7/31/92

KANSAS STATE BOARD OF HEALING ARTS
235 SW TOPEKA BLVD
TOPEKA KS 66603-3059
PHONE: 913-296-7413

APPLICATION FOR ENDORSEMENT

☒ MEDICINE AND SURGERY ☐ CHIROPRACTIC ☐ OSTEOPATHIC MEDICINE AND SURGERY

PRINT OR TYPE ANSWERS TO ALL QUESTIONS ON THIS FORM IN FULL

I. GENERAL INFORMATION

1. NAME: LeROY (FIRST) HARRISON (MIDDLE) (MAIDEN) CARHART, Jr (LAST)
2. NAME AS YOU WISH IT TO APPEAR ON YOUR LICENSE:
3. MAILING ADDRESS: 105 E. Mission Bellevue Ne 68005 PHONE 402-292-4164
4. CURRENT PLACE OF RESIDENCE: confidential Omaha Ne 68123 PHONE confidential
5. CURRENT PLACE OF PRACTICE: 105 E. Mission Bellevue Ne 68005 PHONE 402-292-4164
6. DATE OF BIRTH: confidential 1948 7. S.S. NO. confidential
8. PLACE OF BIRTH: Trenton (CITY) New Jersey (STATE) Mercer (COUNTRY)

9. AS A RESULT OF THIS APPLICATION DO YOU INTEND TO CHANGE THE LOCATION OF YOUR PRACTICE? ☐ YES ☐ NO
If yes, give location and date of intended establishment of practice:
Location UNKNOWN AT THIS TIME Date:

10. E.C.F.M.G. NUMBER IF APPLICABLE: NA

11. PRIMARY SPECIALTY: General Surgery ☐ AMERICAN BOARD CERTIFIED ☒ AMERICAN BOARD ELIGIBLE

12. SECONDARY SPECIALTY: ☐ AMERICAN BOARD CERTIFIED ☐ AMERICAN BOARD ELIGIBLE

13. HAVE YOU EVER BEEN LICENSED TO PRACTICE THE HEALING ARTS IN KANSAS? ☐ YES ☒ NO
IF YES, PLEASE EXPLAIN.

14. FOR EXPLANATION OR COMMENTS BY APPLICANT:

USE ADDITIONAL PAGES IF NECESSARY.

II. PROFESSIONAL ACTIVITIES

LIST IN CHRONOLOGICAL ORDER ALL PROFESSIONAL ACTIVITIES SINCE GRADUATION, INCLUDING INTERNSHIPS, HOSPITAL AFFILIATIONS AND ABSENCES FROM WORK. ALSO LIST ALL PERIODS OF NON-PROFESSIONAL ACTIVITY OR EMPLOYMENT FOR MORE THAN THREE MONTHS. PLEASE ACCOUNT FOR ALL TIME. IF ENGAGED IN PRIVATE PRACTICE, LIST HOSPITAL AFFILIATIONS. IF NONE, PLEASE EXPLAIN. USE ADDITIONAL PAGES IF NECESSARY.

FROM MO/YR	TO MO/YR	LOCATION AND COMPLETE ADDRESS	POSITION HELD
July/73	July/74	USAF Malcolm Grow Hospital Andrews AFB Maryland	Internship
July/74	JAN/76	Hahnemann Hospital + Medical College Broad + Vine Philadelphia Pa	Surgical Resident
JAN/76	JUN/78	Atlantic City Medical Center Atlantic City NJ	Surgical Resident
July/78	Sept/78	Vacation + Moving to Omaha Ne.	
Sept/78	Feb/85	Ehrling Bergquist U.S.A.F. Hospital Offutt A.F.B Nebraska	General Surgeon
Feb/85	Present	Bellevue Health + Emergency Clinic - 105 E Mission, Bellevue Ne 68005	Medical Director
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EXPLANATION:

