APP-SENT 11/27/89

STATE MEDICAL BOARD OF OHIO
REQUEST FOR APPLICATION FORMS

PLEASE TYPE OR PRINT CLEARLY

STATE MEDICAL BOARD OF OHIO 30 E BROAD ST COLUMBUS OHIO 43266-0315

I hereby submit the following information in order to receive an application for licensure:

NAME: STRICKLAND (LAST (Surname)) NEIL (FIRST) RICHARD (MIDDLE) (SUFFIX (Jr., II))

ADDRESS: 14050 ALLISONVILLE ROAD (STREET & NUMBER); NOBLESVILLE (CITY) IN (STATE) 46060 (ZIP) USA (COUNTRY)

TELEPHONE: BUSINESS: (317) 773-1878 (AREA CODE & NUMBER) HOME: (317) 773-1878 (AREA CODE & NUMBER)

BIRTH DATE: 12/10/30 (MO/DAY/YR) BIRTH PLACE: INDIANAPOLIS (CITY) IN (STATE) USA (COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: INDIANA U. SCHOOL OF MED.; 1100 WEST MICHIGAN ST; INDIANAPOLIS, IN; USA
(SCHOOL NAME; STREET ADDRESS; CITY; STATE; COUNTRY)

91 / 52 (FROM: MO/YR) 61 / 56 (TO: MO/YR) M.D. (DEGREE RECEIVED) 6-11-56 (DATE RECEIVED: MO/DAY/YR)

OTHER MEDICAL SCHOOLS ATTENDED: (IF "NONE" ENTER "NONE")

(SCHOOL NAME; STREET ADDRESS; CITY; STATE; COUNTRY)

/ / (FROM: MO/DAY/YR) / / (TO: MO/DAY/YR) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

(SCHOOL NAME; STREET ADDRESS; CITY; STATE; COUNTRY)

/ / (FROM: MO/DAY/YR) / / (TO: MO/DAY/YR) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

E.C.F.M.G. CERTIFICATE: YES _____ NO ✓ NUMBER _____ DATE ISSUED / /

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: _____ (HOSPITAL OR INSTITUTION) AFFILIATED WITH: _____ (NAME OF MEDICAL SCHOOL)
(IF "NONE", ENTER "NONE")

ADDRESS: _____ (STREET & NUMBER; CITY; STATE; ZIP) DATE: / / (FROM) / / (TO)

QUALIFYING EXAM TAKEN: _____ DATE: / /

POSTGRADUATE TRAINING

LIST ALL POSTGRADUATE TRAINING (INTERNSHIP, RESIDENCY OR CLINICAL FELLOWSHIP), UNDERTAKEN IN THE U.S. OR CANADA. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

HOSPITAL: METHODIST HOSPITAL; 1600 N CAPITOL AVE; INDIANAPOLIS IN
(NAME; STREET ADDRESS; CITY; STATE)
POSITION: INTERN - ROTATING DEPARTMENT: _____ DATE: JULY / 1956 (FROM: MO/YR) JULY / 1957 (TO: MO/YR)

HOSPITAL: SAME
(NAME; STREET ADDRESS; CITY; STATE)
POSITION: OB-GYN RESIDENT DEPARTMENT: OB G DATE: JULY / 1957 (FROM: MO/YR) JULY / 1960 (TO: MO/YR)

HOSPITAL: _____
(NAME; STREET ADDRESS; CITY; STATE)
POSITION: _____ DEPARTMENT: _____ DATE: / (FROM: MO/YR) / (TO: MO/YR)

HOSPITAL: _____
(NAME; STREET ADDRESS; CITY; STATE)
POSITION: _____ DEPARTMENT: _____ DATE: / (FROM: MO/YR) / (TO: MO/YR)

LICENSES IN OTHER COUNTRIES

LIST ALL FOREIGN COUNTRIES IN WHICH YOU HOLD OR HAVE HELD A FULL RIGHT TO PRACTICE MEDICINE AND SURGERY. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

COUNTRY: _____ ISSUE DATE: __/__/__ LICENSE # _____ CURRENT: YES__ NO__

COUNTRY _____ ISSUE DATE: __/__/__ LICENSE # _____ CURRENT: YES__ NO__

LICENSES IN THE UNITED STATES

LIST ALL STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY. INDICATE THE LICENSE NUMBER, DATE OF ISSUANCE, WHETHER OR NOT THE LICENSE IS CURRENT, AND THE BASIS OF LICENSURE (E.G., FLEX EXAM, ENDORSEMENT OF OTHER STATE LICENSE, ENDORSEMENT OF DIPLOMATE STATUS, ETC.) IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

STATE: INDIANA ISSUE DATE: 10/10/57 LICENSE #: 01018157 CURRENT: YES ✓ NO__

BASIS OF LICENSURE: EXAMINATION

STATE: _____ ISSUE DATE: __/__/__ LICENSE #: _____ CURRENT: YES__ NO__

BASIS OF LICENSURE: _____

STATE: _____ ISSUE DATE: __/__/__ LICENSE #: _____ CURRENT: YES__ NO__

BASIS OF LICENSURE: _____

STATE BOARD OR FLEX EXAMINATIONS TAKEN

LIST EACH AND EVERY STATE BOARD OR FLEX EXAM WHICH YOU HAVE TAKEN WHETHER IN OHIO OR ANY OTHER STATE, TERRITORY OR PROVINCE. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

