

IOWA STATE BOARD OF MEDICAL EXAMINERS

State Capital Complex
Executive Hills West
Des Moines, Iowa 50319

RECEIVED

OCT 18 1982

RD. OF MED. EXAM.

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE AND SURGERY
OR OSTEOPATHIC MEDICINE AND SURGERY ON THE BASIS OF INTER-STATE ENDORSEMENT OR
BY ACCEPTANCE OF THE CERTIFICATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS OF
THE UNITED STATES OF AMERICA, INC.

To: The Iowa State Board of Medical Examiners:

I hereby make application for a license to practice medicine and surgery or osteopathic medicine and surgery in the State of Iowa and submit for your consideration the following statement concerning my age, moral character, preliminary and medical education and practice.

(Name must coincide with medical diploma)

THIS APPLICATION MUST BE TYPEWRITTEN

- Name LEROY HARRISON CARHART
- Addresses _____
Home Address _____ County _____
- Place of Birth TRENTON, NEW JERSEY Date of Birth OCTOBER 28th, 1941 Age 40
Place Month Day Year
- Name and address (Father) _____
- Name and address (Mother) _____
- Are you a citizen of the United States? YES Give particulars BIRTH
- Identification: Height 6' 00" Weight 210 Color of Hair blond
Color of Eyes Blue Identifying mark None
- PRELIMINARY EDUCATION (Beginning with High School. Give names of institutions attended and location, with concise statement of periods of study.)
High School HAMILTON HIGH SCHOOL, HAMILTON TWP., NEW JERSEY Sep 1957-Jun 1960
(Name, location, dates of attendance)
College RUTGERS-THE STATE UNIVERSITY, NEW BRUNSWICK, NJ Sep 1960-Jun 1964
(Name, location, dates of attendance)
Academic Degree of B.A. Business Adm. RUTGERS-THE STATE UNIVERSITY June 1964
Date

9. MEDICAL EDUCATION

I have spent 4 years in the study of medicine, each year comprising 12 each, in the following institutions:
(Months)

Freshman	<u>HAHNEMANN MEDICAL COLLEGE & HOSPITAL</u>	from <u>AUG</u>	<u>1969</u>	to <u>JUN</u>	<u>1970</u>
	(Name and location of college)	(Month)	(Year)	(Month)	(Year)
Sophomore	<u>Hahnemann Medical College & Hospital</u>	from <u>Jul</u>	<u>1970</u>	to <u>Jun</u>	<u>1971</u>
	(Name and location of college)	(Month)	(Year)	(Month)	(Year)
Junior	<u>Hahnemann Medical College & Hospital</u>	from <u>Jun</u>	<u>1971</u>	to <u>Jun</u>	<u>1972</u>
	(Name and location of college)	(Month)	(Year)	(Month)	(Year)
Senior	<u>Hahnemann Medical College & Hospital</u>	from <u>Jul</u>	<u>1972</u>	to <u>Jun</u>	<u>1973</u>
	(Name and location of college)	(Month)	(Year)	(Month)	(Year)
		from _____	<u>19</u>	to _____	<u>19</u>
	(Name and location of college)	(Month)	(Year)	(Month)	(Year)

I was granted the degree of Doctor of MEDICINE by HAHNEMANN MEDICAL COLLEGE & HOSPITAL
(Name of Institution)

located at PHILADELPHIA, PENNSYLVANIA, on the 7th day of JUNE, 1973.

A photostatic copy of my diploma is submitted herewith. (Photostat must not be larger than 8x10 in. or smaller than 6x8 in.)

I further state that I am the identical person to whom this diploma was granted, that the same was procured in the regular course of instruction without fraud or misrepresentation and that the copy presented herewith is a true copy of the original diploma of said institution.

10. INTERNSHIP

I have served an internship in the following hospital MALCOM GROW USAF MEDICAL CENTER
(will or have) (Name)
ANDREWS AFB, MD from 27 JUNE 1973 to 28 June 1974
(Location)

(A photostatic copy of my internship certificate is submitted herewith.)

11. RESIDENCIES (Give places and dates of each service) I have served Residencies in the following hospitals:

HAHNEMANN MED COL & HOSP Philadelphia Pa from 1 Jul 1974 to 26 Jan 1976

13. STATES AND COUNTRIES IN WHICH YOU ARE LICENSED:

State PENNSYLVANIA License No. 35665 Date 27 Sep 74 How Obtained FLEX EXAM
(Exam. Recip., Nat'l. Bd.)
State NEBRASKA License No. 15162 Date 18 Oct 79 How Obtained RECIP.
State _____ License No. _____ Date _____ How Obtained _____

14. Answer all questions. (If the answer to any question is YES and not fully answered below, give details in a notarized affidavit attached to the application.)

