PLEASE-TYPE-OR-PRINT-CLEARLY

I hereby submi	t the following in	formation in orde	r to recei	ve an appl	ication [©]	for licensure:	
						ر رئي سياني م	
NAME: ST	RICKLAND LAST (Surname)	NEIL		RICHAR	<u>)</u>	SUFFIX (JrII)	•
						0.	
ADDRESS: 140	SO ALLISONVILLE	ROAD NOB	LESVILLE	/N	46060	usa	_
STR	EET & NUMBER	- C1	TY	STATE	ZIP	COUNTRY	
TELEPHONE: BU	SINESS: (317)	773~1878	НОМ	ME: (317) 773-	1878	
	AREA CODI	E & NUMBER		AREA	CODE & N	JMBER	•
BIRTH DATE: 12	/ 10 / 30 BIRTH	PLACE: JUDIANA	POLIS_	CTATE	COUNT	A	_
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Will Stringstone	"Aldref"			11-17-89 DATE	

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OHIO. 43266-0315

My name IN FULL is STRICKLAND	NEIL &	PICHARD
High School or Equivalent: SHORTRIDGE H.S. INDIANAPO		COUNTRY
7 1 /945 6 1 4 9 FROM: MO7YR TO: MO7YR	DIFLEMA	
Undergraduate College or Equivalent: TSUTLER UNIVERSITY INDIANA CHOOL NAME CITY	POLIS IN	COUNTRY
FROM: MO/YR TO: MO/YR	DEGREE	
FROM: MO/YR TO: MO/YR SECHOOL NAME CITY FROM: MO/YR TO: MO/YR	STATE	COUNTRY
Medical School of Graduation: NDIANA UNIVERSITY INDIANAGE SCHOOL NAME CITY		USA COUNTRY
9 /52 6/ 56 FROM: MO/YR TO: MO/YR		M.D. DEGREE
FOR BOARD	-USE-ONLY	
CERTIFIC PRELIMINARY		
	070 31.190	_
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STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43266-0315

PRELIMINARY EDUCATION FORM

My name IN FUL	L is <u>STRICI</u>	KLAND,	NEIL	RICHARD	
•	LÁST		FIRST		MIDDLE
High School or Equivalent:	SHURTRIDGE	HS. INDIN	ANAPOLIS	STATE	USA
	SCHOOL NAME	CIT	1	STATE	COUNTRY
	911144	6/ / / 4 TO (DATE)	19		
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Undergraduate College or					
Equivalent:	BUTLER UNIO	IERSITY IN	BIANAPOCI	STATE	COUNTRY
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	FROM (DATE)	IO (DATE)		DEGRE	2
	SCHOOL NAME	CI	TY	STATE	COUNTRY
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	FROM (DATE)	TO (DATE)		DEGRE	E



My Orman Jan 40

APPLICATION FOR MEDICAL & OSTEOPATHIC LICENSURE

STATE MEDICAL BOARD 77 SOUTH HIGH STREET 17TH FLOOR COLUMBUS, OHIO 43215

ALL RESPONSES MUST BE TYPED

1.	SOCIAL SECURITY NUMBER	Redacted				
2	FULL NAME (Use no initials)	STRICKLAND	NEIL	RICHARD		
3.	NAME (As you pre- fer it inscribed on your Ohio	LAST (Surname)		RST · :	MIDDLE	SUFFIX (Jr., II)
4.	license) ALTERNATE NAMES	STRICKLAND, LAST (Surname)		RICHARD	MIDDLE	SUFFIX (Jr., II)
	(IF "NONE" ENTER "NONE")	(LAST (Surname)	FIRS		ONE MIDDLE	SUFFIX (Jr., II)
5.	CURRENT ADDRESS S	14050 Allisonvi TREET NUMBER & NAME	lle Road			
	. - c 1	Noblesville In	diana TATE	46060 Z	IP CODE	USA COUNTRY
6.	PHYSICAL DESCRIPTION _	71" 210 G HEIGHT WEIGHT F	ray MAIR COLOR	Blue COLOR O		otomy scar IFYING MARKS
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List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time you must state on the resume exactly what your activities were, such as "vacation" or "looking for residency program", as well as your permanent address for this period. For any time in which you worked for an "emergency medical group" or did locum tenens you must list all hospitals where you worked. If in private practice, indicate the hospitals where you hold or have held privileges and include complete addresses. Failure to include complete addresses will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

IN CHI LO	TES RONO- GICAL DER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT		ADMIN.
a.	ਜ਼ਿ ਪ੍ਰ 56 month year	Methodist Hospital Hospital/University/Uther	Rotating intern	100	,
	T0 7 57	1701 N.Senate Blvd. Indianapolis, IN 46202			
_	month year	Street Address City/State Zip			
b.	7 57 month year	Hösmetalsuniversity/Other	OBG Resident	100	
_	TO 7 60 month year	Street Address · City/State Zip			
c.	7 60 month year	same as above Hospital/University/Other	OBG Private Pr.	100	
	TO ? 67 month year	Street Address City/State Zip			
d.	7 60 month year	Community Hospital of Indpls. Hospital/University/Other			
	present month year	1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
و.	1 77 month year	same as above Hospital/University/Other			
ATE MEDICAL BOAPILE	1 77 month year T0 6 87	Street Address City/State 7:-	Emergency	90	10
TE ME	month year	Street Address City/State Zip			

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DATE: IN CHRO! LOGI: ORDE	NO-	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN.	ADMIN.
f.	month year	Hospita1/University/Other			
	TO month year	Street Address City/State Zip			
g.	month year	Hospital/University/Other			
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j.	month year	Hospital/University/other			
	TO month year	Street Address City/State Zip			
k.	month year	Hospital/University/Other			
	TO month year	Street Address City/State Zip			
1.	month year	Hospital/University/Other			
	TO month year	Street Address <u>City/State</u> Zip			

ADDITIONAL INFORMATION

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO FURNISH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON AND DISPOSITION OF THE MATTER. ALL AFFIRMATIVE ANSWERS MUST BE THOROUGHLY EXPLAINED ON A SEPARATE SHEET OF PAPER.

_		YES	NO /
	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	[]	[]
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges for other than reasons of failure to maintain records on a timely basis or failure to attend staff or section meetings?	[]	[/].
3.)	Have you ever resigned, withdrawn, or terminated, or have you ever been requested to resign, withdraw, or otherwise terminate your position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	[1/1	[]
4.	Have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from a medical school, clinical clerkship, externship, preceptorship, or postdoctoral training program?	[]	וינע
5.	Have you ever transferred from one postdoctoral training program to another?	[]	[\(\sigma \)
6.	Have you ever, for any reason, lost Specialty Board Certification in the U.S. or elsewhere?	[]	I [1/]
7.	Has any board, bureau, department, agency, or other body limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand against you?	נ ז	I [灯
8.	Have you ever voluntarily surrendered any professional license, certificate, or registration issued to you by a board, bureau, department, agency, or other body?	[]	1 [1
9.	Have you ever been requested to appear before any board, bureau, department, agency, or other body concerning allegations against you?	[]] [']
10.	Have you ever entered into an agreement of any kind with respect to a professional license, whether oral or written, in lieu of formal disciplinary action, with any board, bureau, department, agency or other body?	[]] [1
11.	Have you ever been notified of any charges or complaints filed against you with any board, bureau, deparment, agency, or other body with respect to a professional license?	[]] [/]
12.	Are to now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or other drugs affecting the central nervous system, or any drugs which may cause physical or psychological dependence?	[] [4