STATE: _____ DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

STATE: _____ DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

STATE: _____ DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

ADDITIONAL ELIGIBILITY INFORMATION -- ANSWER ALL QUESTIONS

DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS? PENDING ____ YES ____ NO ✓ DATE __/__

DIPLOMATE OF THE NATL BOARD OF OSTEO MEDICAL EXAMINERS? PENDING ____ YES____ NO ✓ DATE __/__

ARE YOU APPLYING TO SIT FOR THE FLEX EXAM IN OHIO? YES ____ NO ✓

A LICENTIATE OF THE MEDICAL COUNSEL OF CANADA? YES ___ NO ✓ DATE __/__/__

A U.S. CITIZEN? YES ✓ NO ___ BASIS OF CITIZENSHIP BIRTH DATE: 12/10/30

A GRADUATE OF A MEXICAN MEDICAL SCHOOL? YES ___ NO ✓ DATE __/__/__

DEGREE OBTAINED (CHECK ONLY ONE): ACTA_____ TITULO_____ MEDICO CIRUJANO_____

HAVE YOU ACHIEVED A SCORE OF AT LEAST TWO HUNDRED THIRTY (230) ON THE TEST OF SPOKEN ENGLISH OF THE EDUCATIONAL TESTING SERVICE AS REQUIRED UNDER SECTION 4731.09, O.R.C.? (THE TOEFL, ECFMG EXAM, etc., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TSE) YES____ NO____

OHIO RESIDENT AT THE TIME OF ADMISSION TO MEDICAL SCHOOL? YES ___ NO ✓

IF YES, GIVE FULL ADDRESS AT THAT TIME:

_____ _____ _____ _____

STREET ADDRESS CITY STATE ZIP

CERTIFICATION

I, NEIL R. STRICKLAND, M.D. , HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING REQUEST FOR APPLICATION FORM; THAT THE STATEMENTS THEREIN ARE STRICTLY TRUE IN EVERY RESPECT AND THAT I HAVE READ AND UNDERSTAND THIS CERTIFICATION.

Neil R. Strickland M.D. 11-17-89

SIGNATURE DATE

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

AM

12-33

PRELIMINARY EDUCATION FORM

My name IN FULL is STRICKLAND (LAST) NEIL (FIRST) RICHARD (MIDDLE)

High School or Equivalent: SHORTRIDGE H.S. (SCHOOL NAME) INDIANAPOLIS (CITY) IN (STATE) USA (COUNTRY)

1 1945 (FROM: MO/YR) 6149 (TO: MO/YR) DIPLOMA (DEGREE)

Undergraduate College or Equivalent: BUTLER UNIVERSITY (SCHOOL NAME) INDIANAPOLIS (CITY) IN (STATE) USA (COUNTRY)

9149 (FROM: MO/YR) 6152 (TO: MO/YR) B.S. (DEGREE)

STATE MEDICAL BOARD OF OHIO JAN 2 PM 4:02

(SCHOOL NAME) (CITY) (STATE) (COUNTRY)

/ (FROM: MO/YR) / (TO: MO/YR) (DEGREE)

Medical School of Graduation: INDIANA UNIVERSITY (SCHOOL NAME) INDIANAPOLIS (CITY) IN (STATE) USA (COUNTRY)

9152 (FROM: MO/YR) 6156 (TO: MO/YR) M.D. (DEGREE)

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: 76070

DATE ISSUED: 3/1/90

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.

Ray 2. Bumgarner
Entrance Examiner

Henry G. Cramblett M.D.
Secretary

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43266-0315

PRELIMINARY EDUCATION FORM

My name IN FULL is STRICKLAND, NEIL RICHARD
LAST FIRST MIDDLE

High School or Equivalent:

SCHOOL NAME	CITY	STATE	COUNTRY
SHORTRIDGE H.S.	INDIANAPOLIS	IN	USA

FROM (DATE)	TO (DATE)	DEGREE
9/1/44	6/1/49	

Undergraduate College or Equivalent:

SCHOOL NAME	CITY	STATE	COUNTRY
BUTLER UNIVERSITY	INDIANAPOLIS	IN	USA

FROM (DATE)	TO (DATE)	DEGREE
9/ /49	6/ /52	B.S.

SCHOOL NAME	CITY	STATE	COUNTRY

FROM (DATE)	TO (DATE)	DEGREE
/ /	/ /	

Medical School of Graduation:

SCHOOL NAME	CITY	STATE	COUNTRY
INDIANA UNIVERSITY	INDIANAPOLIS	IN	USA

FROM (DATE)	TO (DATE)	DEGREE
9/ /52	6/ /56	M.D.