III. EDUCATION

IF YOU HAVE RECEIVED TRANSFER CREDIT OR QUIZZED OUT OF CERTAIN COURSES IN ANY EDUCATIONAL INSTITUTION, PLEASE EXPLAIN. USE ADDITIONAL PAGES IF NECESSARY

EDUCATION	POST-GRADUATE TRAINING
HIGH SCHOOL: HAMILTON HIGH EAST - CITY: HAMILTON TWP STATE OR COUNTRY: N. J. MO/YR ENTERED: Sep 56 MO/YR GRADUATED: JUN / 60	POST GRADUATE: USAF - MALCOLM GROW HOSP CITY: ANDREWS AFB STATE OR COUNTRY: MD MO/YR ENTERED: JUL / 73 MO/YR GRADUATED: JUN / 74 SPECIALTY: Rotating Surgical Internship
PRE-PROFESSIONAL: Rutgers - CITY: New Brunswick STATE OR COUNTRY: New Jersey MO/YR ENTERED: Sep / 60 MO/YR ATTENDED: JUN / 64 TYPE DEGREE: BA	HOSPITAL: HAHNEMANN HOSPITAL + MED Col. CITY: PHILADELPHIA STATE OR COUNTRY: PA MO/YR ENTERED: July / 74 MO/YR GRADUATED: JAN / 76 SPECIALTY: General Surgery
PRE-PROFESSIONAL: SAINT Mary's University CITY: SAN ANTONIO STATE OR COUNTRY: Texas MO/YR ENTERED: Sep / MO/YR GRADUATED: JAN / TYPE DEGREE:	HOSPITAL: ATLANTIC CITY Medical Center CITY: Atlantic City STATE OR COUNTRY: N. J. MO/YR ENTERED: JAN / 76 MO/YR GRADUATED: JUN / 78 SPECIALTY: General Surgery
PROFESSIONAL SCHOOL: HAHNEMANN MED COLLEGE CITY: PHILADELPHIA STATE OR COUNTRY: PA. MO/YR ENTERED: Sep / 69 MO/YR GRADUATED: JUN / 73 TYPE DEGREE:	HOSPITAL: CITY: STATE OR COUNTRY: MO/YR ENTERED: / MO/YR GRADUATED: / SPECIALTY:
PROFESSIONAL SCHOOL: CITY: STATE OR COUNTRY: MO/YR ENTERED: / MO/YR GRADUATED: / TYPE DEGREE:	HOSPITAL: CITY: STATE OR COUNTRY: MO/YR ENTERED: / MO/YR GRADUATED: / SPECIALTY:
5TH PATHWAY IF APPLICABLE: CITY: STATE OR COUNTRY: MO/YR ENTERED: / MO/YR GRADUATED: / TYPE DEGREE:	HOSPITAL: CITY: STATE OR COUNTRY: MO/YR ENTERED: / MO/YR GRADUATED: / SPECIALTY:

EXPLANATION:

IV. PREVIOUS LICENSURE

LIST ALL STATES IN WHICH YOU HAVE BEEN LICENSED OR ARE CURRENTLY LICENSED. MAKE NO OMISSIONS CONCERNING PREVIOUS LICENSURE OR ANY DISCIPLINARY ACTION.

STATE/COUNTRY	LICENSE NO.	DATE	HOW OBTAINED (Exam., Recip., Nat'l Bd., FLEX)	DISCIPLINARY ACTIONS	CURRENT (Circle)
Pennsylvania	MD035665L	1974	Flex	None	(YES) NO
New Jersey	MA36541	1978	Recip.	None	(YES) NO
Nebraska	15162	1979	Recip.	None	(YES) NO
Iowa	23312	1982	Recip.	None	(YES) NO
Ohio	57427	1989	Recip.	None	(YES) NO
INDIANA	01040632	1992	Recip	None	(YES) NO

EXPLANATION OR COMMENTS: Wisconsin - Temporary in 1992 - None

V. PROFESSIONAL LIABILITY INSURANCE (MALPRACTICE)

If you are rendering professional services in Kansas, you are required by K.S.A. 40-3401-3419 to maintain professional liability insurance of not less than $200,000 per occurrence (per claim) subject to not less than $600,000 annual aggregate for all claims made during the policy period and to participate in the Kansas Health Care Stabilization Fund.