- A. Name states and/or foreign countries in which you have practiced and length of time in each _____
PENNSYLVANIA, 4 years; NEBRASKA, 4 years
- B. Do you intend to practice your profession in this state? YES Where? COUNCIL BLUFFS & GLENWOOD
- C. List hospital staff positions (Give address and dates of service) METHODIST HOSPITAL, PHILADELPHIA, PA
1974-1978, Creighton University-St. Jos. Hospital 1978-present
- D. Have you ever been denied Staff Membership in any hospital? _____
- E. Have you ever been warned or censured by, or requested to withdraw from any hospital in which you have trained, been a staff member, or held hospital privileges? _____
- F. Have you ever been notified, or requested to appear before any Medical Society in regard to charges or complaints filed against you? _____ Have you ever been rejected by a Medical Society? _____
- G. Have you ever failed to pass any State Medical or Osteopathic Board Examination, National Board or FLEX examination? _____ If so, where and how many times? _____
- H. Have you ever been denied a certificate by, or the privilege of taking an examination before any State Medical Board? _____ Have you ever been notified by, or requested to appear before any State Medical Board in regard to charges or complaints filed against you? _____ Has any State Medical Board suspended or revoked a license it had granted you? _____
- I. Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or habit-forming drugs? _____
- J. Are you now or have you ever been emotionally or mentally ill? _____ Have you ever received psychotherapy? _____ Have you ever been a patient (voluntarily or otherwise) in any institution for the treatment of mental or emotional illness, drug addiction, or alcohol problems? _____ Have you ever been treated, but not hospitalized for mental or emotional illness, drug addiction, or alcohol problems? _____
- K. Have you ever been convicted of a felony? _____ A misdemeanor? _____ Have any judgements ever been entered against you? _____ Have you ever been sued for malpractice? _____
- L. Do you understand that if the license asked for is granted by this Board, it will be on the truth of the statements contained herein, which if false, will subject you to criminal prosecution, and revocation of the said license certificate? _____

15. AFFIDAVIT OF APPLICANT:

State of NEBRASKA

ss.

County of SARPY

I, LEROY HARRISON CARHART, being duly sworn state, under penalty of perjury, that the foregoing information contained in this application and any attachment is true and correct, and the attached photo is a true likeness of myself.

(Signature of Applicant)

Sworn to before me this 14th day of Oct, 1979

16. RECOMMENDATION OF SECRETARY OF LOCAL, COUNTY MEDICAL OR OSTEOPATHIC SOCIETY: If you are not a member of a county medical society, this affidavit must be signed by the Chief of Staff of the Hospital in which you are practicing or the head of the Department in which you are receiving hospital training.

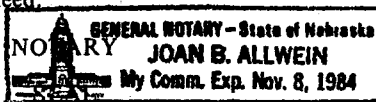
I, James R. Staten, General Surgeon
Lehigh-Berks Hospital USAF Hospital
Medical or Osteopathic Society-Hospital-Department & Hospital
Secretary, Chief of Staff, Department Head
certify that Dr. Leroy Carhart, of Sargey County NE

is personally known to me, and that he/she is an ethical practitioner and is of good moral and professional character; I further certify that the said Dr. Leroy Carhart is engaged in the reputable practice of medicine and surgery in the State of Nebraska. I have carefully examined all the statements made by the applicant and believe them to be true in every respect. I also state the photograph attached to this application is a recent one and the likeness of said Leroy Carhart.

Signed James R. Staten M.D.
Date 10-4-82 Title Chief Gen-Surgeon

*AFFIDAVIT OF SECRETARY OF COUNTY MEDICAL OR OSTEOPATHIC SOCIETY,
CHIEF OF STAFF OR HEAD OF DEPARTMENT IN WHICH YOU ARE TRAINING.

County of Sargey ss.
State of Nebraska
In Lehigh-Berks Sargey Nebraska, on the 4th
City County State
day of October, 19 82, before me personally appeared James R. Staten
to me known to be the party executing the foregoing instrument, and he/she acknowledged said instrument, by him/her executed, to be his/her voluntary act and deed.



Joan B. Allwein
(Notary Public)
Lehigh-Berks, NE 68113
(Address)

Commonwealth of Pennsylvania
Department of State
STATE BOARD OF MEDICAL EDUCATION AND LICENSURE
Harrisburg, Pennsylvania 17120

NAME: LEROY HARRISON CARHART FLEX WEIGHTED AVERAGE [REDACTED]

BASIC SCIENCE: Anatomy [REDACTED]
Physiology [REDACTED]
Biochemistry [REDACTED]
Pathology [REDACTED]
Microbiology [REDACTED]
Pharmacology [REDACTED]
Basic Science Average: [REDACTED]

CLINICAL SCIENCE: Medicine [REDACTED]
Surgery [REDACTED]
Obstetrics [REDACTED]
Public Health [REDACTED]
Pediatrics [REDACTED]
Psychiatry [REDACTED]
Clinical Science Average: [REDACTED]

CLINICAL COMPETENCE AVERAGE: [REDACTED]

FLEX Session: JUNE 11,12,13, 1974

SPOA-1420-6-78

REGISTRATION EXPIRED 12-31-78--PLACED ON INACTIVE STATUS

Acting on behalf of the PENNSYLVANIA Board of Medical Examiners, I hereby certify to the reputability of Dr. LEROY HARRISON CARHART, based on the records of this Board, and recommend him to the Iowa State Board of Medical Examiners as a fit and proper person to receive a license to practice Medicine and Surgery.

