



# APPLICATION FOR LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

State Form 29495 (R6 / 3-92)  
Approved by State Board of Accounts, 1992

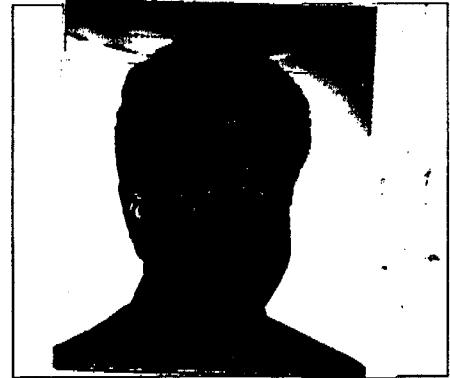
92005583

Health Professions Bureau  
402 W. Washington St., Rm. O41  
Indianapolis, Indiana 46204  
Telephone Number: (317) 232-2960

Application fee	250
Date fee paid (month, day, year)	5-27-92
Receipt number	118-280-01/03
Application number	
License number	01040632
License issuance date (month, day, year)	7-30-92

\* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

Permit fee	
Date fee paid (month, day, year)	
Receipt number	
Permit number	1139
Permit issuance date (month, day, year)	6-2-92



**DO NOT WRITE ABOVE THIS LINE**

APPLICANT INFORMATION			
Name (last, first, middle, maiden) CARHAET LeROY HARRISON		* Social Security number [REDACTED]	
Address (number and street or Rural Route) 105 East Mission Avenue		City Bellevue	State NE
Telephone number (daytime) 402, 292 - 2291		Birthdate (month, day, year) October 28, 1941	Birthplace Trenton, New Jersey
		State NE	ZIP code 68005

TEMPORARY PERMIT INFORMATION		
Do you desire a permit? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently possess an Indiana permit? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, enter your permit number here

EXAMINATION	
Check appropriate box indicating which examination you have taken.	
<input checked="" type="checkbox"/> FLEX EXAMINATION: Request that scores be sent directly to this office. Contact the Federation of State Medical Boards, 6000 Western Place, Suite 707, Fort Worth, TX 76107-4618. Telephone: (817) 735-8445.	<input type="checkbox"/> NATIONAL BOARD EXAMINATION: Request that your official scores be sent directly to this office. M. D. s contact the National Board of Medical Examiners Office, 3930 Chestnut Street, Philadelphia, PA 19104. Telephone: (215) 349-6400. D. O. s contact the National Board of Osteopathic Medical Examiners, 2700 River Road, Suite 407, Des Plaines, IL 60018. Telephone: (312) 635-9955.
<input type="checkbox"/> LMCC EXAMINATION: Request that your official scores be sent directly to this office. Contact the Medical Council of Canada, 1867 Alta Vista Drive, Case Postale, Box 8234, Ottawa, Canada K1G 3H7 Telephone: (613) 521-6012.	<input type="checkbox"/> STATE BOARD EXAMINATION: You must have the state board complete the "VERIFICATION OF STATE LICENSURE" form and attach the subjects, scores, date of examination and average. Examination taken in which state?

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY			
Name of School Hahnemann Med. Col & Hosp.	Check one: <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO	Location Philadelphia, PA	Date of Graduation (Month, Day, Year) Jun 3, 1973

HAVE YOU PREVIOUSLY TAKEN THE FLEX EXAMINATION?			
FLEX Component I <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, how many times? 1	Date of most recent test (month, year) Jun 1974	Where taken (state or country) Harrisburg, PA
FLEX Component II <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, how many times?	Date of most recent test (month, year)	Where taken (state or country)
Pre 1985 FLEX <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No See Above	If Yes, how many times? 1	Date of most recent test (month, year) Jun 1974	Where taken (state or country) Harrisburg, PA

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL FOR THE LAST 10 YEARS	
GENERAL LOCATION	DATE
Mt. Laurel, New Jersey	Aug 1969 to Sep 1978
Omaha, Nebraska	Sep 1978 to Present

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL FOR THE LAST 10 YEARS		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE
USAF Medical Corps 1978 to 1985	General Surgeon	Retired 1 Feb 85
Bellevue Health And Emergency Center	Medical Director	Feb 85 to Present

**APPLICATION AFFIRMATION**

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of Applicant: *LeRoy H. Carhart*  
 LeRoy H. Carhart, MD

Date: *May 29, 92*

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for medical licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

**AFFIRMATION**

I hereby swear or affirm that I have read the above statements and agree to same.