STATE MEDICAL BOARD
89 DEC -5 PM 2:25

OMA pre-Conv. post Indianapolis 2-1-90

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 (LAST/Surname) NEIL (FIRST) RICHARD (MIDDLE) (SUFFIX Jr., II)

3. NAME (As you prefer it inscribed on your Ohio license): STRICKLAND, (LAST/Surname) NEIL (FIRST) RICHARD (MIDDLE) (SUFFIX Jr., II)

4. ALTERNATE NAMES (IF "NONE" ENTER "NONE"): (LAST/Surname) (FIRST) NONE (MIDDLE) (SUFFIX Jr., II)

5. CURRENT ADDRESS: 14050 Allisonville Road (STREET NUMBER & NAME)

Noblesville (CITY) Indiana (STATE) 46060 (ZIP CODE) USA (COUNTRY)

6. PHYSICAL DESCRIPTION: 71" (HEIGHT) 210 (WEIGHT) Gray (HAIR COLOR) Blue (COLOR OF EYES) Sternotomy scar (IDENTIFYING MARKS)

7. SEX: MALE [X] FEMALE [ ] FOR STATISTICS ONLY (Optional)

8. CITY IN OHIO WHERE YOU PLAN TO PRACTICE: Cincinatti (CITY) OR (COUNTY)

PLANS OF PRACTICE: One day per week, outpatient Gyn only

9. SPECIALTY BOARDS (USA, Canada and foreign countries)

NAME OF SPECIALTY BOARD	BOARD CERTIFIED YES	NO	YEAR CERTIFIED	COUNTRY
	[ ]	[ ]		
	[ ]	[ ]		
	[ ]	[ ]		

STATE MEDICAL BOARD 90 JAN 22 PM

FOR OFFICE USE ONLY 34 35

1-7
12-33-63
1-24-90
185.00 pc 1760

PAPERCLIP (DO NOT STAPLE) YOUR CHECK OR MONEY ORDER HERE

RESUME

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.

Brickland

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	CLIN. %	ADMIN. %
a. July 56 (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. 7 57 (month year) TO 7 60 (month year)	same as above (Hospital/University/Other) Street Address City/State Zip	OBG Resident	100	
c. 7 60 (month year) TO ? 67 (month year)	same as above (Hospital/University/Other) Street Address City/State Zip	OBG Private Pr.	100	
d. 7 60 (month year) TO present (month year)	Community Hospital of Indpls. (Hospital/University/Other) 1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
e. 1 77 (month year) TO 6 87 (month year)	same as above (Hospital/University/Other) Street Address City/State Zip	Emergency	90	10

STATE MEDICAL BOARD
90 JAN 2 PM 4:02

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	CLIN. %	ADMIN. %
f. month year TO month year	Hospital/University/Other Street Address City/State Zip			
g. month year TO month year	Hospital/University/Other Street Address City/State Zip			
h. month year TO month year	Hospital/University/Other Street Address City/State Zip			
i. month year TO month year	Hospital/University/Other Street Address City/State Zip			
j. month year TO month year	Hospital/University/other Street Address City/State Zip			
k. month year TO month year	Hospital/University/Other Street Address City/State Zip			
l. month year TO month year	Hospital/University/Other Street Address City/State 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
1.	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?	[✓]	[ ]
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?	[ ]	[✓]
5.	Have you ever transferred from one postdoctoral training program to another?	[ ]	[✓]
6.	Have you ever, for any reason, lost Specialty Board Certification in the U.S. or elsewhere?	[ ]	[✓]
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?	[ ]	[✓]
8.	Have you ever voluntarily surrendered any professional license, certificate, or registration issued to you by a board, bureau, department, agency, or other body?	[ ]	[✓]
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?	[ ]	[✓]
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 you 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?	[ ]	[✓]

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?	[ ]	[✓]
14.	Have you ever been treated but not hospitalized, for emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
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?	[✓]	[ ]
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?	[ ]	[✓]
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?	[ ]	[✓]

Additional information

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

R Strickland MD

FORM 1

AMG

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

I, 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 17 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: Excellent
His/~~her~~ relationship with patients is: Excellent
Additional comments: _____

I hereby recommend him/~~her~~ for full licensure to practice medicine/~~osteopathic medicine~~ in Ohio.

Ted W. Grisell MD
Signature of Recommending Physician

Ted W. Grisell MD
Name of Recommending Physician
(Please print or type)

5317 E. 16th St
Indpls IN 46218
Address of Recommending Physician
(Include City, State, Zip)

317-359-8261
Telephone Number
(Include Area Code)

01021489 Indiana
State of Licensure and License Number
of Recommending Physician

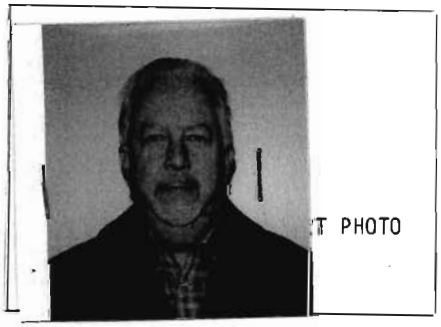
(SEAL)

Subscribed and sworn to this 12th day of Jan, 1990.

James Theodore Hill Jr
Notary Public
Resident of Marion County
State of Indiana

2/1/93
Date Commission Expires

County of Marion


T PHOTO

Upon completion return to:

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

STATE MEDICAL BOARD
90 JAN 19 AM 9:57

Neil Strickland MD
Signature of Applicant

1-9-90
Date Photo Taken

FORM 1

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

I, WAYNE H. THOMPSON MD, a licensed and practicing physician in the state of
Name of Recommending Physician
INDIANA affirm that NEIL STRICKLAND MD, has been known
Name of Applicant
to me personally and professionally for 30 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: Excellent
His/her relationship with patients is: Excellent
Additional comments: He would make a fine addition to your medical staff

I hereby recommend him/her for full licensure to practice medicine/osteopathic medicine in Ohio.