LINKS BELOW

23312

Page 1233

1-15, 1982

BOARD OF
AMINERS

board or
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Leroy Harrison Carhart

3, Box #263

1-4, 1982
1-4, 1984

DICAL EXAMINERS
Application)

Chairman
Vice-Chairman

Secretary

APPLICANT MUST FILL FOLLOWING BLANKS

Name LEROY HARRISON CARHART

Present Address [REDACTED]

Age 40

Date and Place of Birth 28 OCTOBER 1941

TRENTON, NEW JERSEY

Applicants Social Security or Tax No. [REDACTED]

Name of College Issuing Diploma HAHNEMANN

MEDICAL COLLEGE AND HOSPITAL

Located at PHILADELPHIA, PENNSYLVANIA

Date of Graduation June, 1973

School of Practice [REDACTED]

MEDICINE AND SURGERY
Medicine or Osteopathic Medicine and Surgery

P. O. Address to which you desire license and future renewal notices sent: [REDACTED]

Street [REDACTED]

City [REDACTED]

County [REDACTED]

Richard L. Carhart
Board Member

Allyn M. Janslow
Board Member

Allyn M. Janslow
Board Member

Board Member

Board Member

Board Member

Instructions

Application must be accompanied by:

1. Fee of \$150 (personal checks not accepted).
APPLICATION FEES ARE NOT REFUNDABLE.

2. Photostatic copies, notarized, of the following:

- Diploma from Medical College or Osteopathic College.
- Certificate of one year of post-graduate training in a hospital approved by this Board.
- Copy of original state license by examination.
- A National Board Diplomate must file current certification of examination results signed by an authorized officer of the National Board.
- FOREIGN MEDICAL GRADUATES must present a photostatic copy of a standard certificate issued by the Educational Council for Foreign Medical Graduates.
- Foreign credentials must be translated into English.

The filing of this application does not grant any special privileges.

(Photostatic copies must be certified and exact copies of the original and must not be larger than 8x10 inches no smaller than 6x8 inches.) This application will not be accepted unless properly completed in every detail, signed and sworn to by the applicant, and properly notarized.

PAGES ONE, TWO AND FOUR MUST
BE TYPEWRITTEN

Address all correspondence to:

IOWA STATE BOARD OF MEDICAL EXAMINERS
State Capitol Complex
Executive Hills West
Des Moines, Iowa 50319

CPD-76037 1/82

Iowa
State Board of Medical Examiners

STATE CAPITOL COMPLEX
Executive Hills West
DES MOINES, IOWA 50319

October 20, 1983

Phone 515/281-5171

RONALD V. SAF
Executive Director

LeRoy Harrison Carhart, M.D.
[REDACTED]

Dear Doctor Carhart:

This letter is a follow up to your phone calls of 10/19/83 and 10/20/83 regarding your original medical license.

You were originally licensed on October 15, 1982 and your license was mailed to you shortly after that date. It was mailed to R.R. #73, Box #263, Omaha, NE 68123. Since the license was never returned to this office, we assumed you received it. We suggest that you check with your local post office to be sure it is not there.

If after further checking you do not find your license, please send this office a signed notarized affidavit indicating that you have never received your original medical license number 23312 issued effective October 15, 1982. At that time, we will be able to duplicate your license. If you desire your license mailed to a different address than the above, please advise.

Very truly yours,

Rose M. Leonhardt
Licensing Secretary

rml



Iowa
a place to grow

The State of



Nebraska

Department of Education Trenton

Medical Certificate

This Certifier, that LE ROY H. CARHART

has presented satisfactory evidence of having completed an academic education covering four years of approved high school education, or the equivalent, and of having completed the prescribed course of four years of college education in accordance with the Medical Practice Stat. A. B. JUNE, 1964

In testimony whereof, this certificate is granted under the seal of the

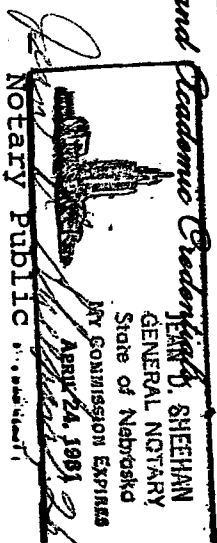
Department of Education, this sixteenth day of October 1978.

Fred A. Price

Fred A. Burke

Bureau of Teacher Education and Academic Standards
Commissioner of Education

State of Nebraska
County of Sarpy
THIS IS A TRUE COPY.



TO THE APPLICANT: Please complete this section of the Form and mail to each state Board in which you are now or have ever been licensed to practice medicine and surgery or osteopathic medicine and surgery. If necessary, you may xerox this Form for additional copies.

Name LeRoy H. CARHART Birth Date 28 October 1941

Address [REDACTED]

Certificate No. 35665 Date Issued 27 Sept '74

TO THE BOARD: Please provide the information requested and return directly to the address indicated below.

CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING LICENSE

I, LORETTA M. FRANK SECRETARY of the
(Name) (Title)
Pa. Bd. of Med. Ed + Licensure, hereby certify
that HORACE LOFFRE PRESCOTT, a registered physician,
was granted State Certificate No. 35665-2 to practice MEDICINE
+ SURGERY in the State of PENNSYLVANIA
on the 27th day of SEPT 1974, on the basis of:

 Exemption

 Oral Examination

X Written Examination

 Reciprocity (State)

 Endorsement (State)

 National Boards

I further certify that our records do do not X show
information of a derogatory nature concerning this physician and said
license is X is not in good standing.