13.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or alcohol problem?	Ĺ]	[7]
14.	Have you ever been treated but not hospitalized, for emotional or mental illness, drug addiction or abuse, or alcohol problem?	[]	[V]
15.	Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, been requested to appear before or fined by the responsible agency?	[]	[1]
16.	Have you ever been convicted or been found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	С] ·	凹
17.	Have you ever forfeited collateral, bail or bond for breach or violation of any law, police regulation, or ordinance other than for minor traffic violation, been summoned into court as a defendant, or had any lawsuit (other than malpractice suit) filed against you?	[]	ا با
18.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf or paid such a claim yourself?	[•	7	[]
19.	Have you ever been denied, or relinquished, participation in any third party reimbursement program, whether governmental or private, or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?			[1]
20.	Have you ever been denied licensure, application for licensure, or privilege of taking examination, or withdrawn any application, in any state, territory, province, or country for any reasons?	[]	[1

- 3. Resigned voluntarily from partnership in Emergency Medicine to resume private Gyn practice in June, 1987.
- 18. Legal
- a.1972 Court judgement my favor. Gynecology case
- b. Out of court settlement for 20,000 dollars jointly with Dr. J.R. Brillhart and Community Hospital of Indianapolis on a cerebral palsy baby. 1976

Attuckland is

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED Ted W. Grisell, a licensed and practicing physician in the state of Name of Recommending Physician Indiana _____ affirm that Neil Strickland, has been known Name of Applicant to me personally and professionally for _ [7] years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure: I rate his/her medical knowledge and technique as: Excellent His/her command of the English language is: Excellent I rate his/her ability to work well with peers and medical staff as: <u>Excellent</u> His/her relationship with patients is: <u>Excellent</u> Additional comments: I hereby recommend him/ter for full licensure to practice medicine/osteopathic medicine in Ted W. Grisell MD Name of Recommending Physician Signature of Recommending Physician 5317 E. 16 th 5t (Please print or type) Address of Recommending Physician 317-359-8261 Telephone Number (Include City, State, Zip) (Include Area Code) 01021489 State of Licensure and License Number (SEAL) of Recommending Physician Subscribed and sworn to this 12th day of Jan т РНОТО Upon completion return to: STATE MEDICAL BOARD 77 SOUTH HIGH STREET 17TH FLOOR

COLUMBUS, OHIO 43215

1-9-90.

Signature of Applicant

Date Photo Taken

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CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT	COMPLETE	UNLESS	PHOTOGRAPH	OF	APPLICANT	IS	ATTACHED
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I, NAYNE H. THUMPNUN MD, a licensed	d and practicing physician in the state of
Name of Recommending Physician	
FNOIMA affirm that d	VEIL STRICKLIME MD, has been known
	ame of Applicant
to me personally and professionally for $\mathcal{Z}_{\mathcal{O}}$	years and that he/she is of good moral and
ethical character. Further, the photograph af	
applicant. I offer the following support of h	-
approance. I offer the forformy support of	rsy ner approacton for fair freehalte.
I rate his/her medical knowledge and His/her command of the English langua	technique as: Excelent
His/her command of the English langua	ge is: inclin
I rate his/her ability to work well w	ith peers and medical staff as: 3
His/her relationship with patients is	: 50
Additional comments: // wall was	Executed to your merel stop
Auditoronal Commerces.	The state of the s
I hereby recommend him/her for full licensure Ohio.	to practice medicine/osteopathic medicine in
Clayse of I Lugar uno	NATUR H-THOMPSON M.D
Signature of Recommending Physician	Name of Recommending Physician
54701216355	(Please print or type)
INDIANAPONI, END YGLIS	317 - 359-8895
Address of Recommending Physician	Telephone Number
(Include City, State, Zip)	(Include Area Code)
•	FRDIAMA L.N. 16256
(SEAL)	State of Licensure and License Number
17th	of Recommending Physician
Subscribed and sworn to this 12th day of	January, 1990.
	Wornin of Shumur
	Notary Public
	9/18/91
	Date Commission Expires
1 (1)	
Г РНОТО	Upon completion return to:
	CTATE MEDICAL DOADD
	STATE MEDICAL BOARD 77 SOUTH HIGH STREET
	17TH FLOOR
Will strulland on	STATE MEDICAL BOARD 77 SOUTH HIGH STREET 17TH FLOOR COLUMBUS, OHIO 43215
10.0.0	12:
Signature of Applicant	\$27 .TQ

Date Photo Taken

FORM 2



CERTIFICATE OF POST-GRADUATE TRAINING

MAIL TO HOSPITAL OR INSTITUTION OF POSTGRADUATE TRAINING IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice medicine in the State of Ohio. The State Medical Board of Ohio requires that my postgraduate training be certified. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

This certifies that <u>NEIL RICHARD STRICK</u> (Name of Applicant)	LAND, M.D. has rendered satisfactory
and continuous service as a(n)	[] intern [x] resident in OB/GYN [] clinical fellow (Department)
at <u>Methodist Hospital Graduate Medic</u> (Name of Hospital) Cente	
from 07/01/56 beginning (month/day/year)	to $\frac{06/30/60}{\text{ending (month/day/year)}}$. It is
further certified that the above name	[X] was awarded a certificate on $\frac{06/30/60}{\text{(month/day/year)}}$
and that the training	[χ] was accredited by ACGME/AOA. [] was not
	Signature of Medical Director or Program Director (Original signatures only, name stamps will not be accepted) J. Thomas Benson, M.D.
	Name (Please print or type) 12/21/89 Date

If the hospital has no seal, please indicate and have form notarized.

Upon completion return to:

STATE MEDICAL BOARD 77 SOUTH HIGH STREET 17TH FLOOR COLUMBUS, OHIO 43215



Health Professions Bureau

December 19, 1989^{EC} 2:

One American Square Stite #1020, Box 82067 Indianapolis, Indiana 46282 (317) 232-2960

Ohio State Medical Board 77 S High St 17th F1r Columbus, OH 43215

To Whom It May Concern:

THIS IS TO CERTIFY THAT:

Neil Richard Strickland

BECAME A LICENSED:

PHYSICIAN

NUMBER:

01018157

DATE OF ISSUANCE:

September 04, 1957

EXPIRATION DATE:

June 30, 1991

STATUS:

CURRENT

LICENSURE BASIS:

State Board Examination

Anatomy, Histology & Embryology	075	Ophthalmology & Otology (out of 20)	19
Pathology & Bacteriology	079	Surgery	085
Physiology	079	Chemistry (out of 50)	40
Sanitation & Hygiene (out of 50)	40	Medical Jurisprudence (out of 10)	10
Medicine	088	Neurology (out of 10)	08
Materia Medica & Therapeutics	094	Obstetrics	093
Gynecology (out of 50)	44	Pediatrics (out of 10)	09
Physical Diagnosis	081		
		General Average	84.40

Unless otherwise indicated this license has not been disciplined by the State of Indiana. If other information is needed, please contact our office by mail or by telephoning (317) 232-2960.