1. In what company do you carry professional Liability Insurance? ST. PAUL
2. Have any malpractice suits, claims or settlements been made against you? If so, how many and provide a letter from your attorney explaining each case. [X] YES ☐ NO
   See letter from Kennedy, Holland, Delacy & Svoboda

V. (a) ☐ I am in military service and will render no professional services in Kansas outside my military duties without complying with the insurance laws specified in Part V.

VI. DISCIPLINE

WE ROUTINELY RECEIVE INFORMATION FROM VARIOUS STATES, FEDERAL AND PRIVATE AGENCIES AND ASSOCIATIONS ABOUT ACTION TAKEN AGAINST LICENSEES OR PRACTITIONERS. ALL INFORMATION RECEIVED WILL BE CHECKED ACCORDINGLY TO VERIFY THE TRUTH AND VERACITY OF YOUR ANSWERS. IN OTHER WORDS, IF THE QUESTION IS IN ANY WAY APPLICABLE, ANSWER YES AND THEN EXPLAIN IN THE SPACE PROVIDED.

1. Have you ever been rejected for membership or notified by or requested to appear before any medical, osteopathic or chiropractic society?
   YES (NO) (Circle one)
2. Have you ever been denied the privilege of taking an examination administered by a licensing agency?
   YES (NO) (Circle one)
3. Have you ever been denied a license to practice the healing arts or other health care profession?
   YES NO (Circle one) Wisconsin License Application Still Pending
4. confidential
5.
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation, or other practice organization, either public or private?
   YES (NO) (Circle one)
7. Have you ever, for any reason, lost American Board certification?
   YES (NO) (Circle one)
8. Has any licensing or disciplinary agency limited, restricted, suspended or revoked a license you have held?
   YES (NO) (Circle one)
9. Have you ever voluntarily surrendered a license issued to you by a licensing or disciplinary agency?
   YES (NO) (Circle one)
10. Have you ever been notified or requested to appear before any licensing or disciplinary agency?
    (YES) NO (Circle one) See Notice of Dismissal
11. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?
    (YES) NO (Circle one) " " " "
12. confidential
13.
14.
15. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics controlled substances registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?
    YES (NO) (Circle one)
16. Have you ever surrendered your state or federal controlled substances registration or had it restricted in any way?
    YES (NO) (Circle one)
17. confidential
18. Have you ever been a defendant in a legal action involving professional liability (Malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself?
    (YES) NO (Circle one) See Letter from Kennedy Holland, DeLacy & Svoboda
19. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs?
    YES (NO) (Circle one)
20. Have you ever terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicare Programs?
    YES (NO) (Circle one)

BLANK SPACE IS PROVIDED FOR YOUR USE IN ANSWERING THE ABOVE QUESTIONS. IF MORE SPACE IS NEEDED, USE ADDITIONAL PAGE.

VII. STATEMENT OF HEALTH

confidential

VIII. CERTIFICATE OF STATE, NATIONAL BOARD OR FLEX

NATIONAL BOARD AND FLEX APPLICANTS ARE TO REQUEST A GRADE TRANSCRIPT TO BE SENT TO THE KANSAS BOARD IN LIEU OF THE CERTIFICATION.

I, ______________________, Secretary of the ______________________
Licensing Agency

hereby certify that Dr. ______________________ was granted License No. ______________

on the __________ day of ______________ 19____, by the ______________________

based upon diploma and written examination in the following subjects:

Subject	Percent	Subject	Percent

Results Requested from FLEX

General Average ________

I hereby certify that the above license is current and in good standing, has never been revoked, and that the photograph attached to this form is a true likeness of Dr. ______________________ and the person to whom this license was issued.