Remarks: LICENSE WAS PUT ON INACTIVE
STATUS ON 8/28/80.

Signed: T. Hodge

Title: Typist

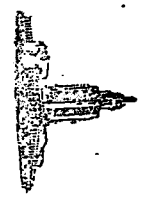
Date: 10/13/82

S E A L)

Forward to: Iowa State Board of Medical Examiners
State Capitol Complex
Executive Hills West
Des Moines, Iowa 50319

tate of Nebraska
County of Sarpy
THIS IS A TRUE COPY.

Notary Public



John W. Harrison
Notary Public



Department of Statistics

To All To Whom These Presents Shall Come Greeting:

Whereas, It appears by the report of the
State Board of Medical Education and Licensure
of the Commonwealth of Pennsylvania that

LEROY HARRISON CARHART

having given satisfactory evidence of fitness as to age, character, preliminary education, medical instruction and all other matters required by law,
was fully examined by the members of the State Board of Medical Education and Licensure whose signatures are hereto attached, and found duly
qualified for the practice of medicine and surgery; is hereby, in accordance with the provisions of the Act of the General Assembly approved
June 3, A.D. 1911, and amendments thereto, granted this License to Practice

Medicine and Surgery

in the Commonwealth of Pennsylvania

John W. Harrison

John W. Harrison
Notary Public
My Commission Expires April 24, 1981



9. Whereas Whereof, We have become as our hands and caused the Seal of
of the Commissioner of Professional and Occupational Affairs to be affixed as
Harrisburg the 27th day of September 1971

John P. Utter
Commissioner

PENNSYLVANIA MEDICAL SOCIETY

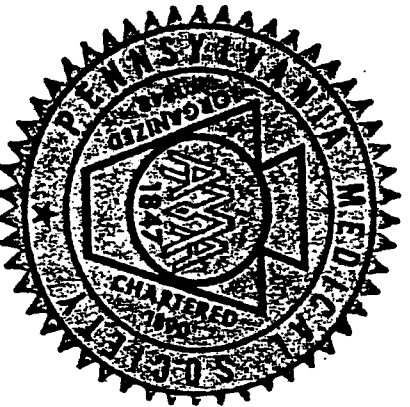
Certificate of Membership
This Certifies That

LEROY H CARHART MD

*is a member in good standing by complying with the ethical standards
and the continuing medical education requirements of the profession.*

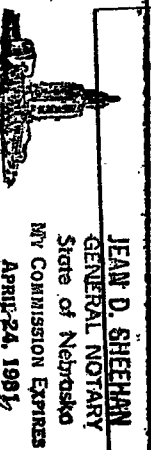
John H. Penner

Executive Vice President



Membership Year

1978



STATE OF NEBRASKA
COUNTY OF SARPY
This is a true copy.

Illustrationes
Arithmetice
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Algebrae
Ab
OMNIBUS HAS LITERAS PRÆSENTES VISURIS
Sculptum

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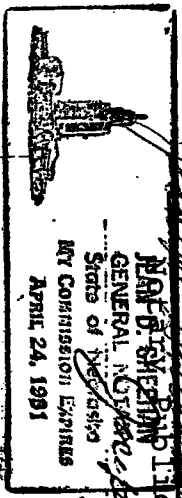
THE ROYAL INDIAN GARDEN

Illicitum Iudicium

[illegible]

Robert Shuman

Answers.



State of Nebraska
County of Sarpy
THIS IS A TRUE COPY.

James H. McPherson 26 March 1928

JEAN D. SHEPARD, Lic.
GENERAL NOTARY Public
State of Nebraska
NEW Castle, Nebraska

R. D. McPherson, H. L.
Grantsville, Mo. Term: 63-7 years

Charles F. Hughes and
Technical Consultants

State of Nebraska
County of Sarpy,
THIS IS A TRUE COPY

JEAN D. SHEEHAN
GENERAL NOTARY
State of Nebraska
MY COMMISSION EXPIRES
APRIL 24, 1981

James H. Sheehan
Notary Public

Malcolm Grow USAF Medical Center

This is to certify that

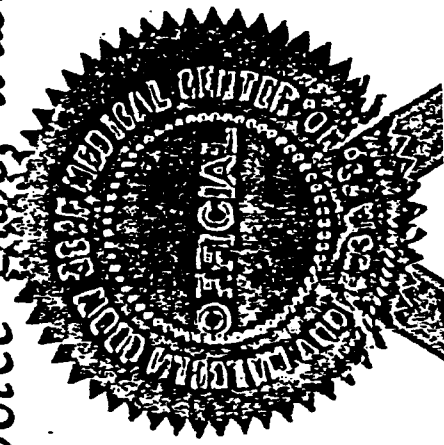
LeRoy H. Carhart, M.D.

has satisfactorily completed the 1st Year
POSTGRADUATE MEDICAL TRAINING, from 1 July 1973 to 30 June 1974

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

Paul M. Frank M.D.
Director of Professional Education

Robert J. Peterson
Surgeon General USAF



T. Vandenberg
Medical Center Commander

21 June 1974
Date of Presentation

Atlantic City Medical Center

Atlantic City, New Jersey

This is to Certify that

Frederic H. Garhart, Jr., M.D.

has served in the Atlantic City Medical Center as

Third and Fourth Year and Chief Resident in General Surgery

January 31, 1976 to June 30, 1978

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



STATE OF NEBRASKA
COUNTY OF SARPY

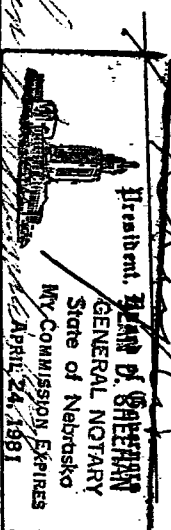
This is a true copy.

