APPLICATION FOR LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

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

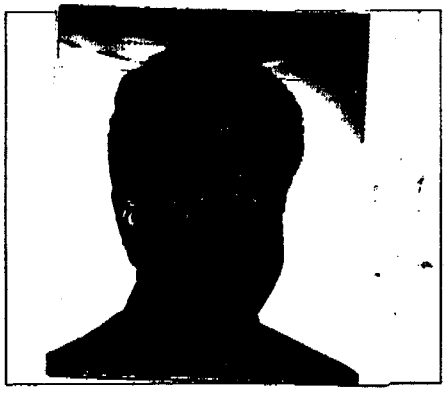
9200583

Health Professions Bureau
402 W. Washington St., Rm. 041
Indianapolis, Indiana 46204
Telephone Number: (317) 232-2960

*** 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.**

Application fee	250
Date fee paid *(month, day, year)*	5.27.92
Receipt number	118-280-01103
Application number	
License number	01040632
License issuance date *(month, day, year)*	7-30-92

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)*	* Social Security number
CARHARTT LeROY HARRISON	[redacted]

Address *(number and street or Rural Route)*	City	State	ZIP code
105 East Mission Avenue	Bellevue	NE	68005

Telephone number *(daytime)*	Birthdate *(month, day, year)*	Birthplace
(402) 292 - 2291	October 28, 1941	Trenton, New Jersey

TEMPORARY PERMIT INFORMATION

Do you desire a permit?	Do you currently possess an Indiana permit?	If Yes, enter your permit number here
☒ Yes ☐ No	☐ Yes ☒ No	

EXAMINATION

Check appropriate box indicating which examination you have taken.

☒ 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.

☐ 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.

☐ 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 KIG 3H7 Telephone: (613) 521-6012.

☐ 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	Check one:	Location	Date of Graduation *(Month, Day, Year)*
Hahnemann Med. Col & Hosp.	☒ MD ☐ DO	Philadelphia, PA	Jun 3, 1973

HAVE YOU PREVIOUSLY TAKEN THE FLEX EXAMINATION?

	If Yes, how many times?	Date of most recent test *(month, year)*	Where taken *(state or country)*
FLEX Component I ~~☒ Yes ☐ No~~	1	~~Jun 1974~~	~~Harrisburg, PA~~ error JR
FLEX Component II ☐ Yes ☐ No	If Yes, how many times?	Date of most recent test *(month, year)*	Where taken *(state or country)*
Pre 1985 FLEX ☒ Yes ☐ No See Above	1	Jun 1974	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

[redacted]

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, MD — Date: May 24, 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)* — Signature of Applicant: LeRoy H. Carhart, MD — May 24 92

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 Hospitasl 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.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☒ No
2. 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
3. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem? ☐ Yes ☒ No
4. Have you ever been charged with drug addiction? ☐ Yes ☒ No
5. Have you ever been convicted of, pled guilty or *nolo contendre* to:
   A. 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
   B. To any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines)* ☐ Yes ☒ No
6. 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
7. 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
8. 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

Universitatum Medicinae Collegium
et
Nosocomium Philadelphiae

OMNIBUS HAS LITERAS PRÆSENTES VISURIS

Salutem

Cum Academiae ubique gentium institutae sint Philosophiae Scientiis Medicinae Litterisve Humanioribus excultos aut de Republica bene meritos titulo justo et congruente condecorare soliti sint:

Nos igitur Curatores Collegii et Nosocomii Hahnemannianae Philadelphiae auctoritate reipublicae Pennsylvaniensis nobis commissa

LeRoy Harrison Garhart

bene indole praeditum omnibus muneribus atque officiis quae hujus Academiae legibus ei impositi sunt constanter et fideliter expletis ad gradum

Medicinae Doctoris

rite admissimus eique omnia jura honores privilegia ad hunc gradum pertinentia libenter concessimus.

Cujus rei testimonio huic diplomati nomini nostro hoc die Ante Idus Junias

Anno Domini millesimo nongentesimo septuagesimo tertio Philadelphiae scripsimus et quo major sit fides auctoritasque Curatores consentientes Collegii nostri sigillum appensi jussimus

Wharton Sholes
Praeses

THE HAHNEMANN MEDICAL COLLEGE & HOSPITAL OF PHILADELPHIA — CHRISTUS IN OMNIBUS LIBERTAS IN OMNIBUS CARITAS

Joseph R. DiPalma, M.D.
Praesidis Vice Gerens Et Decani

C. Tate Ashcraft III
Secretarius Curatorium

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

Broad & Vine
Philadelphia, PA
19102 1192

July 28, 1992

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

Frank Palmer
Registrar

FP/cvs

cc: Student's File

Atlantic City Medical Center

Atlantic City, New Jersey

This is to Certify that

Leroy H. Carhart, 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.

ATLANTIC CITY MEDICAL CENTER
1927
1977

Director of Medical Education

Administrator

President, Board of Governors

President, Medical Staff

STATE OF IOWA

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 Hatt

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

Malcolm Grow USAF Medical Center

This is to certify that

LeRoy H. Carhart, M.D.

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.