SEAL

____
Secretary

____
Name of Board

Dated at ______________________

this ________ day of ______________, 19____.

IX. CERTIFICATE OF POST GRADUATE MEDICAL EDUCATION—If applicable

This certifies that Dr. ______________________ has rendered satisfactory and continuous service as an intern or resident in the ______________________ hospital at ______________

from ______________ to ______________

Dated ______________

____
Superintendent of Hospital or Director of Medical Education

Certificate ATTACHED

____
Print or Type Name

SEAL

Address ______________________

State ______________________

Phone ______________________

X. CERTIFICATE OF PROFESSIONAL COLLEGE

PLEASE ENCLOSE TRANSCRIPT OF PROFESSIONAL SCHOOL AND NOTARIZED COPY OF SCHOOL DIPLOMA, TRANSLATED.

If the student took courses or clinical clerkships at a site, campus or hospital other than the main campus, please give location and affiliation of the institution where the course work was taken.

A certified statement from the Dean or Registrar of the Professional College attended by the applicant, giving the exact number of months attended in each year during the four year course, must follow here, over the seal of the College.

I hereby certify that Dr. ______________________ attended:

Sent to Hahnemann

1st Year ______________________ (Name and location of professional school) from ________ (Mo.) 19____ (Yr.) to ________ (Mo.) 19____ (Yr.)

2nd Year ______________________ (Name and location of professional school) from ________ (Mo.) 19____ (Yr.) to ________ (Mo.) 19____ (Yr.)

3rd Year ______________________ (Name and location of professional school) from ________ (Mo.) 19____ (Yr.) to ________ (Mo.) 19____ (Yr.)

4th Year ______________________ (Name and location of professional school) from ________ (Mo.) 19____ (Yr.) to ________ (Mo.) 19____ (Yr.)

and was granted ______________________ (Degree) on the ______________

day of ______________ 19____.

SCHOOL SEAL

______________________ Registrar

DATED ______________________

X. CERTIFICATE OF PROFESSIONAL COLLEGE

PLEASE ENCLOSE TRANSCRIPT OF PROFESSIONAL SCHOOL AND NOTARIZED COPY OF SCHOOL DIPLOMA, TRANSLAT

If the student took courses or clinical clerkships at a site, campus or hospital other than the main campus, please give location and affiliation of the institution where the course work was taken.

A certified statement from the Dean or Registrar of the Professional College attended by the applicant, giving the exact number of months attended in each year during the four year course, must follow here, over the seal of the College.

I hereby certify that Dr. LeRoy H. Carhart attended:

	Name and location of professional school	from (Mo / 19 Yr)	to (Mo / 19 Yr)
1st Year	Hahnemann University	9/8/69	5/29/70
2nd Year	Hahnemann University	6/1/70	12/5/70
3rd Year	Hahnemann University	6/7/71	3/11/72
4th Year	Hahnemann University	6/5/72	6/7/73

and was granted Doctor of Medicine (Degree) on the Seventh day of June 19 73

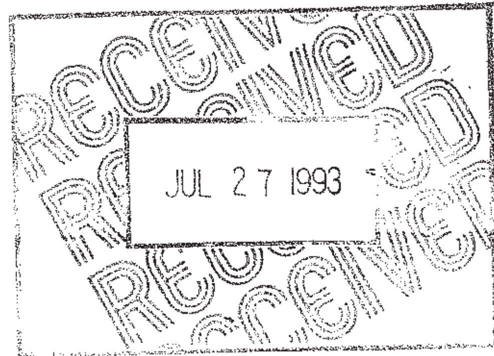
[signature]

President, Secretary, Dean or Registrar

Frank Palmer; Registrar

SCHOOL SEAL

DATED 8/02/93



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AUG 10 1993

KANSAS STATE BOARD OF HEALING ARTS

XI. RECOMMENDATIONS FROM TWO REPUTABLE PHYSICIANS

1. This is to certify that I have known Dr. LEROY H. CARHART of Bellview, Neb, whose photograph is hereto attached, for 5 years; that he/she is a capable physician and is not addicted to alcohol or narcotics.