Notary Public

William L. Swank
Director of Medical Education

Administrator

Donald R. Brown
President, Medical Staff



23312

Application for Iowa Physician License

IOWA BOARD OF MEDICINE

400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686, (515)-281-6641

PAID

Section 1—Type of License

Indicate the type of license you are applying for below. If you have questions about the type of license you should apply for, call (515) 281-6641.

- ☐ **Permanent License—\$505 Application Fee**
This license allows an M.D. or D.O. to practice medicine and surgery or osteopathic medicine and surgery in Iowa.
- ☐ **Resident License—\$205 Application Fee**
This license is for physicians who are entering a post-graduate training program in Iowa. A resident license restricts a physician's practice to the board-approved program listed in Section 15 of the application and is valid only for practice within that program under the supervision of a licensed physician.
- ☐ **Special License—\$355 Application Fee**
This license is for physicians who do not meet qualifications for permanent licensure, but are held in high esteem for their unique contributions to medicine and are being appointed as a member of the academic staff at a college of medicine or osteopathic medicine. A special license restricts a physician's practice to the college of medicine or osteopathic medicine.
- ☐ **Temporary License—\$155 Application Fee**
This license is for physicians who are participating in one of the following board approved activities. Temporary licensure is not meant to be used as a way for a physician to practice before permanent licensure is granted. It is not intended for locum tenens physicians. Indicate which board approved activity you will be participating in.
- ☐ Covering for an Iowa licensed physician who unexpectedly is not available to provide medical care to his/her patients.
 - ☐ Demonstrating or proctoring that involves providing hands-on patient care to patients in Iowa.
 - ☐ Conducting a procedure on a patient in Iowa when the consultant's expertise in the procedure is greater than that of the Iowa-licensed physician who requested the procedure.
 - ☐ Providing medical care to patients in Iowa if the physician is enrolled in an out-of-state resident training program and does not hold a resident or permanent license in the home state of the resident training program.
 - ☐ Serving as a camp physician.
 - ☐ Participating as a learner in a program of further medical education that allows hands-on patient care when the physician does not currently hold a license in good standing in any United States jurisdiction.
 - ☐ Another activity approved by the Board.
- ☒ **Reinstatement of Inactive Iowa License—\$555 Application Fee**
This process applies only to physicians who hold a permanent Iowa license that has been inactive for more than 12 months.

Applicant Name: CARHART

LeROY

HARRISON

Section 2— Identifying Information

Complete every item. Enter your full legal name. Do not enter an initial for your middle name, unless an initial is your legal middle name. Licenses are issued in the physician's legal name. List other names you have used, such as a nickname or name that is used on the diploma, if different from your legal or maiden name. Describe any identifying marks, such as scars, birthmarks, or tattoos. An e-mail will be sent to the applicant's e-mail address and the other e-mail address listed after a review of the application is completed. The other e-mail address can be for the person assisting you with the application process.

Full Legal Name:

Last

CARHART

First

LeROY

Middle

HARRISON

Suffix

JR.

Other Name(s) Used: ☒ Check if Not Applicable**Maiden Name:****Current Home Address:**

Street, City, State, Zip

(County— for Iowa addresses only)

Home Phone: 402-292-4164**Current Work Address:**

Street, City, State, Zip,

(County— for Iowa addresses only)

BELLEVUE HEALTH AND EMERGENCY CLINIC, INC.

1002 W. MISSION AVENUE

BELLEVUE, NE 68005

Work Phone: 402-292-4164**Applicant E-mail:** admin@drcarhart.com**Other E-mail:** janine70aol.com**Mailing/ Website Address:** This address will be the address used for all correspondence from this office and will be displayed on our website with your license information.

Work



Home

Social Security Number: [REDACTED]

Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. Section 666(a)(13), Iowa Code Section 252J.8(1), 261.126(1)(2007), and 272D.8(1)(Supp.2008). The number will be used in connection with the collection of child support & student loan obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code Section 421.18.

Height:

6 ft

0 in

Weight:

255 lbs

Hair Color: GRAY**Eye Color:** BLUE**Identifying Marks:**

Check if not applicable

8 CM SCAR (R) ELBOW

U.S. Citizen?

Yes



No

If No, Visa Type or Alien Registration Number:**Applicant Name:** CARHART

LeROY

HARRISON

Section 3—Birth Information

Complete every item. Provide your date of birth in month/day/year format.