Date (Month, Day, Year): *May 26, 92*

Signature of Applicant: *LeRoy H. Carhart*  
 LeRoy H. Carhart, MD

**GENERAL NOTARY-State of Nebraska**  
**PAMELA S. HATT**  
 My Comm. Exp. Sept. 21, 1993

*Pamela S. Hatt*  
*5.26.92*

Include ALL internships, residencies and/or fellowships.

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA			
NAME OF SCHOOL	LOCATION	FROM (Mo. Yr.)	TO (Mo. Yr.)
Malcolm Grow USAF Hospital	Andrews AFB, MD	Jul 73	Jun 74
Hahnemann Medical College & Hospital	Philadelphia, PA	Jul 74	Jan 76
Atlantic City Medical Center an Affiliate Hospital of Hahnemann	Atlantic City, NJ	Jan 76	Jun 78

Do you hold, or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation?  Yes  No

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.

STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
PA	M.D. by FLEX	MD035665L	1974	Active
NJ	M.D. by Recip.	MA36541	1978	Active
OH	M.D. by Recip.	57427	1989	Active
NE	M.D. by Recip.	15162	1979	Active
IA	M.D. by Recip	57427	1982	Active

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

- Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?  Yes  No
- Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (including Indiana) or country?  Yes  No
- Are you now being, or have you ever been, treated for a drug abuse or alcohol problem?  Yes  No
- Have you ever been charged with drug addiction?  Yes  No
- Have you ever been convicted of, pled guilty or *nolo contendere* to:
  - A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?  Yes  No
  - To any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines)  Yes  No
- Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?  Yes  No
- Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?  Yes  No
- Have you ever had a malpractice judgment against you or settled any malpractice action?  Yes  No

PRE-MEDICAL / OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED
Rutgers The State University of NJ	New Brunswick, New Jersey	Sep 60 - Jun 64
Saint Mary's University	San Antonio, Texas	Sep 66 - Jan 67

MEDICAL / OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED
Hahnemann Medical College & Hospital,	Philadelphia, PA	Aug 69 - Jun 73

**THE MEDICAL COLLEGE OF THE STATE OF MISSISSIPPI**  
**et**  
**UNIVERSITY OF THE MEDICAL SCIENCES**  
**OMNIBUS HAS LITERAS PRESENTES VISURUS**  
**Scribitur**

*Quam studentium aliquor graduum institutio circa Philadelphiam Floridae Medicinae litterarum studiorum procuratoribus auctoritate de Republica bene meritis sitis, pro et congruo emulcerentur ad hoc sint.*  
*Resignatus laureator Collegii et. Auctorem: Philocommuni: Philadelphie auctoritate publica*

**Dr. Rog. Harrison Barhart**

*bona indole proclivium omnibus universis aliis officis pro hujus studentium legibus si impetrata sunt contentores et fideliter scriptis ad graduum*

**Medicinae Doctoris**

*et ad omnium reges omnia, pro honoris privilegia, ad hunc gradum pertinentia liberet omnibus*  
*Legibus et testimoniis hanc diplomati: omnia nostra hodie State Salus Quibus*  
*Chano: Summi: millesimo: congruatur: ad hunc gradum: hodie: Philadelphie: scriptis: et pro magister*  
*Philocommuni: hanc: laureator: ex auctoritate: Collegii: nostri: sigillum: affixi: present*