Wayne H. Thompson MD
Signature of Recommending Physician

WAYNE H. THOMPSON M.D
Name of Recommending Physician
(Please print or type)

5470 E 16 ST
INDIANAPOLIS, IND 46218
Address of Recommending Physician
(Include City, State, Zip)

317 - 359-8895
Telephone Number
(Include Area Code)

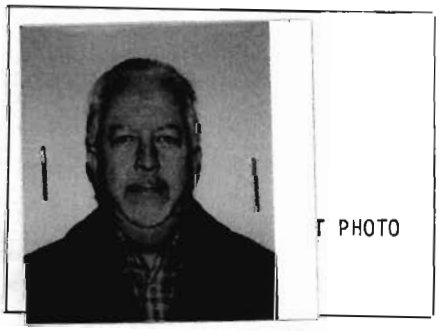
(SEAL)

INDIANA L.N. 16256
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 12th day of January, 1990.

Notary Public

9/18/91
Date Commission Expires



T PHOTO

Upon completion return to:

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

90 JAN 18 PM 12:49
STATE MEDICAL BOARD

Neil A. Strickland MD
Signature of Applicant

1-9-90
Date Photo Taken

STATE MEDICAL BOARD
89 DEC 26 PM 4:43

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 NEIL RICHARD STRICKLAND, M.D. (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[ ] intern
[X] resident in OB/GYN (Department)
[ ] clinical fellow

at Methodist Hospital Graduate Medical Center (Name of Hospital), 1701 North Senate Boulevard (Complete Address of Hospital)

from 07/01/56 (beginning (month/day/year)) to 06/30/60 (ending (month/day/year)). It is further certified that the above name

[X] was awarded a certificate on 06/30/60 (month/day/year)
[ ] was not

and that the training

[X] was accredited by ACGME/AOA.
[ ] was not

X _____
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

STATE OF INDIANA

STATE MEDICAL BOARD

89 DEC 27 PM 2:58

EVAN BAYH - Governor

Health Professions Bureau
One American Square
Suite #1020, Box 82067
Indianapolis, Indiana 46282
(317) 232-2960

December 19, 1989

Ohio State Medical Board
77 S High St 17th Flr
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:
RD Henderson
Ms. Rejina D. Henderson
Records Division Coordinator

FORM 3

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 applicants who are applying for endorsement of another state license.

Acting on behalf of the _____
Name of State Board

I do hereby certify that Dr. _____
Name of Licensee

was on the _____ day of _____ 19____, granted a license to practice _____ in the State of _____ based upon written examination of:

[ ] FLEX Examination administered in this state

[ ] Examination administered in _____, but accepted as if taken in this state

[ ] Written examination prepared by this state

[ ] Other (Please specify)_____

***License current? Yes___ No___ If not, please explain_____

I further certify that the aforesaid physician in his/her written examination before this Board on _____, obtained a general average of _____or a FLEX Weighted Average of _____ in the following subjects:

SUBJECT	PERCENTAGE	SUBJECT	PERCENTAGE

or a Component I score of_____on _____ and Component II score of _____on _____.
month/year month/year

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES_____ NO _____CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state? Yes _____ NO_____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state? YES_____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

_____
Signature of Secretary, President or Executive Secretary, Original signatures only, name stamps will not be accepted.

Upon completion, return to:

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

_____
Date

AFFIDAVIT AND RELEASE

STATE MEDICAL BOARD
OF OHIO
90 JAN 22 PM 4:03

AFFIDAVIT AND RELEASE OF APPLICANT

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.

Neil R. Strickland M.D.
Signature of Applicant

Subscribed and sworn to before me this 18th day of January 1990.

Brenda J. Thomas
Notary Public Signature

(NOTARY SEAL)

May 5th 1992
Date Commission Expires

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO 76070

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.

Ray L. Baumgartner
Entrance Examiner

Henry S. Cranblas M.D.
Secretary

3-1-90
Date Issued

FOR BOARD USE ONLY 033600

NAME: Strickland, Neil F.

CERTIFICATE #: 59955 DATE ISSUED 6-5-90

FILED November 27, 19 89

FEE

DETERMINATION:

BOARD ACTION: 2/90 PV

BASIS OF LICENSURE:

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 02/22/

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: /

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
NAME: WAYNE THOMPSON MD CITY: INDPLS STATE: IN

SPECIALITY CODE:
SPECIALITY CODE:
SPECIALITY CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:		X	
FED INFO:		X	
REC FORM:		X	
ECFMG:		Y	

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
HENRY G. CRAMBLETT, MD			
JUDITH S. DANIELS, MD			
THOMAS E. GRETTER, MD			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
JOHN E. RAUCH, DO	✓		
CAROL ROLFES			
JOHNATHAN S. ROSS,MD			
TIMOTHY L. STEPHENS, JR., MD			