Verified By:

Ms. Rejina D. Henderson

Records Division Coordinator

CERTIFICATE OF STATE BOARD

TO ALL STATE BOARDS-DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED STATE MEDICAL BOARD

This form must be completed for a license.	pplicants who are applyin	g fo <u>r</u> e <mark>bijorsement</mark>	of Agother state
Acting on behalf of the			
I do hereby certify that Dr.	Name of State Board		
_	Name of Licensee		
was on the day of	19, granted a	license to pract	ice
	in the State of _		based upon
written examination of:			
[] FLEX Examination administered	• •	state	ion prepared by this
[] Examination administered in but accepted as if taken in \overline{t}	his state		ecify)
***License current? Yes	No If not, please e	explain	
I further certify that the aforese	· •		
on,		ige of	or a FLEX Weighted
Average of in the fol	lowing subjects:		
SUBJECT	PERCENTAGE	SUBJECT	PERCENTAGE
			
or a Component I score of	on a	nd Component II so	ore ofon
•	month/year	,	
month/year		•	
Is the applicant currently the su disciplinary authority in your st LAW If yes, please attach details. investigation. Have formal disciplinary proceedi	Include information as	CANNOT ANSWER U	NDER CURRENT STATE
a disciplinary authority in your STATE LAW If yes, please attach details.	state? YesNO	CANNOT ANSW	ER UNDER CURRENT
Has the applicant ever been warne applicant's license been revoked, disciplinary authority in your st LAW If yes, please attach details.	suspended, or in any ot	her manner limite	d by a licensing or
NOTE: If any portion of the abovexplanation.	re certification is delet	ed or modified, p	lease attach an
(AFFIX BOARD SEAL) (NOT VALID WITHOUT SEAL)			
		or Executive Se	cretary, President cretary, <u>Original</u> , name stamps will
Upon completion, return to:		-	,
STATE MEDICAL BOARD 77 SOUTH HIGH STREET		Date	
17TH FLOOR		Da CE	
COLUMBUS, OHIO:43215			ž

AFFIDAVIT AND RELEASE STATE MEDICAL BOARD

AFFIDAVIT AND RELEASE OF APPLICANT 90 JAN 22 PH 4: 03

The affidavit and release below must be completed by ALL applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being returned to you.

SS	STATE OF	Indiana
	COUNTY OF	_Hamilton

I, Neil Richard Strickland, M.D. hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and the Routes to Licensure and I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable or transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that failure to complete this application as requested by the Board within six months can be considered as abandonment of any request for licensure and that any fee I submitted is not refundable or transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives, and any person furnishing information, any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization, or similar institution; or to any professional association.

I further understand that a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained therein or to be furnished, which if false, can subject me to permanent denial of said certificate.

Notary Public Signature

(NOTARY SEAL)

Date Commission Expires

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

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This is to certify that this applicant has met preliminary education requirements for the study of medicine in conformity with the statutes of Ohio and the regulations of the State Medical Board of Ohio.

Be 2. C.

Entrance Examiner

May D. Cranfactor.

Secretary

2-190

Date Issued

FOR BOARD USE ONLY

033600

CERTIFICATE #: 59955 DATE ISSUED 6 5-80

DETERMINATION:

BOARD ACTION:

BASIS OF LICENSURE:

NAME: STRICKLAND, NEIL RICHARD SCHOOL: INDIANA UN SCH MED. INDIANAPOLIS IN DEGREE CONFERRED: MD DATE CONFERRED: 06/11/56 INTERMSHIP_____ HOSFITAL: CITY: ENDING DATE: / STARTING DATE: / RESIDENCY____ HOSPITAL: KETHODIST HOSP CITY: IMDPLS ST: IN STARTING DATE: 07/57 ENDING DATE: 07/60 HOSPITAL: CITY: ST: ENDING DATE: / STARTING DATE: / STATE BOARD EXAM_____ DATE OF EXAM: 09/57 STATE EXAM WAS TAKEN: IN SCORE: 84,4% LETTERS OF RECOMMENDATION. NAME: TED GRISELL HD CITY: ENDPLS STATE! IN CITY: INDPLS NAME: WAYNE THOMPSON NO STATE: IN SPECIALITY CODE: BOARD: cone: cobe: . NOT IN OK N/A AMA/ADA: TSE SCORE: Y FED INFO: Х REC FORM: ECEMB: I APPROVE I DISAPPROVE I ABSTAIN I RONALD C. AGRESTA, MD RAYMOND ALBERT HENRY G. CRAMBLETT: MD JUDITH S. DANIELS, MD THOMAS E. GRETTER, ND RONALD J. KAPLANSKY, DPM CARLA S. O'DAY: MD JOHN E. RAUCH, DO CAROL ROLFES JOHNATHAN S. ROSS:MD TIMOTHY L. STEPHENS, JR., MD 1

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	DATES IN	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING	Bricklar	nd	_
	CHRONO- LOGICAL ORDER	WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN.	ADMIN.
	a. month year TO 7 57 month year	Methodist Hospital Hospital/University/Uther 1701 N.Senate Blvd. Indianapolis, IN 46202 Street Address City/State Zip	Rotating intern	100	
	7 57 b. month year	หอิริติริเลาวิบกิโซิริริเบyOther	OBG Resident	100	
	7 60 month year	Street Address City/State Zip			
	c. month year	same as above Hospital/University/Other	OBG Private Pr.	100	
	? 67 month year	Street Address City/State Zip			
	d. month year	Community Hospital of Indpls. Hospital/University/Other	,		
	TO present month year	1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
	e. month year	same as above Hospital/University/Other	,		
1	TO 6 87 month year	Street Address City/State Zip	Emergency	90	10
	<u> </u>				

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LOG	ONO- ICAL	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE	POSITION &	CLIN.	ADMIN.
ORD	มีประ 56 month year	Methodist Hospital Hospital/University/Other	Rotating intern	100	*
	TO 7 57 month year	1701 N.Senate Blvd. Indianapolis, IN 46202 Street Address City/State Zip			
b.	7 57 month year	ห็อริทิร์เลาีวิบก็ไข้ะYริity/Other	OBG Resident	100	
	7 60 month year	Street Address · Cfty/State Zip			_
c.	7 60 month year	same as above Hospital/University/Other	OBG Private Pr.	100	
	70 ? 67 month year	Street Address City/State Zip			
d.	7 60 month year	Community Hospital of Indpls. Hospital/University/Other			
	present month year	1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
· cavo	month year	same as above Hospital/University/Other			
e caroa izwiduk dIYIS	TO 6 87 month year	Street Address City/State Zip	Emergency	90	10
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NAME: STRICKLAND, NEIL RICHARD SCHOOL: INDIANA UN SCH MED, INDIANAPOLIS IN DEGREE CONFERRED: MD DATE CONFERRED: 06/11/56 HOSPITAL: CITY: STARTING DATE: / ENDING DATE: RESIDENCY_____ HOSPITAL: METHODIST HOSP CITY: INDPLS ST: IN ENDING DATE: 07/60 STARTING DATE: 07/57 HOSPITAL: ST: CITY: STARTING DATE: / ENDING DATE: STATE BOARD EXAM.... DATE OF EXAM: 09/57 STATE EXAM WAS TAKEN: IN LETTERS OF RECOMMENDATION NAME: TED GRISELL MD CITY: INDPLS NAME: WAYNE THOMPSON NO CITY: INDPLS SPECIALITY SPECIALITY CODE: BOARD10005: CORE: . иот ји 0KN/A AMAZAQA: TSE SCORE: X FED INFO: Х REC FORM: ECFM6: I APPROVE I DISAPPROVE I ABSTAIN RONALD C. AGRESTA, MD RAYMOND ALBERT ••**••**••••••••• HENRY G. CRAMBLETT, ND JUDITH S. DANJELS, MD THOMAS E. GRETTER, MD TROU YHTOMIT RONALD J. KAPLANSKY, DPM CARLA S. G'DAY: MD JOHN E. RAUCH, DO CAROL ROLFES •••••••••••••••••••••••••••••••••••• JOHNATHAN S. ROSS,MD TIMOTHY L. STEPHENS: JR., MD