*Winton Stiles*

*Signum*



*Dr. R. O. Nelson, M.D.*

*Chano: Summi: millesimo: congruatur: ad hunc gradum: hodie: Philadelphie: scriptis: et pro magister*

THIS IS A TRUE COPY OF A ORIGINAL

**GENERAL NOTARY - State of Nebraska**  
**PAMELA S. HATT**  
 My Comm. Exp. Sept. 21, 1993

*Pamela S. Hatt*



**Hahnemann University**

July 28, 1992

Broad & Vine  
Philadelphia, PA  
19102 1192

Health Professions Bureau  
Indiana Government Center  
402 W. Washington Street  
Room 041  
Indianapolis, IN 46204

To Whom It May Concern:

This letter is to verify that Leroy H., J. Carhart, M.D.,  
matriculated into the Hahnemann Medical College of Philadelphia  
on September 8, 1969. He successfully completed four years of  
medical education and was granted the degree of Doctor of  
Medicine on June 7, 1969.

I trust that the above information will be helpful to you. If  
you have any further questions, please contact our office at  
(215) 762-7601.

Sincerely yours,

Frank Palmer  
Registrar

FP/cvs

cc: Student's File

# Atlantic City Medical Center

Atlantic City, New Jersey

This is to Certify that

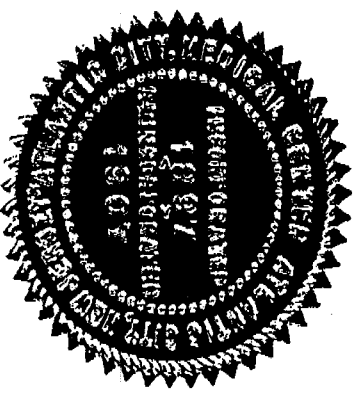
**Troy R. Garhart, M.D.**

has served in the Atlantic City Medical Center as

Third and Fourth Year and Chief Resident in General Surgery

January 31, 1976 to June 30, 1978

In Witness Whereof we attach our names and seal this  
thirtieth day of June, 1978.



*William J. ...*  
Director of Medical Education

*Richard ...*  
President, Board of Governors

*Donald ...*  
President, Medical Staff



TERRY E. BRANSTAD, GOVERNOR  
CHRISTOPHER G. ATCHISON  
DIRECTOR OF PUBLIC HEALTH

IOWA STATE BOARD  
OF MEDICAL EXAMINERS  
THIS IS TO CERTIFY THAT

LICENSE NO. 23312 EXPIRING 10/01/93

CARHART, LEROY HARRISON MD  
105 E MISSION AVE  
BELLVUE NE 68005

HAS RENEWED IN THE STATE OF IOWA  
A LICENSE TO PRACTICE  
MEDICINE AND SURGERY

THIS IS A TRUE COPY OF A ORIGINAL

*Pamela S. Matt*

GENERAL NOTARY-State of Nebraska  
PAMELA S. MATT  
My Comm. Exp. Sept. 21, 1993

Malcolm  
Grow USAF Medical Center  
LeRoy H. Carhart, M.D.

This is to certify that

has satisfactorily completed the 1st Year

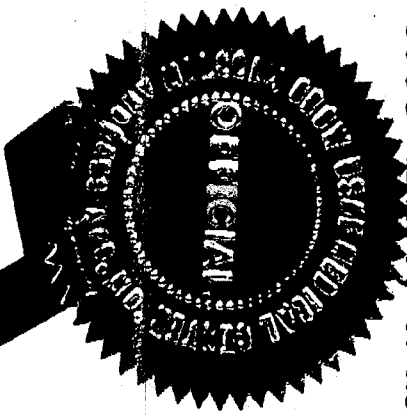
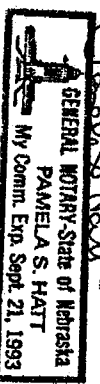
POSTGRADUATE MEDICAL TRAINING, from 1 July 1973 to 30 June 1974

at the Malcolm Grow USAF Medical Center,  
Andrews Air Force Base, Washington, D. C.