STATE MEDICAL BOARD OF OHIO
FEB 28 90

RESUME

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Brickland

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	CLIN. %	ADMIN. %
a. July 56 (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. 7 57 (month year) TO 7 60 (month year)	same as above — Hospital/University/Other Street Address City/State Zip	OBG Resident	100	
c. 7 60 (month year) TO ? 67 (month year)	same as above — Hospital/University/Other Street Address City/State Zip	OBG Private Pr.	100	
d. 7 60 (month year) TO present (month year)	Community Hospital of Indpls. — Hospital/University/Other 1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
e. 1 77 (month year) TO 6 87 (month year)	same as above — Hospital/University/Other Street Address City/State Zip	Emergency	90	10

STATE MEDICAL BOARD

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 02/22/

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:
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DATE OF EXAM: 09/57 STATE EXAM WAS TAKEN: IN SCORE: 84.4%

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SPECIALITY CODE:
SPECIALITY CODE:
SPECIALITY CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:		X	
FED INFO:		X	
REC FORM:		X	
ECFMG:		X	

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
HENRY G. CRAMBLETT, MD			
JUDITH S. DANIELS, MD			
THOMAS E. GRETTER, MD			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
JOHN E. PAUCH, DO			
CAROL ROLFES			
JOHNATHAN S. ROSS,MD			
TIMOTHY L. STEPHENS, JR., MD	✓		

STATE MEDICAL BOARD OF OHIO

MAR 14 90

RESUME

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d. 7 60 (month year) TO present (month year)	Community Hospital of Indpls. (Hospital/University/Other) 1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
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STATE MEDICAL BOARD

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 02/22/

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
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CODE:
CODE:

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AMA/AOA:		X	
TSE SCORE:		X	
FED INFO:		X	
REC FORM:		X	
ECFMG:		Y	

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT	✓		
HENRY G. CRAMBLETT, MD			
JUDITH S. DANIELS, MD			
THOMAS E. GRETTER, MD			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
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JOHNATHAN S. ROSS,MD			
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e.	1 77 (month year) TO 6 87 (month year)	same as above Hospital/University/Other Street Address City/State Zip	Emergency	90	10

STATE MEDICAL BOARD OF INDIANA
MAR 06 90
STATE MEDICAL BOARD OF INDIANA

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 02/22/

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
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CITY: ST:
STARTING DATE: / ENDING DATE: /

STATE BOARD EXAM

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LETTERS OF RECOMMENDATION

NAME: TED GRISELL MD CITY: INDPLS STATE: IN
NAME: WAYNE THOMPSON MD CITY: INDPLS STATE: IN

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:		X	
FED INFO:		X	
REC FORM:		X	
ECFMG:		X	

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
HENRY G. CRAMBLETT, MD			
JUDITH S. DANIELS, MD	✓		
THOMAS E. GRETTER, MD			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
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STATE MEDICAL BOARD OF OHIO

MAR 0 6 90

STATE MEDICAL BOARD OF OHIO

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 02/22/

NAME: STRICKLAND, NEIL RICHARD
SCHOOL: INDIANA UN SCH MED, INDIANAPOLIS IN
DEGREE CONFERRED: MD
DATE CONFERRED: 06/11/56

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HOSPITAL:
CITY: ST:
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RESIDENCY

HOSPITAL: METHODIST HOSP
CITY: INDPLS ST: IN
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	NOT IN	OK	N/A
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REC FORM:		X	
ECFMG:		X	

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
HENRY G. CRAMBLETT, MD			
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a.	July (month) 56 (year) TO 7 (month) 57 (year)	Methodist Hospital Hospital/University/Other 1701 N.Senate Blvd. Indianapolis, IN 46202 Street Address City/State Zip	Rotating intern	100	
b.	7 (month) 57 (year) TO 7 (month) 60 (year)	same as above Hospital/University/Other Street Address City/State Zip	OBG Resident	100	
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STATE MEDICAL BOARD OF OHIO
MAR 06 90

AMERICAN MEDICAL GRADUATE
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b.	7 57 (month year) TO 7 60 (month year)	same as above Hospital/University/Other Street Address City/State Zip	OBG Resident	100	
c.	7 60 (month year) TO ? 67 (month year)	same as above Hospital/University/Other Street Address City/State Zip	OBG Private Pr.	100	
d.	7 60 (month year) TO present (month year)	Community Hospital of Indpls. Hospital/University/Other 1500 N. Ritter Ave. Indianapolis, IN 46219 Street Address City/State Zip	OBG Private Pr.	100	
e.	1 77 (month year) TO 6 87 (month year)	same as above Hospital/University/Other Street Address City/State Zip	Emergency	90	10

STATE MEDICAL BOARD OF OHIO

MAR 0 6 90

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 02/22/

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: /

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
NAME: WAYNE THOMPSON MD CITY: INDPLS STATE: IN

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:		X	
FED INFO:		X	
REC FORM:		X	
ECFMG:		Y	

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD	✓		
RAYMOND ALBERT			
HENRY G. CRAMBLETT, MD			
JUDITH S. DANIELS, MD			
THOMAS E. GRETTER, MD			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
JOHN E. RAUCH, DO			
CAROL ROLFES			
JOHNATHAN S. ROSS,MD			
TIMOTHY L. STEPHENS, JR., MD			

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Strickland

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AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 02/22/

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
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NAME: WAYNE THOMPSON MD CITY: INDPLS STATE: IN

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:		X	
FED INFO:		X	
REC FORM:		X	
ECFMG:		Y	

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
HENRY G. CRAMBLETT, MD			
JUDITH S. DANIELS, MD			
THOMAS E. GRETTER, MD			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
JOHN E. RAUCH, DO			
CAROL ROLFES	✓		
JOHNATHAN S. ROSS,MD			
TIMOTHY L. STEPHENS, JR., MD			

STATE M... OF...