Date of Birth: October 28, 1941

City of Birth: TRENTON

State of Birth: NEW JERSEY

Country of Birth: USA

Father's Full Name: LeROY HARRISON CARHART

Mother's Full Name: VERONA ELIZABETH MORGAN (CARHART)

Section 4—Medical Education

List all medical schools you have attended, even those you did not graduate from. Provide an explanation below if 1) it took longer than five years or fewer than four years to complete your medical education, 2) had a break in your medical education, or 3) the end date of your education is different than the date of your degree.

039-010

Institution	City, State, Country	From (Mo/Yr)	To (Mo/Yr)
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL	PHILADELPHIA, PA USA	08/69	06/73

Degree Received: M.D.

Date of Degree (Mo/Yr): 06/73

A copy of my diploma is submitted herewith. I further state that I am the identical person to whom this diploma was granted, that the same was procured in the regular course of study without fraud or misrepresentation and that the copy presented is a true copy.

Explanation:

If you are an international medical graduate, are you currently certified by the Educational Commission for Foreign Medical Graduates (ECFMG) or did you complete a Fifth Pathway Program?

ECFMG: ☐ Yes

☒ No

Fifth Pathway Program:

☐ Yes

☒ No

Applicant Name: CARHART

LeROY

HARRISON

Section 5—Post-Graduate Medical Training

List all post-graduate training programs you have attended in the United States or Canada, even those you did not complete. List internships, residencies, and fellowships separately. Applicants applying for a special or temporary license must also list post-graduate training programs attended outside the United States or Canada.

Name of Facility: MALCOLM GROW USAF HOSPITAL	From (Mo/Yr) 07/73	To (Mo/Yr) 06/74
Address: (Street, City, County, State, Zip) ANDREWS, AFB PRINCE GEORGE COUNTY MARYLAND, 20762		

Type of Training: ☒ Intern ☐ Resident ☐ Chief Resident ☐ Fellow ☐ Research

Program Specialty: GENERAL MEDICINE

Name of Facility: HAHNEMANN MEDICAL COLLEGE/HOSP	From (Mo/Yr) 07/74	To (Mo/Yr) 12/76
Address: (Street, City, County, State, Zip) 230 N. BROAD STREET PHILADELPHIA COUNTY PHILADELPHIA, PA 19102		

Type of Training: ☐ Intern ☒ Resident ☐ Chief Resident ☐ Fellow ☐ Research

Program Specialty: GENERAL MEDICINE

Name of Facility: ATLANTIC CITY MEDICAL CENTER	From (Mo/Yr) 01/77	To (Mo/Yr) 06/77
Address: (Street, City, County, State, Zip) 1925 PACIFIC AVENUE ATLANTIC COUNTY ATLANTIC CITY, NJ 08401		

Type of Training: ☐ Intern ☒ Resident ☐ Chief Resident ☐ Fellow ☐ Research

Program Specialty: GENERAL MEDICINE

Name of Facility: ATLANTIC CITY MEDICAL CENTER	From (Mo/Yr) 07/77	To (Mo/Yr) 06/78
Address: (Street, City, County, State, Zip) 1925 PACIFIC AVENUE ATLANTIC COUNTY ATLANTIC CITY, NJ 08401		

Type of Training: ☐ Intern ☐ Resident ☒ Chief Resident ☐ Fellow ☐ Research

Program Specialty: GENERAL MEDICINE

Applicant Name: CARHART

LeROY

HARRISON

Section 6—Chronology of Activities

Provide a chronological listing of all medical and non-medical activities from the date you entered medical school to the present date, with no gaps in time. Do not substitute a resume or a curriculum vitae for this section. Include exact nature, location, and time frame of each activity. For any non-working time, you must state on the form exactly what your activities were such as "vacation" or "seeking employment." Applicants may copy this page or attach additional sheets of paper, labeled with your name and signed by you, if more space is needed.

Activity	Location (City/State)	From (Mo/Yr)	To (Mo/Yr)
CLASS PRESIDENT	PHILADELPHIA, PA	08/69	06/73
MEMBER - STUDENT COUNCIL	PHILADELPHIA, PA	08/70	06/73
SECRETARY-STUDENT COUNCIL	PHILADELPHIA, PA	08/71	06/73
FOUNDING MEMBER STUDENT			
AMERICAN MEDICAL ASSOCIATION	PHILADELPHIA, PA	08/70	06/73
V.P. HAHNEMANN CHAPTER,			
STUDENT, AMA	PHILADELPHIA, PA	08/72	06/73
STUDENT REP.-ADM. COMMITTEE	PHILADELPHIA, PA	08/71	06/73
STUDENT REP.-BOARD OF DIR.	PHILADELPHIA, PA	08/72	06/73
COMMISSIONED - MAJOR	USAF	06/73	06/78
MED. INTERN - ROTATING TYPE 4	ANDREWS AFB, MD	07/73	06/74
RESIDENCY-HAHNEMANN	PHILADELPHIA, PA	07/74	12/76
GEN. SURGERY RESIDENCY	ATLANTIC CITY, NJ	01/77	06/77
CHIEF RESIDENCY, GENERAL SURG.	ATLANTIC CITY, NJ	07/77	06/78
PROMOTED, LT. COLONAL	USAF	06/78	02/85
ER M.D.-EMERGENCY MED. ACCOS.	CHESTER PA	07/74	06/78
CHIEF OF ER MEDICINE, CHIEF OF	GENERAL SURGERY,		
CHAIRMAN, DEPT. OF SURGERY	EHRLING BERGQUIST USAF	09/78	02/85
ER STAFF PHYS.- ST. JOSEPH HOSP.	OMAHA, NE	07/78	06/83
ER STAFF PHYSICIAN-SPECTRUM	EMERGENCY CARE		
JENNIE EDMUNDSON HOSPITAL	COUNCIL BLUFFS, IA	01/82	02/85
ER PHYS.-LUTHERAN MEDICAL CTR	OMAHA, NE	01/85	08/86
ER STAFF-FISHER/MANGOLD CORP.	DAVENPORT, IA	09/86	06/87
BELLEVUE HEALTH/EMER. CLINIC	BELLEVUE, NE	02/85	03/10