*Robert M. J. ... M.D.*  
Director of Professional Education

*Robert ...*  
Surgeon General USAF

THIS IS A TRUE COPY OF A ORIGINAL



*J. Vandenberg*  
Medical Center Commander

Date of Presentation  
21 June 1974



# State of Iowa



## State Board of Medical Examiners

Hereby Authorizes And Licenses

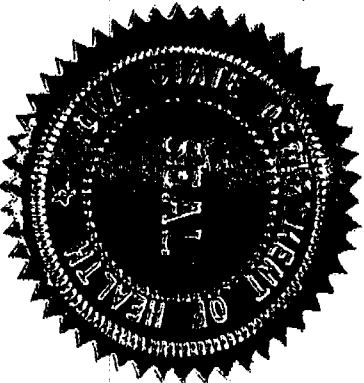
LEROY HARRISON CARRHART, M.D.

*to practice Medicine and Surgery in the State of Iowa under and pursuant to the provisions of Chapter one hundred forty seven, Iowa Statutes Annotated and acts amendatory thereof and supplemental thereto.*

*Given under the hands and seal of the Iowa Department of Health*

*this* 15th *day* of *October*, *A.D.* 19 *82*

*Ronald W. Wolf*  
Executive Director



*Alvin L. Swanson, M.D.*  
Chairman  
*Herbert L. Paulsen*  
Commissioner of Health

License No. 23312 Book 5 Page 1233  
THIS IS A TRUE COPY OF A ORIGINAL

GENERAL NOTARY STATE OF IOWA  
PAMELA S. WATT  
My Comm. Exp. Sept. 21, 1993

JUN 30 1992

HEALTH PROFESSIONS  
BUREAU

STATE MEDICAL BOARD  
JUN 25 AM 10:58



VERIFICATION OF STATE LICENSURE  
State Form 7143 (R2 / 10-91)

• PRIVACY NOTICE •

This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1. Disclosure is mandatory, and this form will not be processed without it.

HEALTH PROFESSIONS BUREAU  
Indiana Government Center South  
402 W. Washington St., Rm 041  
Indianapolis, Indiana 46204  
Telephone: (317) 232-2960

INSTRUCTIONS: Type and complete the top section. Make copies to send to each state that you hold or have held a license. Have the state(s) send this directly to our office.

Name (Last, first, middle, maiden) CARHART, LeROY HARRISON		Health Profession License Held M.D.	Social Security Number *
Address (Number, street, or / rural route) 105 East Mission Avenue		City Bellevue,	State NE ZIP code 68005
License number 57427	Date of Issuance (month, day, year) 1989	Date of Birth (month, day, year) October 28, 1941	
I hereby authorize the State of _____ to furnish the Health Profession Bureau of Indiana with the information below.			
Signature <i>[Signature]</i>			

\* Required pursuant to IC 4-1-8-1

DO NOT WRITE BELOW THIS LINE

License number 57427	Date of Issuance (month, day, year) 9/23/88	Licensed by <i>and (2)leg PA</i> <input type="checkbox"/> Exam <input checked="" type="checkbox"/> Endorsement <input type="checkbox"/> Other
Type of Examination	Date of Administration (month, day, year)	Please Affix Board Seal
Attach subjects, scores, date of examination and average.		
License is current and in good standing <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	License is or has been invalid <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Any derogatory information? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If license has been encumbered in any way, please provide certified copies of all related documents.		
FORM COMPLETED BY:		
Name Debra L. Jones	Title Chief, P.M.E. Records & Renewal	
Signature <i>Debra L. Jones</i>	State Board <i>Ohio State Med Bd</i>	Date (month, day, year) 6/25/92

JUL 1 1992

HEALTH PROFESSIONS  
BUREAU



**VERIFICATION OF STATE LICENSURE**

State Form 7143 (R2 / 10-91)

**\* PRIVACY NOTICE \***

This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1. Disclosure is mandatory, and this form will not be processed without it.