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a. month year	1701 N.Senate Blvd. Indianapolis, IN 46202	Rotating intern	100	
month year 7 57 b. month year TO 7 60	r Hospitalyuniversity/Other	OBG Resident	100	
c. month year	same as above	OBG Private Pr.	100	
month year 7 60 d. month year TO present	Community Hospital of Indpls Hospital/University/Other 1500 N. Ritter Ave. Indianapolis, IN 46219	OBG Private Pr.	100	
e. month year	same as above Hospital/University/Other	Emergency	90	10
month year	Street Address City/State Zip OF OF ONE OF ONE OF SHEET ADDRESS CITY/State Zip	•		

NAME: STRICKLAND: NEIL RICHARD SCHOOL: INDIANA UN SCH MED, INDIANAPOLIS IN DEGREE CONFERRED: MD DATE CONFERRED: 06/11/56 INTERNSHIP_____ HOSPITAL: ST: CITY: ENDING DATE: / STARTING DATE: / HOSPITAL: METHODIST HOSP ST: IN CITY: INDPLS STARTING DATE: 07/57 ENDING DATE: 07/60 HOSPITAL: ST: CITY: ENDING DATE: STARTING DATE; / _____ STATE BOARD EXAM______ DATE OF EXAM: 09/57 STATE EXAM WAS TAKEN: IN SCORE: 84.4% LETTERS OF RECOMMENDATION NAME: TED GRISELL MD CITY: INDPLS STATE! IN CITY: INDPLS NAME: WAYNE THOMPSON ND SPECIALITY SPECIALITY CODE: BOARDI CODE: CODE: -NOT IN OK N/A :AUA/AUA: X TSE SCORE: X FED INFO: X REC FORM: Х ECFMG: 1 APPROVE 1 DISAPPROVE 1 ABSTAUM 1 ••••••: RONALD C. AGRESTA, ND RAYMOND ALBERT HENRY G. CRAMBLETT, HD JUDITH S. DANIELS, MD THOMAS E. GRETTER, ND TIMOTHY JOST RONALD J. KAPLANSKY, DPM CARLA S. O'DAY: MD. ••••; JOHN E. RAUCH, DO CAROL ROLFES JOHNATHAN S. ROSS,ND -TIMOTHY L. STEPHENS, JR., MD

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a	то	Methodist Hospital Hospital/University/Other 1701 N.Senate Blvd. Indianapolis, IN 46202 Street Address City/State Zip	Rotating intern	100	\$
b	7 57	หอิริตรีเลาวิบลีโขยรัฐity/Other	OBG Resident	100	
 c	TO 7 60 month year 7 60 month year	Street Address · City/State Zip same as above Hospital/University/Other	OBG Private Pr.	100	· ************************************
_	TO 2 67 month year	Street Address City/State Zip		***	
d	7 60 month year	Community Hospital of Indpls. Hospital/University/Other			
_	TO present month year	1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
् e	1 77 month year	same as above Hospital/University/Other			
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TIMOTHY L. STEPHENS, JR., HD

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a	### 56 month year	Methodist Hospital Hospital/University/Uther	Rotating intern	100	*
_	TO 7 57 month year	1701 N.Senate Blvd. Indianapolis, IN 46202 Street Address City/State Zip			
b	7 57 month year	Hospital7University/Other	OBG Resident	100	
_	TO 7 60 month year	Street Address City/State Zip			
c	7 60 month year	same as above Hospital/University/Other	OBG Private Pr.	100	
_	TO ? 67 month year	Street Address City/State Zip		:	
d	. month year	Community Hospital of Indpls. Hospital/University/Other			
_	present month year	1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
e Larva	Q :	same as above Hospital/University/Other			
	T0 6 87 month year	Street Address City/State Zip	Emergency	90	10
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CAROL ROLFES

JOHNATHAN S. ROSS, MD

TIMOTHY L. STEPHENS: JR., MD

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a.	जैसी ए 56 month year	Methodist Hospital Hospital/University/Uther	Rotating intern	100	
	TO 7 57 month year	1701 N.Senate Blvd. Indianapolis, IN 46202 Street Address City/State Zip			
b.	7 57 month year	Hospital Juniver Sity/Other	OBG Resident	100	
	TO 7 60 month year	Street Address · City/State Zip			
c.	7 60 month year	same as above Hospital/University/Other	OBG Private Pr.	100	
	T0				
	month year	Street Address City/State Zip			
d.	7 60 month year	Community Hospital of Indpls Hospital/University/Other			
	то	1500 N. Ritter Ave.			
	present month year	Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
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<u>.</u>	month year	Street Address City/State Zip			
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TIMOTHY L. STEPHENS, JR., MD

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DATES IN CHRONO- LOGICAL ORDER	ENTER NAME OF HOSP UNIVERSITY WHERE TO REMPLOYED, OR OT WORKING OR NON-WOR ACTIVITY AND COMPLADDRESSES	TRAINED THER RKING	POSITION & DEPARTMENT		ADMIN.
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month	Street Address C Community Hospi year Hospital/Universit	City/State Zip			
	o 1500 N. Ritter Indianapolis, I year Street Address (1	OBG Private Pr.	100	
e. month	same as above Hospital/Universit	ty/Other			
. 6	87 year Street Address (Emergency	90	10

STATE MEDICAL BOARD OF OHIO

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AMERICAN MEDICAL GRADUATE ENDORSEMENT OF OUT-OF-STATE LICENSES

SCHOOL: DEGREE CONFERRED: DATE CONFERRED:	06/11/56	MED, INDIA		
INTERNSHIP				
HOSPITAL: CITY: · STARTING DATE:	,	ENDING 1	ST: DATE: /	
RESIDENCY				
CITY; STARTING DATE; HOSPITAL: CITY; STARTING DATE;	,	ENDING		
STATE BOARD EXAM				
DATE OF EXAM: 09				
LETTERS OF RECOMMENDA				
NAME: TED GRYSELL NAME: WAYNE THOMPS	מא אס		Y: [NDPLS Y: INDPLS	STATE: IN
SPECIALITY CODE: CODE: CODE:		SPECI BOA	ALITY	
		או דסא	No. 21 - 11 Mar 24 - 110 - 12 - 12 - 12 - 12 - 12 - 12 - 1	
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RONALD C. AGRESTA, MD	1		l	1
RAYMOND ALBERT		* * * * * * * * * * * * * * * * * * * *	l , , , , , , , , , , , , , , , , , , ,	1 , , , , , , , , , ,
HENRY G. CRAMBLETT, M		* * * * * * * * * * *	l , , , , , , , , , , , , , , , , , , ,	[, , , , , , , , , , , ,]
SHINDLE S. HTIQUE		********	l , , , , , , , , , , , , , , , , , , ,	[,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
THOMAS E. GRETTER, ND		* * * * * * * * * * * * * * * * * * * *	l , , , , , , , , , , , , , , , , , , ,	
TIMOTHY JOST	,,	,,,,,,,,	l , , , , , , , , , , , , , , , , , , ,	l , , , , , , , , , , , . [
RONALD J. KAPLANSKY,		*****	l , , , , , , , , , , , , , , , , , , ,	l , , , ; , , ; , , , , , , , , , , , ,
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JOHN E. RAUCH, DO	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	*****	[,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	l , , , , , , , , , , , , 1 l
CAROL ROLFES			l , : , , , , , , , , , , , , , , , , ,	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
JOHNATHAN S. ROSS, MD		******	l , , , , , , , , , , , , , , , , , , ,	I , , , , , , , , , , , I I
TIMOTHY L. STEPHENS,		* * * * * * * * * *	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	[