Director of Professional Education

Surgeon General USAF

OFFICIAL

X. Vandenbos
Medical Center Commander

21 June 1974
Date of Presentation

THIS IS A TRUE COPY OF A ORIGINAL

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

State of Iowa

State Board of Medical Examiners

Hereby Authorizes And Licenses

LeROY HARRISON CARHART, 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 V. Sas
Executive Director

Alexander Lovanian, M.D.
Chairman

Norman L. Pawlewski
Commissioner of Health

GENERAL NOTARY-State of Nebraska
PAMELA S. HATT
My Comm. Exp. Sept. 21, 1983

License No. 23312 Book 5 Page 1233

THIS IS A TRUE COPY OF A ORIGINAL

JUN 30 1992

HEALTH PROFESSIONS
BUREAU

STATE MEDICAL BOARD OF OHIO
92 JUN 29 AM 8:33

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)*	Health Profession License Held	Social Security Number *
CARHART, LeROY HARRISON	M.D.	[redacted]

Address *(Number, street, or / rural route)*	City	State	ZIP code
105 East Mission Avenue	Bellevue,	NE	68005

License number	Date of Issuance *(month, day, year)*	Date of Birth *(month, day, year)*
57427	1989	October 28, 1941

I hereby authorize the State of _____ to furnish the Health Profession Bureau of Indiana with the information below.

Signature [signature]

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

DO NOT WRITE BELOW THIS LINE

License number	Date of Issuance *(month, day, year)*	Licensed by
57427	9/23/88	☐ Exam ☒ Endorsement ☐ 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	License is or has been invalid	Any derogatory information ?
☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No

If license has been encumbered in any way, please provide certified copies of all related documents.

FORM COMPLETED BY:

Name	Title
Debra L. Jones	Chief, C.M.E. Records & Renewal

Signature	State Board	Date *(month, day, year)*
Debra L. Jones	Ohio State Med Bd	6/25/92

JUL 1 1992

HEALTH PROFESSIONS BUREAU

VERIFICATION OF STATE LICENSURE

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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)*	Health Profession License Held	Social Security Number *
CARHART LEROY HARRISON	M.D.	[redacted]

Address *(Number, street, or rural route)*	City	State	ZIP code
105 East Mission Avenue	Bellevue,	NE	68005

License number	Date of Issuance *(month, day, year)*	Date of Birth *(month, day, year)*
15162	1979.	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	Date of Issuance *(month, day, year)*	Licensed by Recip. with PA
15162	10-17-79	☐ Exam ☐ Endorsement ☒ 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	License is or has been invalid	Any derogatory information ?
☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No

If license has been encumbered in any way, please provide certified copies of all related documents.

FORM COMPLETED BY:

Name	Title
Katherine A. Brown	Executive Secretary

Signature	State Board of	Date *(month, day, year)*
Katherine A. Brown	Examiners in Medicine and Surgery	6-25-92

VERIFICATION OF STATE LICENSURE

State Form 7143 (R2 / 10-91)

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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)	Health Profession License Held	Social Security Number *
CARHART, L[redacted] HARRISON	M.D.	[redacted]

Address (Number, street, or rural route)	City	State	ZIP code
105 East Mission Avenue	Bellevue,	NE	68005

License number	Date of Issuance (month, day, year)	Date of Birth (month, day, year)
23312	10/15/1982	October 28, 1941

I hereby authorize the State of [redacted] to furnish the Health Profession Bureau of Indiana with the information below.

Signature [redacted]

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

DO NOT WRITE BELOW THIS LINE

License number	Date of Issuance (month, day, year)	Licensed by
23312	10/15/82	☐ Exam ☒ Endorsement PA ☐ Other

Type of Examination	Date of Administration (month, day, year)	Please Affix Board Seal
NA	NA	

Attach subjects, scores, date of examination and average.

License is current and in good standing	License is or has been invalid	Any derogatory information ?
☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No

If license has been encumbered in any way, please provide certified copies of all related documents.

FORM COMPLETED BY:

Name	Title	
Rosemary Devine	ADN 3FCR	
Signature	**State Board**	**Date (month, day, year)**
Rosemary Devine	IOWA	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.

[redacted]

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

George L. Shevlin

George L. Shevlin
Commissioner

PREPARED BY CMIC

VERIFICATION OF STATE LICENSURE

State Form 7143 (R2 / 10-91)

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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)*	Health Profession License Held	Social Security Number *
CARHART, LeROY HARRISON	M.D.	[redacted]

Address *(Number, street, or / rural route)*	City	State	ZIP code
105 East Mission Avenue	Bellevue,	NE	68005

License number	Date of Issuance *(month, day, year)*	Date of Birth *(month, day, year)*
MA36541	4/92	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	Date of Issuance *(month, day, year)*	Licensed by
MA36541	8/8/79	☐ Exam ☒ Endorsement ☐ Other

Type of Examination	Date of Administration *(month, day, year)*	Please Affix Board Seal
FLEX ENDORSEMENT	N/A	

Attach subjects, scores, date of examination and average.

License is current and in good standing	License is or has been invalid	Any derogatory information ?
☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No

If license has been encumbered in any way, please provide certified copies of all related documents.

FORM COMPLETED BY:

Name	Title
CHARLES A JANOUSEK	EXECUTIVE DIRECTOR

Signature	State Board	Date *(month, day, year)*
Charles A Janousek	OF MEDICAL EXAMINERS OF N.J.	6/25/92

batch 3608

01040632001063093900050005063095400100008O5

RENEWAL OF PRACTITIONER'S LICENSE

State Form 9962 (R5/2-89) Fiscal Content SBA 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

Type of renewal: PHYSICIAN

* Those with multiple CSR's MUST list ALL practice locations on a separate paper.

* Practice location	Phone number
	( )

Number	From	To
01040632	06/30/93	06/30/95

A

Renewal fee: $ 50.00

Sex M/F	Date of Birth (Mo., Day, Yr.)	SOCIAL SECURITY # (Required IC 4-1-8-1)
M	10/28/41	[redacted]

CARHART, LEROY HARRISON
105 EAST MISSION AVENUE
BELLEVUE NE 68005

Enter address change here

Street City State, Zip Code

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."