   I further certify that to the best of my knowledge and belief Dr. LeRoy H. CARHART is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

   Signed [signature] MD

   GEORGE R. TILLER, MD
   Print or Type Name

   Address 5101 E. Kellogg
   State Wichita, KAN
   Phone 316 684 5255

2. This is to certify that I have known Dr. LeRoy H. Carhart of Bellevue, Neb - whose photograph is hereto attached, for 2 years; that he/she is a capable physician and is not addicted to alcohol or narcotics.

   I further certify that to the best of my knowledge and belief Dr. Carhart is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

   Signed [signature]

   NORMAN R HARRIS MD
   Print or Type Name

   Address 5101 E. Kellogg
   State Wichita, Kansas
   Phone 316 - 684 - 5285

XII. AFFIDAVIT

I, LeRoy Harrison Carhart, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine and surgery, osteopathic medicine and surgery or chiropractic in the state of Kansas and may subject me to a fine not exceeding $10,000 and term of imprisonment not exceeding 5 years for each violation. (K.S.A. 21-3805)

[signature]
Signature of Applicant

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XIII. RELEASE

STATE OF Nebraska
COUNTY OF Sarpy
THE APPLICANT LeRoy H. Carhart

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the Kansas State Board of Healing Arts or its successors any information, files or records requested by that board in connection with this application. I further authorize the Kansas State Board of Healing Arts or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

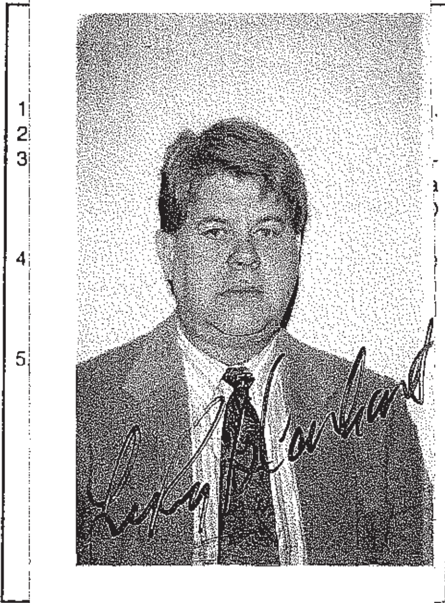
[signature]
Applicant's Signature

Subscribed and sworn ... 12th day of July, 1993

[signature]
Notary Public

My appointment expires on the 2 day of July, 1996

XI



Address to which Certificate will be mailed.

Certificates will be mailed in AUG and FEBRUARY. Please give address to be used at that time or notify Board office of change.

Name LeRoy H. Carhart
Street 105 E. Mission
City Bellevue
State Ne Zip Code 68005
Date address effective Immed

To be Filled Out by Board Office

ENDORSEMENT

The Kansas State Board of Healing Arts

OFFICE RECORD—(Leave blank)