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		ES ONO- ICAL	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE	CAPICKLY POSITION &		ADMIN.
	ORD		ADDRESSES	DEPARTMENT		Z
	a.	month year	Methodist Hospital Hospital/University/Uther	Rotating intern	100	
		T0 7 57	1701 N.Senate Blvd. Indianapolis, IN 46202			
		month year	Street Address City/State Zip			
	b.	7 57 month year	Hösmitaliuniversity/Other	OBG Resident	100	
		TO 7 60 month year	Street Address · City/State Zip			
	c.	7 60 month year	same as above Hospital/University/Other	OBG Private Pr.	100	_
		TO 7 67 month year	Street Address City/State Zip			
	d.	7 60 month year	Community Hospital of Indpls. Hospital/University/Other			
		present month year	1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
 S	e.	1 77 month year	same as above Hospital/University/Other			
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a.	month year	Methodist Hospital Hospital/University/Other	Rotating intern	100	
	то ,	1701 N.Senate Blvd.			
	7 57 month year	Indianapolis, IN 46202 Street Address City/State Zip			
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c.	7 60 month year	same as above Hospital/University/Other	OBG Private Pr.	100	
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d.	7 60 month year	Community Hospital of Indpls Hospital/University/Other			
_	TO present month year	1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
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ر ال	month year	Street AddressCity/StateZip			

AMERICAN MEDICAL GRADUATE ENDORSEMENT OF OUT-OF-STATE LICENSES

NAME: STRICKLAND, NEIL RICHARD SCHOOL: INDIANA UN SCH MED, INDIANAPOLIS IN DEGREE CONFERRED: MD DATE CONFERRED: 06/11/56 ------INTERNSHIP ______ HOSPITAL: CITY: ST: STARTING DATE: / ENDING DATE: RESIDENCY HOSPITAL: METHODIST HOSP CITY: INDPLS ST: IN STARTING DATE: 07/57 ENDING DATE: 07/60 HOSPITAL: CITY: ST: STARTING DATE: / ENDING DATE: DATE OF EXAM: 09/57 STATE EXAM WAS TAKEN: IN SCORE: 84,4% LETTERS OF RECOMMENDATION NAME: TED GRISELL MD CITY: INDPLS STATE! IN NAME: WAYNE THOMPSON MD CITY: INDPLS SPECIALITY SPECIALITY CODE: BOARD: CODE: CODET NOT IN OK MYA STATE MEDICAL BOARD AMA/AOA: X OF OHIO TSE SCORE: Y FED INFO: Х MAR 0 1 90 REC FORM: Х ECFM6: | APPROVE | DISAPPROVE | ABSTAIR RONALD C. AGRESTA, MD RAYMOND ALBERT HENRY G. CRAMBLETT, MD ••••••• JUDITH S. DANIELS, MD •••>••> THOMAS E. GRETTER, MD TIMOTHY JOST RONALD J. KAPLANSKY, DPN | CARLA S. D'DAY: MD JOHN E. RAUCH, DO CAROL ROLFES JOHNATHAN S. ROSS, MD TIMOTHY L. STEPHENS, JR., MD !

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time you must state on the resume exactly what your activities were, such as "vacation" or "looking for residency program", as well as your permanent address for this period. For any time in which you worked for an "emergency medical group" or did locum tenens you must list all hospitals where you worked. It in private practice, indicate the hospitals where you hold or have held privileges and include complete addresses. Failure to include complete addresses will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

DATE IN CHRO)NO-	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING	Brickler		
LOG1 ORDE		ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN.	ADMIN.
	Tuly 56 month year	Methodist Hospital Hospital/University/Uther 1701 N.Senate Blvd. Indianapolis, IN 46202	Rotating intern	100	
	month year	Street Address City/State Zip			
b.	7 57 month year	หรือพระสาริยศใช้ใช้รถ่ty/Other	OBG Resident	100	
	7 60 month year	Street Address City/State Zip			
GRAC C.	month!! year	same as above Hospital/University/Other	OBG Private Pr.	100	
	TO ? 67 month year	Street Address City/State Zip			
d.	7 60 month year	Community Hospital of Indpls. Hospital/University/Other			
-	present month year	1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
e.	1 77 month year	same as above Hospital/University/Other			
Latua issionka	TO 6 87 month year	Street AddressCity/StateZip	Emergency	90	10
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List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time you must state on the resume exactly what your activities were, such as "vacation" or "looking for residency program", as well as your permanent address for this period. For any time in which you worked for an "emergency medical group" or did locum tenens you must list all hospitals where you worked. It in private practice, indicate the hospitals where you hold or have held privileges and include complete addresses. Failure to include complete addresses will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

DATES IN CHRONO- LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT		ADMIN.
a. month year TO 7 57 month year	Methodist Hospital Hospital/University/Other 1701 N.Senate Blvd. Indianapolis, IN 46202 Street Address City/State Zip	Rotating intern	100	
b. month year	Hospitaliuniversity/Other	OBG Resident	100	
7 60 month year	Street Address City/State Zip same as above Hospital/University/Other	OBG Private Pr.	100	
TO ? 67 month year	Street Address City/State Zip		-	
d. month year	Community Hospital of Indpls. Hospital/University/Other			
present month year	1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
e. month year	same as above Hospital/University/Other			
T0	Street Address City/State Zip	Emergency	90	10



Jeffrey A. Boester, M.D., F.A.C.O.G.

Steven A. Foley, M.D.

May 30, 1990

State of Ohio State Medical Board 77 S. High St., 17th Floor Columbus, OH 43215

06 t 0 NUL

To Whom It May Concern,

This letter is written at the request of Dr. Neil Strickland M.D. for the purpose of confirming his medical staff membership at:

Community Hospitals of Indianapolis 1500 North Ritter Avenue Indianapolis, IN 46219

Dr. Strickland joined the medical staff at Community Hospital of Indianapolis in July of 1960 as an active member of the medical staff. In 1979 he changed his department membership from the Department of Obstetrics and Gynecology to the Emergency Room Department. he became a courtesy member of the Department of Obstetrics and Gynecology. He presently retains his medical staff membership category of courtesy in the Department of Obstetrics and Gynecology.

I have no record of any quality assurance problems, probationary actions, or restriction of priviledges during Dr. Strickland's membership in the Department of Obstetrics and Gynecology at Community Hospitals of Indianapolis. Dr. Strickland voluntarily ceased the practice of Obstetrics in 1976, but continued to practice Gynecology until he began working in the Emergency Room in 1979. He again resumed a Gynecologic practice in 1987 when he became a courtesy member of the Department of Obstetrics and Gynecology.

I hope that this information is helpful to you. If you have any further questions, please feel free to contact me.

