Alabama	06/22/2011	12/31/2011	Inactive
MD	41688	Tennessee	12/07/2006	09/30/2023	Active

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

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

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

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

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

If "Yes," provide the following:

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

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

4. DISASTER

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

Name: Cherise M. Felix

5. EDUCATION / TRAINING HISTORY

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

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

School Name	School Address	Dates of Attendance: From-To (MM/DD/YYYY)	Date Degree Received (MM/DD/YYYY)
East Tennessee State University - Quillen College of Medicine	178 Maple Avenue Mountain Home, Tennessee 37684 United States	08/01/1999 to 05/30/2004	05/30/2004
		to	
		to	
		to	

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

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

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

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

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

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

Program Name/Address	Specialty Area	Dates of Attendance: From-To (MM/DD/YYYY)	Credit Received?
University of Tennessee / 1100 East Third Street Chattanooga, Tennessee 37403 United States	Family Medicine	07/01/2004 to 12/31/2004	☒ Y ☐ N
University of Tennessee / 979 East Third Street Chattanooga, Tennessee 37403 United States	Obstetrics and gynecology	01/01/2005 to 12/15/2008	☒ Y ☐ N
		to	☐ Y ☐ N

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

E. Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? ☐ Yes ☒ No

If you responded "Yes," complete the following:

Board Name	Certification/Specialty/Subspecialty	Date of Certification (MM/YYYY)

Name: Cherise M. Felix

6. FIFTH PATHWAY CERTIFICATE HOLDERS ONLY **N/A to all of the following.**

Answer the questions in this section only if you hold a Fifth Pathway Certificate.

A. Did you attend an international medical school and do not possess a valid ECFMG Certificate? ☐ Yes ☐ No

B. Did you receive a bachelor's degree from an accredited United States college or University? ☐ Yes ☐ No

C. Did you study at a medical school which is recognized by the World Health Organization? ☐ Yes ☐ No

D. Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National Board of Medical Examiners or the Educational Commission for Foreign Medical Graduates Examination equivalent? ☐ Yes ☐ No

E. Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent? ☐ Yes ☐ No

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

All Fifth Pathway Certificate holders must submit the following:

☐ Verification of your Fifth Pathway program

☐ Verification of NBME I & II examination, USMLE or ECFMG examination equivalent score reports

7. EXAMINATION HISTORY

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

☐ State Board (prior to 1974)

☐ State Board (after 1974) and SPEX

☐ LMCC and SPEX

☒ National Examination (NBME, FLEX, or USMLE III)

☐ Combination (prior to 2000)- View https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64B8-5 for more information.

Exam Taken	Exam Date (MM/DD/YYYY)
USMLE Step 3	06/29/2006

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

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

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

Name: Cherise M. Felix

8. EMPLOYMENT HISTORY

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

Name of Employer	Employer Address	Position Title	Employment Dates: From-To (MM/DD/YYYY)
Providence Obstetrics and Gynecology	7909 Concord Hills Drive, Ste 201 Brentwood, Tennessee 37027 United States	OB/GYN and Physician Owner	05/01/2012 to Present
Choices, Memphis Center for Reproductive Health	1203 Poplar Avenue Memphis, Tennessee 38104 United States	OB/GYN	03/01/2021 to Present
			to
			to

9. ACADEMIC FACULTY APPOINTMENTS / STAFF PRIVILEGES

A. Do you currently hold a faculty appointment at an accredited medical school? ☐ Yes ☒ No

B. Have you had the responsibility for graduate medical education within the last ten years? ☐ Yes ☒ No

If you responded "Yes," complete the following:

Name of Institution	City/State	Title of Appointment

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

If you responded "Yes," complete the following:

Name of Facility	City/State	Type of Privileges	From-To (MM/DD/YYYY)
			to
			to

D. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? ☐ Yes ☒ No

If you responded "Yes," complete the following:

Name of Facility	Address	From-To (MM/DD/YYYY)	Under Appeal?
		to	☐ Y ☐ N
		to	☐ Y ☐ N

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

☐ **A written self-explanation** on a separate sheet describing in detail the circumstances

☐ **Supporting documents** from the applicable entity

10. OTHER ITEMS REQUIRED

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

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

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

Name: Cherise M. Felix

This information is exempt from public records disclosure.

11. HEALTH HISTORY

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

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

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

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

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

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

☐ **A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

12. DISCIPLINE HISTORY

A. Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory, or country?
☐ Yes ☒ No

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

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

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of all pertinent information including **Administrative Complaint(s), Final Order(s), and current disposition**.

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

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

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ **A letter** from the state board/entity explaining the results of the investigation.