MAR 0 5 90

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	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:		X	
FED INFO:		X	
REC FORM:		X	
ECFMG:		X	

STATE MEDICAL BOARD OF OHIO
MAR 0 1 90

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
HENRY G. CRAMBLETT, MD			
JUDITH S. DANIELS, MD			
THOMAS E. GRETTER, MD			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM	✓		
CARLA S. O'DAY, MD			
JOHN E. RAUCH, DO			
CAROL ROLFES			
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AMA/AOA:		X	
TSE SCORE:		X	
FED INFO:		X	
REC FORM:		X	
ECFMG:		X	

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RAYMOND ALBERT			
HENRY G. CRAMBLETT, MD	✓		
JUDITH S. DANIELS, MD			
THOMAS E. GRETTER, MD			
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TO present (month) (year)	Street Address City/State Zip			
e. 1 (month) 77 (year)	same as above Hospital/University/Other	Emergency	90	10
TO 6 (month) 87 (year)	Street Address City/State Zip			

Castleton Obstetrics
AND GYNECOLOGY, INC

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

JUN 0 1 90

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. In 1987 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,

Jeffrey A. Boester, M.D., FACOG

JAB/csg

7250 Clearvista Drive, Indianapolis, Indiana 46256
Suite 240 (317) 842-4341

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

Returned 12/5/89

11/27/89

Dear Doctor: Strickland,

Your Request for Application Form has been received. However, the following must be completed:

_____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

_X_ Complete the Preliminary Education form

_XX_ Other: Dr. Strickland, you did not return your Preliminary Education Form. Enclosed you will find another one. Please complete and return to the MEDICAL BOARD as soon as possible

Thank you.

STATE MEDICAL BOARD
89 DEC -5 PM 2:25

Only those sections marked with an "X" apply to you. All responses must be completed on the enclosed form(s).

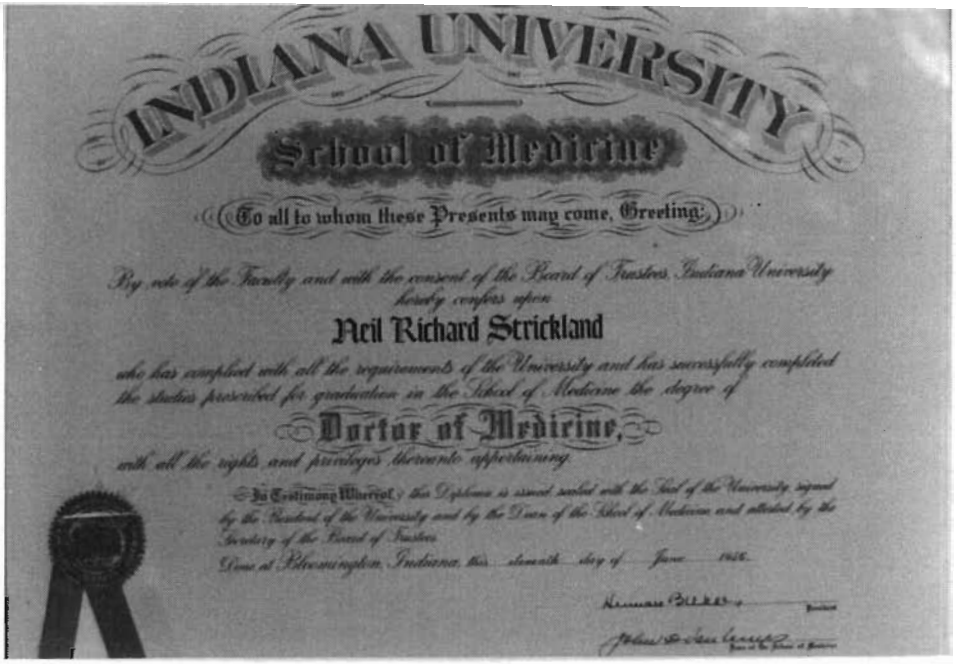
Sincerely,

Penny McKenzie

Penny McKenzie
Chief, Licensure

PM/ad

Enclosure



INDIANA UNIVERSITY

School of Medicine

To all to whom these Presents may come, Greeting:

By vote of the Faculty and with the consent of the Board of Trustees, Indiana University hereby confers upon

Neil Richard Strickland

who has complied with all the requirements of the University and has successfully completed the studies prescribed for graduation in the School of Medicine the degree of