Sincerely,

Ny

Jeffrey A. Boester, M.D., FACOG

JAB/csq

STATE OF OHIO THE STATE MEDICAL BOARD 77 South High Street 17th Floor Columbus, Ohio 43266-0315

Returned 84

11/27/89

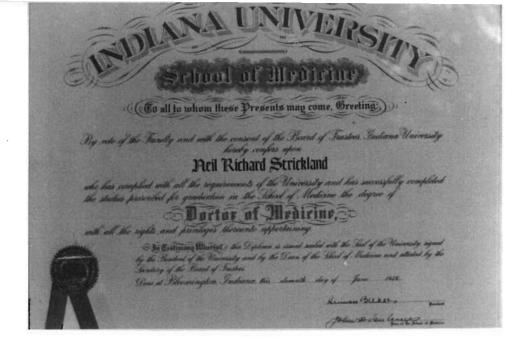
Da a	Destant GL 1 1 2 2	
Dear	Doctor: Strickland,	
	Request for Application Form has been received. However, the following be completed:	3
	Complete the Medical Education portion	
	List all postgraduate training (internship, residency or clinical fellowship) undertaken in the U.S. or Canada.	
	List all licenses in other countries in which you hold or have held a full right to practice medicine and surgery.	
,	List all licenses in the United States or Canada in which you hold or have held a license to practice medicine and surgery.	
,	List each and every State Board or FLEX exam which you have taken.	
,	Answer all questions under Additional Eligibility Information	
	Sign and date the enclosed form	بخ
	X Complete the Preliminary Education form	्
	Complete the Preliminary Education form XX Other: Dr. Strickland, you did not return your Preliminary Complete the Preliminary Education form Education Form Enclosed you will find another one. Please	
	Education Form. Enclosed you will find another one. Please	
	complete and return to the MEDICAL BOARD as soon as possible	
	Thank you.	
	those sections marked with an "X" apply to you. All responses must be eted on the enclosed form(s).	
	Sincerely,	

Penny McKenzie

Chief, Licensure

PM/ad

Enclosure



THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

CERTIFIES THAT

NEIL R. STRICKLAND, M.D.

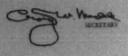
HAVING FULFILLED THE REQUIREMENTS
HAS BEEN ELECTED A FELLOW OF THIS COLLEGE

WHICH IS DEDICATED TO THE MAINTENANCE OF THE HIGHEST STANDARDS
IN PATIENT CARE, MEDICAL EDUCATION AND RESEARCH IN OBSTETRICS AND GYNECOLOGY

DECEMBER 31, 1963

Geny & Just MESIDENT





I HEREBY CERTIFY THAT I HAVE RECEIVED MY WALL CERTIFICATE
NUMBER 59955, ON 8-1-90
NUMBER (Date)
NEK R. STRICKLAND, mD
Name AUTSAWALE RY
Street Address AMILTON COUNTY
MORIECVILLE, 11V: 46060
NORLESVILLE, IIV: 46060 City State/County Zip
City State/County Zip Mul Astrulland Signature
Signature
PLEASE CHECK IF THIS IS A CHANGE OF ADDRESS

MED 1013 (4/89)

As soon as you know your new address, mail this card to all the people, businesses, and publications who send you mail.

For publications, tape an old address label over name and old address sections and complete new address.

Apartle 11-29.91

	Print or Type—Last Name, First Name, Middle Initial			. , ,
Your name	NEIL R. STRICKLAND, M	Δ .		
Old	No and \$44050 ALLISONVILLE RD.	Apt. Suite No.	P.O. Box	R.D. No.
Address	Post Office State LICENSE NO. 59955	ZIP Code		
New	NEIL R. STRICKLAND, mb.	Apt. Suite_No.	P.O. Bax	R.D. No.
Address	Post Office State FISHERS, IN 46038	ZIP Code		
Sign Here	continued for	address in effect	Account N	lo. (II any) -05- 3955

PS FORM 3576, JAN. 1984 ou.s. c.e.o. 1985-470-019 RECEIVER: Be sure to record the above new address in your address book at home or office.

MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315 *21 GY NECO LOGY* CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE
STATE OF OHIO. THAT I HAVE COMPLETED DURING THE LAST BIENNIUM
THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION
PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN
EVERLY RESPECT. SPECIALTY CODE(S) CORRECT AS LISTED IF THE SPECIALTY CODE(S) ARE IN ERROR, EVERY RESPECT ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3 CHANGE OF ADDRESS (SIGNATURE OF APPLICANT) (DATE) IDENTIFICATION NUMBER AMOUNT DUE DATE DUE 07/01/92 35-05-9955 \$160.00 NEIL RICHARD STRICKLAND, M.D. 14050 ALLISONVILLE RD FISHERS IN 46038 0935059955 1196969696211 4°00000160004° in a board approved program. Any questions question if you have successfully completed other than the State Medical Board of Ohio? possession, distribution or use of any drug? suffering from, drug or alcohol dependency 3.) Surrendered, or consented to limitation 4.) Had any clinical privileges suspended, board and have subsequently adhered to limited or revoked for reasons other than all statutory requirements as contained in against you by any state licensing board 1.) Been addicted to or dependent upon treatment at a program approved by this provisions, or you are currently enrolled upon: a) A license to practice medicine; been treated for, or been diagnosed as or abuse? You may answer "no" to this 2.) Had a license denied by or had any A federal or state law regulating the concerning approval can be directed alcohol or añy chemical substance; or section 4731.224, O.R.C., and related failure to maintain records or attend disciplinary action taken or initiated OR b) State or federal privileges to prescribe controlled substances? PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT HAV度 YOU BEEN FOUND GUILTY OF, OR AT 蘇隊 TIME SINCE SIGNING YOUR LASE APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU: Reda (Optional for purposes of identification PLED GUILTY OR NO CONTEST TO A.) A felony or misdemeanor. to the board offices staff meetings? ASSOS9955 BLIQUNT # 9 Ş Š 7 00225 BATCH 8 30 00 Total Page Street AMOUNT

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suffering from, drug or alcohol dependency question if you have successfully completed AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU: or pled guilty or no Been found guilty of, or pled guilty or no all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and 6.) Surrendered, or consented to limitation 8.) After January 14, 1993, referred a patient, or initiated against you by any state licensing board other than the State Medical contest to a federal or state law regulating board and have subsequently adhered to 7.) Had any clinical privileges suspended, the possession, distribution or use of any than failure to maintain records or attend Had malpractice insurance cancelled treatment at a program approved by this 3.) Been addicted to or dependent upon participated in an arrangement or scheme for been treated for, or been diagnosed as upon: a) A license to practice medicine; or abuse? You may answer "no" to this Zip Code enrolled in a board approved program. questions concerning approval can be 5.) Had any disciplinary action taken or restricted or revoked for reasons other related provisions, or you are currently alcohol or any chemicai substance; or referral of a patient, for clinical laboratory or limited for other than failure to pay PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: OR b) State or federal privileges to prescribe controlled substances? contest to a felony or misdemeanor directed to the board offices. State 1.) Been found guilty of, staff meetings? Board of Ohio? premiums? drug? 7 9 20 7 7 7 2 8 1 NO 8 50599 1011 County ES ES YES ÉS

you or a member of your immediate family has

an ownership or investment interest, or any

Redacted

Optional for purposes of identification

services to a person or facility in which either

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	MD & DO SPECIALTY CODES CURRENTLY ON RECORD
STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315 CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.	SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. REPORT ANY CHANGE OF ADDRESS STREET STREET CITY STATE COUNTY
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PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: Street Country AT INNY TIME SINCE SIGNING YOUR LAST APPLICATION FOR THENEWAL OF YOUR CERTIFICATE HAVE YOU: YES NO 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES NO 2.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES NO 3.) Been addicted to or dependent upon a suffering from, drug or alcohol dependency or abuse? You may answer "no" to this been treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and realted provisions, or you are currently entaiting aboard approved program. Any entaiting concerning approved program. Any	



STATE MEDICAL BOARD OF OHIO
77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

Date: June 28, 1996

NEIL R STRICKLAND MD 22210 HINKLE CREEK RD NOBLESVILLE IN 46060

Dear Doctor:

Please be advised that in reviewing your renewal application card for your Ohio license, we find that you failed to answer the following question(s). To continue processing your renewal, answer each checked question below:

AT A	YY T	[ME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE (only those questions marked with a / apply to you)	HAVE	YOU:
٥	1.)	Been found guilty of, or pled guilty or no contest to a felony or misdemeanor?	YES	NO ②
	2.)	Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?		
	3.)	Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "NO" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.		9
	4.)	Had malpractice insurance canceled or limited for other than failure to pay premiums?		•
	5.)	Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?		2
	6.)	Surrendered, or consented to limitation upon: a) a license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?		2
	7.)	Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?		Ð
	8.)	Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?		
A	ĺ	YOU DID NOT ANSWER ANY OF THE QUESTIONS. ANSWER EACH QUESTION (1 - 8) A	BOVE	:.

MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO OOR, COLUMBUS, OHIO 43266 - 0315 GYN GYNECOLOGY CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION OF THE STATE BOARD. SPECIALTY CODE(S) CORRECT AS LISTED-IF CORRECTIONS ARE NECESSARY, PLEASE PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY ENTER ALL SPECIALTY CODES. RESPECT. CODE CODE2 CODE3 3-2 REPORT ANY CHANGE OF ADDRESS (SIGNATURE OF APPLICANT) (DATE) IDENTIFICATION NUMBER AMOUNT DUE DATE DUE 35-05-9955-S \$179.00 05/01/98 NEIL RICHARD STRICKLAND, M.D. 22210 HINKLE CREEK RD NOBLESVILLE IN 46080 119696969621 0935059955 "00000 1 7900" suffering from, drug or alcohol dependency question if you have successfully completed AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION 2.) Been found guilty of, or pled guilty or no sections 4731.224 and 4731.25 O.R.C., and arrangement or scheme for referral of a patient, 1.) Been found guilty of, or pled guilty or no -6.) Surrendered, or consented to limitation contest to a federal or state law regulating initiated against you by any state licensing 7.) Had any clinical privileges suspended, the possession, distribution or use of any board and have subsequently adhered to all statutory requirements as contained in than failure to maintain records or attend Had malpractice insurance cancelled treatment at a program approved by this or facility in which either you or a member of Been addicted to or dependent upon been treated for, or been diagnosed as upon: a) A license to practice medicine; restricted or revoked for reasons other or abuse? You may answer "no" to this enrolled in a board approved program. 5.) Had any disciplinary action taken or R.) Referred a patient, or participated in an your immediate family has an ownership or 46 442 related provisions, or you are currently questions concerning approval can be directed to the board offices. FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU alcohol or any chemical substance; or for clinical laboratory services to a person or limited for other than failure to pay investment interest, or any compensation 121 (15 TIRLE 1917 121 RS 1 WASTING OR b) State or federal privileges to PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: contest to a felony or misdemeanor. board other than the State Medical prescribe controlled substances? Redacted 1 K Board of Ohio? staff meetings? premiums? drug? MAIRILOIN 7 7 8 8 8 9 7 1 200 NO 90 7

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	I wish to apply for Emeritus status:
	MD & DO SPECIALTY CODES CURRENTLY ON RECORD
STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315	GYN GYNECOLOGY
CERTIFICATION	
I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO,	
THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-1999 REGISTRATION	/
PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION	SPECIALTY CODE(S) CORRECT AS LISTED
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.	IF CORRECTIONS ARE NECESSARY, PLEASE
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ATE I	enrolled in a board-approved a questions concerting approva directed to the board offices. 4.) Had malpractice insurance or limited for other than failure premiums? 5.) Been notified by any board department, agency, or other limicluding those in Ohio, other board, of any investigation coyou, or any charges, allegation complaints filed against you? 6.) Surrendered, or consented in any jurisdiction: a) A licens medicine; OR b) State or feder to prescribe controlled substant or prescribe controlled substant or revoked for reasons other the maintain records or attend standing or revoked for reasons other the maintain records or attend standing of the proposes of identification.
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Street Street	YES

DETACH HERE AND REMIT THIS PORTION WITH FEE MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127 CERTIFICATION GYN GYNECOLOGY I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1999-2001 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION

AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EYERY RESPECT. SPECIALTY CODE(S) CORRECT AS LISTED EM IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE3 7-16-01 RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL (SIGNATURE OF APPLICANT) (DATE) AMOUNT DUE DATE DUE IDENTIFICATION NUMBER 35-05-9955-S \$305.00 10/01/01 NEIL RICHARD STRICKLAND, M.D. 22210 HINKLE CREEK RD 1416101610 ZIP CODE NOBLESVILLE IN 46080 46060 119696969621 0935059955** #0000030500# AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE: to maintain or to attend successfully completed treatment at a program approved by this board and have 6.) Have you had any clinical privileges or dependent upon alcohot or any chemical substance; or been treated for, or been 3.) Have any malpitactice awards been paid by you or on your behalf for acts occurring in any state other than Ohio? Have you surrendered, or consented to limitation of, or to reprimand or probation substances in any jurisdiction? You may 1.) Have you been found guilty of, or pled drug or alcohol dependency or abuse? You may answer "NO" to this question if you have statutory as contained in sections 4731.224 and 4731.25, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to Has any board, bureau, department, agency, or other body, including those in Ohio, other than this board, filed any complaints a license to practice any healthcare profession or state or federal controlled answer "NO" to this question if the only such surrender or consent was given to authority restricted or revoked for conviction of, a misdemeanor or felony? Check this Box if you have NO principal you been addicted subsequently adhered to all Redacte as suffering from, institutional reasons other than failure ò on a timely basis intervention WUST BE ENTERED AT EACH RENEWAL no contest to, DEO!!!DED charges, allegations the board offices. similar ŏ requirements against you? concerning, suspended, Practice address. 2.) Have diagnosed this board. privileges guilty or reatment records other

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MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127 GYNECOLOGY GYN 77 SOUTH HIGH STREET, CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2001 - 2003 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION

AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT. SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3 7-15-0 RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL (SIGNATURE OF APPLICANT) (DATE) AMOUNT DUE DATE DUE \$50 Late Fee Due After IDENTIFICATION NUMBER 01/01/04 35-05-9955-S \$305.00 10/01/03 STRICKLAND, M.D. NEIL RICHARD 18871 LITTLE CHICAGO NOBLESVILLE IN 46060 11+1AMI

DETACH HERE AND REMIT THIS PORTION WITH FEE

0935059955 30500 AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR 1.) Have you been found guilty of, or pled guilty or, contest to, or received treatment or intervention in 2.) Have you been addicted to or dependent upon alcohol or been treated for, or been any chemical substance; or diagnosed as suffering from, drug or alcohol dependency have successfully completed or abuse? You may answer "NO" to this question if you enrolled in, a program approved by this Board and have adhered to all statutory requirements if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, other than this board, filed any charges, allegations or or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this similar institutional authority suspended, restricted or revoked for reasons other than fallure to you or on your behalf for acts occurring in any Have you had any clinical privileges or other You must answer "YES maintain records on a timely basis or to attend staff meetings? treatment at, or are currently question if the only such surrender or consent lieu of conviction of, misdemeanor or felony? 3.) Have any malpractice awards been paid 5.) Have you surrendered, or consented PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS Check this Box if you have NO principal Zip Code Redacted MUST BE ENTERED AT EACH RENEWAL. State DEOLIDED and subsequent to treatment. complaints against you? was given to this board. CERTIFICATE: state other than Ohio? 8 Ş limitation of, YES Practice address. 3 711700 **0**273 136 7182003 board offices. Street 8 7 8 SE NABATADAM 8 during ÆS, YES ÉS ES.