Name ______

Address ______

City ______

State ______

Reciprocal Certificate No. ______

Application for Certificate through Endorsement with

______

Kansas Certificate No. ______

Issued ______ 19

Certificate { Forwarded ______ 19__
Sent by First Class }

By ______

INSTRUCTIONS FOR APPLICANTS

1. Please read instructions and application carefully. Completely fill out application.
2. All documents must be legible and in the English language, accompanied by a CERTIFIED translation where applicable. Translation must be made by a recognized authority in the translation of the language of the document. (DO NOT SEND EXTRA DOCUMENTS.) (REDUCE DOCUMENTS TO 8½ X11)
3. Applications must be complete with all documents and in this office before a temporary permit may be issued.
4. You must not begin to practice your profession before you are issued either a temporary permit or permanent license.
5. You must submit an original transcript from your professional school.
6. Doctors of Chiropractic must submit proof of 60 hours (transcripts) of pre-Chiropractic college education to be eligible for licensure.
7. A copy of the postgraduate training certificate may be substituted for the certification. - NOTARIZED
8. Recommendations—#XI. The physicians must have known you for at least one year before signing the recommendation.
9. Photograph—#XIV. (1) Sign your name across the front of the photograph. (2) The photographer must sign name and date photo was taken (photo must have been taken within 90 days of application.) (3) The thumbprint should be placed on the back of the photo with the signature and title of the law enforcement officer listed.
10. Address—#XIV. Please list the address to which your certificate can be mailed in AUGUST AND FEBRUARY.

** Chiropractors - Oral interview is required before final application approval.

NOTE: Fee must accompany the application. Fee of $150.00 for endorsement and $30.00 for temporary permit payable to Kansas State Board of Healing Arts. Continuing Education is a requirement for renewal of license each year. $75.00 processing and handling charge on all withdrawn applications.

Hahnemannianum Medicinae Collegium et Nosocomium Philadelphiae

OMNIBUS HAS LITERAS PRÆSENTES VISURIS

Salutem

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Cum Academiae ubique gentium institutae viros Philosophia Scientiis Medicina Litteris Humanitatis excultos aut de Republica bene meritos titulo justo et congruente condecorare solitae sunt, Nos igitur Curatores Collegii et Nosocomii Hahnemanniani Philadelphiae auctoritate Reipublicae Pennsylvaniensis nobis commissa

LeRoy Harrison Earhart

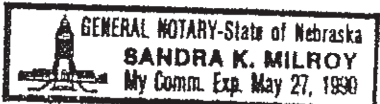
bene moribus praeditum omnibus muneribus atque officiis quae hujus Academiae legibus imposita sunt constanter et fideliter expletis ad gradum

Medicinae Doctoris

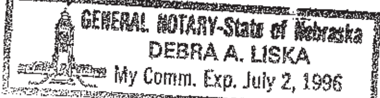
rite admisimus eique omnia jura honores privilegia ad hunc gradum pertinentia libenter concessimus. Cujus rei testimonio huic diplomati nomina nostra hoc die Ante Idus Junias Anno Domini millesimo nongentesimo septuagesimo tertio Philadelphiae scripsimus et quo major sit fides auctoritasque Curatoris consentientes Collegii nostri sigillum apponi jussimus.

Wilberton Shober
Praeses

This is a true copy
M L Earhart



Sandra K. Milroy
6-6-88



Debra A. Liska

Malcolm Grow USAF Medical Center

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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.

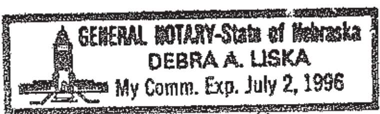
Director of Professional Education

Surgeon General USAF

Medical Center Commander

21 June 1974
Date of Presentation

This is a true copy.



Atlantic City Medical Center

Atlantic City, New Jersey

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This is to Certify that

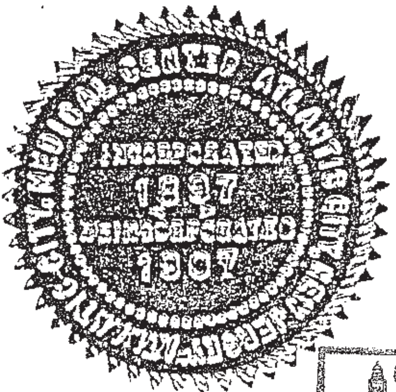
Leroy H. Carhart, Jr., M.D.

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.



Director of Medical Education

Administrator

President, Board of Governors

President, Medical Staff

GENERAL NOTARY-State of Nebraska
DEBRA A. LISKA
My Comm. Exp. July 2, 1996

this is a