Applicant Name: CARHART

LeROY

HARRISON

Section 7—Hospital Privileges

List hospitals where you held privileges within the last five years. Do not list hospital privileges that were granted to you as part of your post-graduate training program. Do not guess on the dates of your privileges; verify the dates with the facility prior to completing the application. You will be required to correct any incorrect dates.



Not Applicable, check here if you have not held any hospital privileges that were not part of your training program.

Hospital Name	Address	From (Mo/Yr)	To (Mo/Yr)

Applicant Name: CARHART

LeROY

HARRISON

Section 8— Medical/Osteopathic License Information

List all state and Canadian provinces where you currently hold or have held any type of medical/osteopathic license. Do not guess on the license number or original issue date of your license, verify the information with the licensing agency prior to completing the application. You will be requested to correct any incorrect information. Applicants applying for a special or temporary license must also list licenses held outside the United States or Canada.

☐ Not Applicable, check here if you have never held any medical/osteopathic licenses.

State/Country	License Number	Original Issue Date (Mo/Yr)	License Type (i.e. Training, Permanent)
INDIANA/USA	MD0356651	09/74	PERMANENT
IOWA/USA	23312	10/82	PERMANENT
KANSAS/USA	04-24866	12/93	PERMANENT
NEBRASKA/USA	15162	10/79	PERMANENT
NEW JERSEY/USA	25MA03654100	08/79	PERMANENT
OHIO/USA	35057427	09/88	PERMANENT
PENNSYLVANIA/USA	MD0356651	09/74	PERMANENT
WISCONSIN/USA	35028-20	12/93	PERMANENT

Section 9— Other Professional License Information

List all state and Canadian provinces where you currently hold or have ever held any professional license, such as a chiropractic, nursing, or physician assistant license. Applicants applying for a special or temporary license must also list licenses held outside the United States or Canada.

☒ Not Applicable, check here if you have not held any other professional licenses.

State/Country	License Number	Original Issue Date (Mo/Yr)	License Type & Profession (i.e. Training/Nurse)

Applicant Name: CARHART, JR

LeROY

HARRISON

Section 10—Examination Information

Indicate the license examination you have taken. If you took a combination of examinations, indicate all that are applicable to your examination history. Applicants who took longer than ten years to pass the USMLE or COMLEX are required to be specialty board certified by a member board of the American Board of Medical Specialties or the American Osteopathic Association. Applicants who do not meet this rule will need to request a waiver of this licensure rule. Contact the Director of Licensure & Administration at (515) 281-6492 to discuss requesting a waiver of this rule.

- | | | | |
|---|--|------------------------------|-----------------------------|
| <input type="checkbox"/> USMLE | Did you pass Steps 1-3 within ten years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> COMLEX | Did you pass Levels 1-3 within ten years | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> NBME | | | |
| <input type="checkbox"/> NBOME | | | |
| <input checked="" type="checkbox"/> FLEX | | | |
| <input type="checkbox"/> LMCC | | | |
| <input type="checkbox"/> State Board Examination | State: | | |
| <input type="checkbox"/> SPEX Examination within the last ten years | | | |
| <input type="checkbox"/> Not Applicable | | | |

Section 11—Practice Information

List your proposed Iowa practice or proposed post-graduate training location. If it is unknown, please explain. Indicate if you are specialty board certified by an American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty board. If you are applying for a temporary or special license, list the specialties for which you are certified and indicate in which country.

Proposed Iowa Practice or Proposed Post-Graduate Training Program Address:
(Institution/Group, Street, City, State, Zip Code)

I have been requested, over the years, to work in various emergency rooms and have not been able to due to the lapse in my Iowa license.

- | | | |
|---|---------------------------|-------------------------------------|
| Are you ABMS specialty board certified? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |
| Are you AOA specialty board certified? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |
| Are you specialty certified in another country? | <input type="radio"/> Yes | <input checked="" type="radio"/> No |

Specialty:	Date Certified:	Country:
1.	1.	1.
2.	2.	2.
3.	3.	3.

Applicant Name: CARHART, JR.

LeROY

HARRISON

Section 12— Question Definitions

It is important to review the definitions below before answering the questions in this section.

"Ability to practice medicine with reasonable skill and safely" means all of the following: The cognitive capacity to make appropriate clinical diagnoses, to exercise reasoned medical judgments and to learn and keep abreast of medical developments; The ability to communicate medical judgments and information to patients and other health care providers; and The capability to perform medical tasks such as physical examinations and surgical procedures, with or without the use of aids or devices.