HEALTH PROFESSIONS BUREAU  
Indiana Government Center South  
402 W. Washington St., Rm 041  
Indianapolis, Indiana 46204  
Telephone: (317) 232-2960

**INSTRUCTIONS:** Type and complete the top section. Make copies to send to each state that you hold or have held a license. Have the state(s) send this directly to our office.

Name (Last, first, middle, maiden) CARHART, LEROY HARRISON		Health Profession License Held M.D.		Social Security Number *	
Address (Number, street, or / rural route) 105 East Mission Avenue		City Bellevue,	State NE	ZIP code 68005	
License number 15162	Date of Issuance (month, day, year) 1979		Date of Birth (month, day, year) October 28, 1941		
I hereby authorize the State of _____ to furnish the Health Profession Bureau of Indiana with the information below.					
Signature					

\* Required pursuant to IC 4-1-8-1

**DO NOT WRITE BELOW THIS LINE**

License number 15162	Date of Issuance (month, day, year) 10-17-79	Licensed by <b>Recip. with PA</b> <input type="checkbox"/> Exam <input type="checkbox"/> Endorsement <input checked="" type="checkbox"/> Other	
Type of Examination	Date of Administration (month, day, year)	Please Affix Board Seal	
Attach subjects, scores, date of examination and average.			
License is current and in good standing <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	License is or has been invalid <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Any derogatory information? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If license has been encumbered in any way, please provide certified copies of all related documents.			
<b>FORM COMPLETED BY:</b>			
Name Katherine A. Brown	Title Executive Secretary		
Signature <i>Katherine A. Brown</i>	State Board of Examiners in Medicine and Surgery	Date (month, day, year) 6-25-92	



### VERIFICATION OF STATE LICENSURE

State Form 7143 (R2 / 10-91)

**\* PRIVACY NOTICE \***

This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1. Disclosure is mandatory, and this form will not be processed without it.

HEALTH PROFESSIONS BUREAU  
Indiana Government Center South  
402 W. Washington St., Rm 041  
Indianapolis, Indiana 46204  
Telephone: (317) 232-2960

**INSTRUCTIONS:** Type and complete the top section. Make copies to send to each state that you hold or have held a license. Have the state(s) send this directly to our office.

Name (Last, first, middle, maiden) CARPENTIER, THOMAS HARRISON		Health Profession License Held M.D.		Social Security Number * [REDACTED]	
Address (Number, street, or / rural route) 105 East Mission Avenue		City Bellevue,	State NE	ZIP code 68005	
License number 23312	Date of Issuance (month, day, year) 10/15/1982		Date of Birth (month, day, year) October 28, 1941		
I hereby authorize the State of _____ to furnish the Health Profession Bureau of Indiana with the information below.					
Signature <i>[Signature]</i>					

\* Required pursuant to IC 4-1-8-1

**DO NOT WRITE BELOW THIS LINE**

License number 83312	Date of Issuance (month, day, year) 10/15/82	Licensed by <input type="checkbox"/> Exam <input checked="" type="checkbox"/> Endorsement <input type="checkbox"/> Other	
Type of Examination NA	Date of Administration (month, day, year) NA	Please Affix Board Seal	
Attach subjects, scores, date of examination and average.			
License is current and in good standing <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	License is or has been invalid <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Any derogatory information? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If license has been encumbered in any way, please provide certified copies of all related documents.			
<b>FORM COMPLETED BY:</b>			
Name Rosemary Devine	Title ADM BFCR		
Signature Rosemary Devine	State Board IOWA	Date (month, day, year) 6/24/92	



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

LEROY HARRISON CARHART  
105 EAST MISSION AVE  
BELLEVUE NE 68005

JUNE 29, 1992

STATE BOARD OF MEDICINE

LEROY HARRISON CARHART

MEDICAL PHYSICIAN AND SURGEON

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON IS LICENSED IN THE COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF STATE, STATE BOARD OF MEDICINE.