Doctor of Medicine,

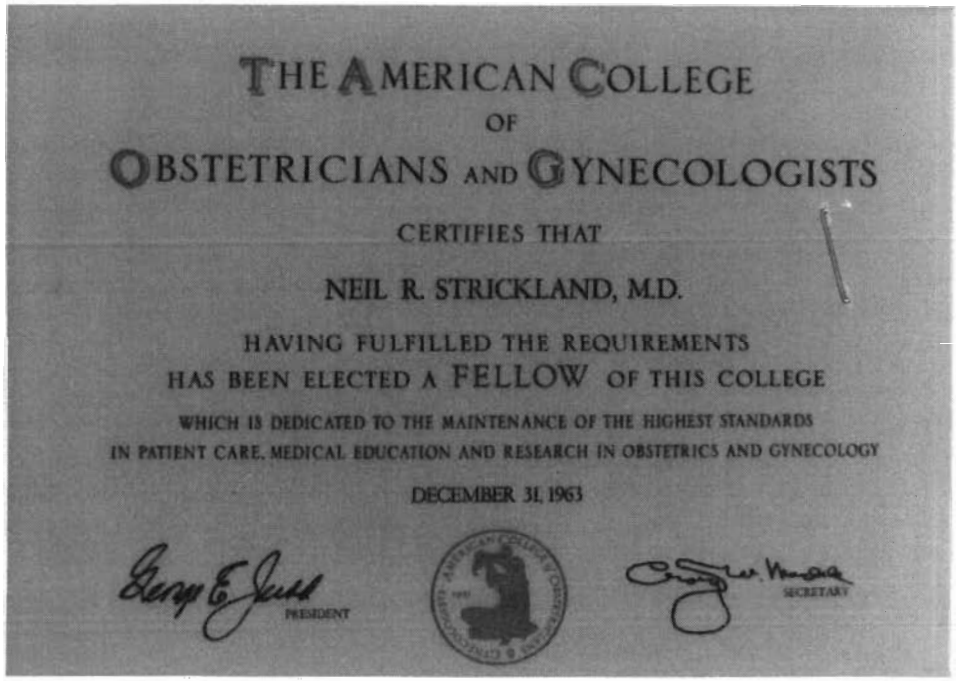
with all the rights and privileges thereunto appertaining.

In Testimony Whereof, this Diploma is issued sealed with the Seal of the University, signed by the President of the University and by the Dean of the School of Medicine and attested by the Secretary of the Board of Trustees.

Done at Bloomington, Indiana, this eleventh day of June 1958.

Herman B Wells
President

John D. Van Gorp
Dean of the School of Medicine



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

George E. Judd
PRESIDENT

AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS 1951

SECRETARY

I HEREBY CERTIFY THAT I HAVE RECEIVED MY WALL CERTIFICATE

NUMBER 59955, ON 8-1-90 (Date)

NEIL R. STRICKLAND, MD
Name

14050 ALLISONVILLE RD HAMILTON COUNTY
Street Address

NOBLESVILLE IN. 46060
City State/County Zip

Neil R Strickland MD
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. updated 11-29-91 RC

Your name	Print or Type—Last Name, First Name, Middle Initial: NEIL R. STRICKLAND, M.D			
Old Address	No. and Street: 14050 ALLISONVILLE RD. NOBLESVILLE, IN 46060	Apt. Suite No.: BC	P.O. Box	R.D. No.
	Post Office State: LICENSE NO. 59955	ZIP Code		
New Address	No. and Street: NEIL R. STRICKLAND, MD ~~14050 ALLISONVILLE RD~~	Apt. Suite No.: 4	P.O. Box	R.D. No.
	Post Office State: FISHERS, IN 46038	ZIP Code		
Sign Here	Signature: X Neil R Strickland MD	Date new address in effect: 11-1-91	Account No. (If any): 35-05-9955	

PS FORM 3576, JAN. 1984 U.S. G.P.O. 1985-470-019 RECEIVER. Be sure to record the above new address in your address book at home or office.

DETACH HERE AND REMIT THIS PORTION WITH FEE

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 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 EVERY RESPECT.

X _____
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-9955	$160.00	07/01/92

NEIL RICHARD STRICKLAND,M.D.
14050 ALLISONVILLE RD
FISHERS IN 46038

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

21 GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935059955 :00000160000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT

Street Street City State Zip Code County

HAVE YOU BEEN FOUND GUILTY OF, OR PLED GUILTY OR NO CONTEST TO :

	YES	NO
A.) A felony or misdemeanor.		X
B.) A federal or state law regulating the possession, distribution or use of any drug?		X

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

	YES	NO
1.) 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 section 4731.224, 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.		X
2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?		X
3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?		X
4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?		X

Redacted

(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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 1992-1994 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.

X Neil R. Strickland MD 12-94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-9955	$250.00	05/01/94

NEIL RICHARD STRICKLAND,M.D.
14050 ALLISONVILLE RD
FISHERS IN 46038

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GYN GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935059955 :00000 25000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

	YES	NO
1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.	☐	☑
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.	☐	☑
4.) Had malpractice insurance cancelled 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?	☐	☑
6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?	☐	☑
7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?	☐	☑
8.) After January 14, 1993, 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	☐	☑

SOCIAL SECURITY NUMBER
(Optional for purposes of identification

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

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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.

X [signature] MD 1-5-96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-9955	$250.00	05/01/96

NEIL RICHARD STRICKLAND,M.D.
14050 ALLISONVILLE RD
FISHERS IN 46038

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GYN GYNECOLOGY

✓ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

I:96969696 2I: 0935059955I" "00000 25000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

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 federal or state law regulating the possession, distribution or use of any drug? YES NO

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 4731.221 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. YES NO

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES NO

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES NO

6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES NO

7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES NO

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? YES NO

SOCIAL SECURITY NUMBER
(Optional for purposes of identification.)