Renewal ID 228064 Page 1 of 2

Date Posted: 2/15/2007 2:55:21 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

registration.	
License Information	
License Number	35.059955
License Name	NEIL STRICKLAND
Email Address	
Fees	
Relicensure Fee	\$305.00
Late Fee	\$50.00
	=======
	Total Fees \$355.00
Specialty Codes	
1. Please select one specialty from the field belo	w
-	EMERGENCY MEDICINE
2. Please select one specialty from the field belo	w if annlicable
2. Trease select one specialty from the field belo	GYNECOLOGY
3. Please select one specialty from the field belo	
	{not Answered}
CME-Physicians	
1. Have you met the above CME requirements for	-
	YES
Discipline	
1. Have you been found guilty of, or pled guilty	
treatment or intervention in lieu of conviction	
	NO
2. Have you surrendered, consented to limitation	
probation concerning, a license to practice an	•
federal privileges to prescribe controlled subs than Ohio?	tances in any jurisdiction other
man Onto.	NO
A 11	
3. Have any malpractice awards been paid by yo	ou or on your benail for acts

occurring in any state other than Ohio?

	NO
4.	Has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u> , filed any charges, allegations or complaints against you?
	NO
5.	Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons <u>other than failure to maintain records on a timely basis or to attend staff meetings?</u>
	NO
6.	Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
	NO
Soc 1.	cial Security Number
	Redacted
Nu	rse Collaboration Info
1.	Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
	NO
2.	List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.
	{not Answered}
do	nderstand that submitting a false, fraudulent, or forged statement or cument or omitting a material fact in obtaining licensure may be grounds for ciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied

with all criteria for applying on line.

Renewal ID 345608 Page 1 of 2

Date Posted: 11/23/2007 6:20:14 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Lio Lio	cense Information cense Number cense Name nail Address	3: NEIL STRIC npstrickland@	
Fe	es licensure Fee		\$205.00
Re	ncensure ree	==	\$305.00
		Total Fees	\$305.00
Sp	ecialty Codes		
1.	Please select one specialty from the field below		
	EME	RGENCY ME	EDICINE
2.	Please select one specialty from the field below, if application	ble. GYNEC	OLOGY
3.	Please select one specialty from the field below, if applica	ble.	
	••	{not An	iswered}
	ME-Physicians Have you met the above CME requirements for your licenteen.		YES
Di	scipline		
	Have you been found guilty of, or pled guilty or no contest treatment or intervention in lieu of conviction of, a misden	neanor or felor	ny?
			NO
2.	Have you surrendered, consented to limitation of, or to sus probation concerning, a license to practice any healthcare federal privileges to prescribe controlled substances in any than Ohio?	profession or s	state or
			NO
3.	Have any malpractice awards been paid by you or on your occurring in any state other than Ohio?	behalf for act	s
			NO

Renewal ID 345608 Page 2 of 2

4.	Has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u> , filed any charges, allegations or complaints against you?
	NO
5.	Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
	NO
6.	Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
	NO
So 1.	cial Security Number
••	Redacted
Nu	rse Collaboration Info
1.	Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
	NO
2.	List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.
	{not Answered}

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 8/15/2009 2:07:47 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration. License Information License Number 35.059955 License Name **NEIL STRICKLAND** Fees Relicensure Fee \$305.00 Total Fees **\$305.00 Specialty Codes** 1. Please select one specialty from the field below GYNECOLOGY 2. Please select one specialty from the field below, if applicable. {not Answered} 3. Please select one specialty from the field below, if applicable. {not Answered} CME-Physicians 1. Have you met the above CME requirements for your license? YES Discipline 1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony? 2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio? NO 3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio? NO

4. Has any board, bureau, department, agency, or any other body, including those

Renewal ID 916876 Page 2 of 2

	in Ohio other than this board, filed any charges, allegations or complaints against you?
	NO
5.	Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons <u>other than failure to maintain records on a timely basis or to attend staff meetings?</u>
	NO
6.	Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
	NO
So	cial Security Number
1.	<u> </u>
	Redacted
Nu	rse Collaboration Info
1.	Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
	NO
2.	List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.
	{not Answered}
1	nderstand that submitting a false fraudulant or forged statement or

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

than Ohio?

Date Posted: 7/14/2011 1:23:50 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of

registration.	may result in denial of		
License Information			
License Number	35.059955		
License Name	NEIL STRICKLAND		
Fees			
Relicensure Fee	\$305.00		
	Total Fees \$305.00		
	10tal rees 5505.00		
Medical Board Correspondence Email			
1. Did you provide a Credential email address? Ple	ease note this information is		
a public record.			
	YES		
Specialty Codes			
1. Please select one specialty from the field below			
	GYNECOLOGY		
2. Please select one specialty from the field below, if a	applicable.		
	{not Answered}		
3. Please select one specialty from the field below, if a	applicable.		
	{not Answered}		
CME-Physicians			
1. Have you met the above CME requirements for you			
	YES		
Discipline			
1. Have you been found guilty of, or pled guilty or no treatment or intervention in lieu of conviction of, a result of the conviction of t			

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other

. NO

	NO
3.	Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
	NO
4.	Has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u> , filed any charges, allegations or complaints against you?
	NO
5.	Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
	NO
6.	Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
	NO
So 1.	cial Security Number
1.	Redacted
Νυ	rse Collaboration Info
	Are you currently in a collaboration agreement with any Clinical Nurse
-•	Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
	NO
2.	List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.
	{not Answered}
Oł	io Employment
1.	Do you practice in Ohio?
	YES
	io Workforce Questions
1.	"Clinical" - direct patient care
	10-14
2.	"Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose
2.	"Research" - study of a treatment, procedure or medication done in a medical

3.	contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)
	$\dots \dots 0$
4.	"Education" - preceptor, mentor, etc.
	$\dots \dots 0$
5.	"Volunteering" - providing medical and medical-related services at no cost
	0
6.	"Other" - medical professional activities not included in above categories
	0
Cli	inical - Practice setting
1.	Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).
	10-14
2.	Enter the number of hours per week spent in "Hospital (in-patient care)".
	0
3.	Enter the number of hours per week spent in "Emergency Room".
	0
4.	Enter the number of hours per week spent in "Urgent Care".
	0
5.	Enter the number of hours per week spent in "Other".
	0
w	orkforce Counties
	Enter the first zip code:
	45429
2.	Enter the first county:
	Montgomery
3.	Enter the second zip code:
	45241
4.	Enter the second county:
	Hamilton
5.	Enter the third zip code:
	{not Answered}
6.	Enter the third county:
	{not Answered}

.....NO

Practice Arrangement (size)

1.	Solo practitioner		
	NO		
2.	Single-specialty Group		
	2-5		
3.	Multi-specialty Group		
	N/A		
4.	Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)		
	NO		
Workforce Language Question 1. Do practitioners or staff in your practice communicate in sign language or in a			
	language other than spoken English?		
	NO		
ΑĒ	BMS Certified		
1.	Are you certified by an ABMS Board?		

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.