THE RECORDS OF THE PENNSYLVANIA STATE BOARD OF MEDICINE SHOW NO DEROGATORY INFORMATION AGAINST THIS LICENSE.

ORIGINAL LICENSURE DATE: SEPTEMBER 27, 1974  
EXPIRATION DATE: DECEMBER 31, 1992  
LICENSE NUMBER: MD-035665-L

*George L. Shevlin*

George L. Shevlin  
Commissioner



### VERIFICATION OF STATE LICENSURE

State Form 7143 (R2 / 10-91)

**\* PRIVACY NOTICE \***

This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1. Disclosure is mandatory, and this form will not be processed without it.

HEALTH PROFESSIONS BUREAU  
Indiana Government Center South  
402 W. Washington St., Rm 041  
Indianapolis, Indiana 46204  
Telephone: (317) 232-2960

**INSTRUCTIONS:** Type and complete the top section. Make copies to send to each state that you hold or have held a license. Have the state(s) send this directly to our office.

Name (Last, first, middle, maiden) CARHART, LeROY HARRISON		Health Profession License Held M.D.		Social Security Number * [REDACTED]	
Address (Number, street, or / rural route) 105 East Mission Avenue		City Bellevue,	State NE	ZIP code 68005	
License number MA36541		Date of Issuance (month, day, year) 1978		Date of Birth (month, day, year) October 28, 1941	
I hereby authorize the State of _____ to furnish the Health Professions Bureau of Indiana with the information below.					
Signature <i>[Signature]</i>					

\* Required pursuant to IC 4-1-8-1

**DO NOT WRITE BELOW THIS LINE**

License number MA36541		Date of Issuance (month, day, year) 8/8/79		Licensed by <input type="checkbox"/> Exam <input checked="" type="checkbox"/> Endorsement <input type="checkbox"/> Other	
Type of Examination FLEX ENDORSEMENT		Date of Administration (month, day, year) N/A		Please Affix Board Seal	
Attach subjects, scores, date of examination and average.					
License is current and in good standing <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		License is or has been invalid <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Any derogatory information? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If license has been encumbered in any way, please provide certified copies of all related documents.					
<b>FORM COMPLETED BY:</b>					
Name CHARLES A JANOUSEK		Title EXECUTIVE DIRECTOR			
Signature <i>[Signature]</i>		State Board OF MEDICAL EXAMINERS OF N.J.		Date (month, day, year) 6/25/92	

batch 3608

0104063200106309390005000506309540010000805



**RENEWAL OF PRACTITIONER'S LICENSE**

State Form 9962 (RS/2-89) Fiscal Contentant SEA Approved - 1983

**INSTRUCTIONS:** Complete the reverse side, sign and return with check or money order made payable to the:

**HEALTH PROFESSIONS BUREAU**

(317) 232-2960

*Handwritten signature: H. J. Harrison*

**CARHART, LEROY HARRISON  
105 EAST MISSION AVENUE  
BELLEVUE**

**NE 68005**

Type of renewal <b>PHYSICIAN</b>	
* Those with multiple CSR's MUST list ALL practice locations on a separate paper.	
* Practice location	
Number <b>01040632</b>	Phone number ( )
From <b>06/30/93</b>	To <b>06/30/95</b>
Renewal fee <b>\$ 50.00</b>	
Sex M/F <b>M</b>	Date of Birth (Mo., Day, Yr.) <b>10/28/41</b>
SOCIAL SECURITY # (Required IC 4-1-8-1) <b>[REDACTED]</b>	

**BACK OF CARD TO BE COMPLETED AND SIGNED**

**NOTE** If your name has changed, submit a document reflecting name change or request a "CHANGE OF NAME AFFIDAVIT."

Enter address change here

Sheet \_\_\_\_\_ City \_\_\_\_\_ State, Zip Code \_\_\_\_\_