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 ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU: (only those questions marked with a ✓ apply to you)		YES	NO
☐	1.) *Been found guilty of, or pled guilty or no contest to a felony or misdemeanor?*	☐	☑
☐	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.*	☐	☑
☐	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?*	☐	☑
☐	6.) *Surrendered, or consented to limitation upon: a) a license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?*	☐	☑
☐	7.) *Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?*	☐	☑
☐	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?*	☐	☑
☐	YOU DID NOT ANSWER ANY OF THE QUESTIONS. ANSWER EACH QUESTION (1 - 8) ABOVE.		

OVER ⇨

DETACH HERE AND REMIT THIS PORTION WITH FEE

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 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 PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Neil R Strickland MD 3-2-98
(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

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GYN GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935059955 00000 17900

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
22155 HINKLE CREEK RD
Street
Street
NOBLESVILLE IN 46060
City State Zip Code
HAMILTON
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL 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 federal or state law regulating the possession, distribution or use of any drug?

YES NO
☐ ☑ 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.

YES NO
☐ ☑ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO
☐ ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO
☐ ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO
☐ ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO
☐ ☑ 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?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)
Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

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 1998-1999 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.

X Neil R Strickland MD

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-9955-S	$305.00	10/01/99

NEIL RICHARD STRICKLAND,M.D.
22210 HINKLE CREEK RD
NOBLESVILLE IN 46080

I wish to apply for Emeritus status: ☐

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GYN GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

⑆969696962⑆ 0935059955⑈ ⑈0000030500⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES ☐ NO ☑ 1.) Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor?

YES ☐ NO ☑ 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?

YES ☐ NO ☑ 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.

YES ☐ NO ☑ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES ☐ NO ☑ 5.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?

YES ☐ NO ☑ 6.) Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances?

YES ☐ NO ☑ 7.) Had any clinical privileges or other authority to practice suspended,restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

Redacted

(Optional for purposes of identification)

00007 071399 9304 305.00 071299 935059955
BATCH P DATE ... AMOUNT BATCHDATE ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

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 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 EVERY RESPECT.

X Neil R. Strickland MD 7-16-01
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-9955-S	$305.00	10/01/01

NEIL RICHARD STRICKLAND,M.D.
22210 HINKLE CREEK RD
NOBLESVILLE IN ~~46080~~ 46060

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
GYN GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 | EM | CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL

22210 HINKLE CREEK ROAD
STREET
STREET
NOBLESVILLE | IN | 46060
CITY STATE ZIP CODE
HAMILTON
COUNTY

:96969696 21: 0935059955 :0000030500:

MUST BE ENTERED AT EACH RENEWAL.
☒ Check this Box if you have NO principal Practice address.
Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

	YES	NO
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 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.	☐	☒
3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?	☐	☒
4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?	☐	☒
5.) Have you surrendered, or consented to limitation of, 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 question if the only such surrender or consent was given to this board.	☐	☒
6.) 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?**	☐	☒

REQUIRED:

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

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.

X Neil R Strickland MD 7-15-03
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-05-9955-S	$305.00	10/01/03	01/01/04

NEIL RICHARD STRICKLAND,M.D.
18871 LITTLE CHICAGO RD
NOBLESVILLE IN 46060

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
GYN GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

18871 LITTLE CHICAGO RD
STREET

STREET

NOBLESVILLE IN 46060
CITY STATE ZIP CODE

HAMILTON
COUNTY

0935059955 30500

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

YES ☐ NO ☑ *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?*

YES ☐ NO ☑ *2.) 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? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.*

07182003 711700
1 0273 136
059955
1 SE 00000305000

YES ☐ NO ☑ *3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?*

YES ☐ NO ☑ *4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?*

YES ☐ NO ☑ *5.) Have you surrendered, or consented to limitation of, 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 question if the only such surrender or consent was given to this board.*

YES ☐ NO ☑ *6.) 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?***

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
☑ *Check this Box if you have NO principal Practice address.*

Street
Street
City *State* *Zip Code*
County

REQUIRED:
SOCIAL SECURITY NUMBER

Redacted

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.

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 below
   ..... EMERGENCY MEDICINE
2. Please select one specialty from the field below, if applicable.
   ..... GYNECOLOGY
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?
   ..... NO
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 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 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

Social Security Number

1.

. . . . . Redacted

Nurse 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: 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.

License Information

License Number	35.059955
License Name	NEIL STRICKLAND
Email Address	npstrickland@fuse.net

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below

. . . . . EMERGENCY MEDICINE

2. Please select one specialty from the field below, if applicable.

. . . . . GYNECOLOGY

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?

. . . . . NO

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 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 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

Social Security Number

1.

. . . . . Redacted

Nurse 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?

. . . . . NO

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

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 **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

Social Security Number

1.

. . . . . Redacted

Nurse 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: 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.

License Information

License Number	35.059955
License Name	NEIL STRICKLAND

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please 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 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?

. . . . . NO

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 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 **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

Social Security Number

1.

. . . . . Redacted

Nurse 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}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio 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

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 0

4. "Education" - preceptor, mentor, etc.

. 0

5. "Volunteering" - providing medical and medical-related services at no cost

. 0

6. "Other" - medical professional activities not included in above categories

. 0

Clinical - 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

Workforce Counties

1. 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}*

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

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

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.