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

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

D. Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization? ☐ Yes ☒ No

E. Have you ever been denied, or surrendered a Drug Enforcement Agency (DEA) registration? ☐ Yes ☒ No

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

☐ **A written self-explanation** on a separate sheet describing in detail the circumstances

☐ **Supporting documents** from the applicable entity

Name: Cherise M. Felix

13. CRIMINAL HISTORY

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

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

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

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

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

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

14. CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS

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

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

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

a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No

c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes" provide supporting documentation)? ☐ Yes ☐ No

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

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

a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

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

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

a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☒ No

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

a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☒ No

a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

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

☐ **A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

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

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

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

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

Name: Cherise M. Felix

15. MALPRACTICE / LIABILITY CLAIM HISTORY

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

B. Within the last ten years have you had any liability claims or actions for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000? ☐ Yes ☒ No

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

☐ **A written self-explanation** listing your involvement in each case

☐ **Completed Exhibit 1 form** for each case (found following the application)

☐ **A copy of the complaint and disposition for each case**

☐ **For judgements when the incident(s) of malpractice occurred after November 2, 2004, the entire case record must be submitted in electronic format** (either PDF or TIFF), preferably on a DVD (do not send originals). The record must include:

- Initial and/or amended complaint
- Trial transcripts
- Evidentiary exhibits
- Final judgement

16. LIVESCAN PRIVACY STATEMENT

☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation (found in the forms following this application).

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

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

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

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

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

Name: Cherise M. Felix

17. APPLICANT SIGNATURE

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

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

I authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 45 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

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

Applicant Signature _____ Date 7/11/2022

You may print this application and sign it or sign digitally. MM/DD/YYYY

This form is required for ALL applicants.

Board *of* Medicine
Financial Responsibility

Name: Cherise M. Felix

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

FINANCIAL RESPONSIBILITY COVERAGE

☐ 1. I **do not** have hospital staff privileges, I **do not** perform surgery at an ambulatory surgical center, and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accord with ch. 675, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.

☐ 2. I **have** hospital staff privileges **or** I perform surgery at an ambulatory surgical center, and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with ch. 675, F.S., for a letter of credit and s. 625.52, F.S., for an escrow account.

☐ 3. I **do not** have hospital staff privileges, I **do not** perform surgery at an ambulatory surgical center, and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.

☐ 4. I **have** hospital staff privileges **or** I perform surgery at an ambulatory surgical center, and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F.S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self- insurance as provided in s. 627.357, F.S.

☐ 5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F.S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F.S.

☒ 6. I am exempt from financial responsibility coverage ***(If you choose this option you must choose one option from the exemption category on the following page.)***

Board *of* Medicine
Financial Responsibility

Name: Cherise M. Felix

EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILTY COVERAGE

☐ 1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

☐ 2. I hold a limited license issued pursuant to s. 458.317, F.S., and practice only under the scope of such limited license.

☐ 3. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents **do not** qualify for this exemption.)

☒ 4. I have no malpractice exposure, because I do not practice in the state of Florida. I will notify the department immediately before commencing practice in the state.

☐ 5. I am exempt from demonstrating financial responsibility due to meeting **all** the following criteria (If you select this option **you must also** complete the **"Financial Responsibility Affidavit of Exemption"** form that follows this page):

a. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
b. I am retired or maintain a part-time practice of no more than 1,000 patient contact hours per year.
c. I have no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period.
d. I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in ch. 458, F.S., or the medical practice act in any other state.
e. I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of ch. 458, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See s. 458.320(5)(f), F.S., for specific notice requirements.

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

Applicant Signature _____ Date 07/11/2022
MM/DD/YYYY

This form is required for ALL applicants.

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

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

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

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

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

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

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

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

Board *of* Medicine
P.O. Box 6330
Tallahassee, FL 32314-6330

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

Board *of* Medicine 4052 Bald Cypress Way Bin C-03 Tallahassee, FL 32399-3253	**AND**	NICA 2360 Christopher Place Tallahassee, FL 32308

Exemptions Include:

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

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

Applicant Name: Cherise M. Felix

Address: 1514 Red Oak Drive Brentwood, Tennessee 37027
Street and Number City State ZIP

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

Applicant Signature _____ Date 7/11/2020
MM/DD/YYYY

LIMITED POWER OF ATTORNEY

Physician Medical Licensing Service, Inc.
1331 East Lafayette Street, Suite D
Tallahassee, FL 32301
(850) 325-1400 fax (850) 877-6417

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

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

7/26/2022
DATE

SIGNATURE

The foregoing was acknowledged before me this 26th day of July, 2022

by Cherise Marie Felix, who is/is not personally known to me and did take an oath.

Notary Public

State of Tennessee

Commission Number

Commission Expiration 03-06-2024

JAMES F. MURPHY JR
STATE OF TENNESSEE
NOTARY PUBLIC
WILLIAMSON COUNTY
MY COMMISSION EXPIRES 3-6-2024

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EP14F July 2022

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Tallahassee, FL 32314-8330

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