"Medical condition" means any physiological, mental or psychological condition, impairment or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" The medical condition has had an ongoing or adverse impact on the ability to function and practice.

"Improper use of drugs or other chemical substances" means all of the following: The use of any controlled drug, legend drug or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and the use of any substance, including, but not limited to, petroleum products, adhesive products, nitrous oxide and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution or use of any chemical substances prohibited by law (e.g. heroin).

Iowa Physician Health Program (IPHP)

The IPHP is a confidential, voluntary program offered to physicians who may be dealing with impairment issues, such as, but not limited to alcohol or drug abuse, dependency or addiction, neuropsychiatric disorder, or physical disability. The IPHP develops an individualized program for each physician, with the goal of allowing the physician to continue to practice with reasonable skill and safety. Oftentimes, the Licensure Committee of the Board will refer physicians with impairment issues to the IPHP for review and bases licensure decisions on its recommendations.

To self-report to the IPHP or obtain additional information, contact the Coordinator of IPHP at 515-281-6491.

Applicant Name: CARHART

LeROY

HARRISON

Section 12—Questions

Respond "yes" or "no" to each item. The Board expects full disclosure of events, whether you consider them to be minor or major in nature. It is better to disclose information than to not disclose it.

For every "yes" response, you must provide a separate statement of explanation that is signed and dated. This statement must include full details, including dates, locations, actions, organizations or parties involved. You must also provide the requested supporting documentation. The Board may request additional supporting information, if needed.

A criminal background check packet will be sent to your home address after your application has been submitted. Your answer to question #6 of the application and the question on the background check waiver should contain the same information. Discrepancies between the application and the criminal background check waiver could result in disciplinary action. Some states have court records available online, which you may want to review if you are unsure how to answer this question. Iowa's court record website is www.iowacourts.state.ia.us.

Applicants must answer all questions. Current IPHP participants, may answer "No" to questions 1 through 5.

Yes No

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?

If yes, provide a description of your condition and submit the "Verification of Medical Condition" form which is to be completed by your treating physician(s).

2. Are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?

If yes, provide details of your treatment or program, copies of treatment evaluations, statement from the program indicating your progress and practice recommendations.

3. Does your field of practice, or the setting or the manner in which you have chosen to practice medicine, reduce or eliminate the limitations or impairments caused by your medical condition or use of alcohol, drugs or other chemical substances?

If yes, provide a description of your practice and how it has changed since the diagnosis of your medical condition.

4. Are you currently engaged in the illegal or improper use of drugs or other chemical substance?

If yes, provide an explanation.

5. Does your current use of alcohol, drugs or other chemical substances in any way impair or limit your ability to practice medicine with reasonable skill and safety?

If yes, explain your current usage and how this impairs your ability to practice.

Applicant Name: CARHART

LeROY

HARRISON

Yes No

6. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon.) Driving under the influence or driving while impaired is not a minor traffic offense.

If yes, provide details of the charge and the final outcome. Provide copies of any court/legal documents related to each incident.

7. During medical school, were you ever terminated, requested to withdraw, or placed on probation?

If yes, provide an explanation.

8. Have you ever received a certificate of non-compliance from the College Student Aid Commission regarding non-payment of a student loan?

If yes, provide an explanation.

9. Have you ever been terminated, asked to withdraw, or asked to repeat a portion of an internship, residency, or fellowship?

If yes, provide an explanation.

10. Have you ever received a warning or reprimand, been asked to participate in remediation or been placed on probation during an internship, residency or fellowship program?

If yes, provide an explanation.

11. Have you ever taken a leave of absence for any reason (maternity, family, personal, financial) during your medical school education, internship, residency, or fellowship?

If yes, provide an explanation.

12. Have you ever been denied a license to practice medicine or a license to practice another profession?

If yes, provide an explanation and a copy of the notice of denial.

13. Have you ever surrendered any professional license for any reason?

If yes, provide an explanation and a copy of all official documents relating to the surrender.

13a. If yes, was a license disciplinary action pending against you or were you under investigation by a professional licensing agency at the time you surrendered the license?

If yes, provide an explanation and a copy of all related official documents.

14. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate?

If yes, provide an explanation and a copy of the notice of denial.

Applicant Name: CARHART

LeROY

HARRISON

Yes No

15. Have you ever surrendered your state or controlled substances registration or had it restricted in any way?

If yes, provide an explanation and a copy of all official documents relating to this.

16. Aside from ordinary initial requirements of proctorship, have you had your clinical privileges or medical staff status at any hospital or health care entity, nursing facility, clinic, or other professional health care organization ever been limited, suspended, revoked, not renewed, voluntarily relinquished, denied, or subject to other disciplinary or probationary conditions?

If yes, provide an explanation and a copy of all related official documents.

17. Have you ever been terminated, sanctioned, penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare or other publicly funded healthcare program?

If yes, provide an explanation and a copy of all related official documents.

18. Have you ever been denied membership or renewal or been subject to any disciplinary action, sanction or warning in any medical or osteopathic organization or professional society?

If yes, provide an explanation and a copy of all related official documents.

19. Have you ever been investigated or subject to an inquiry/review by any professional licensing agency, including investigations or reviews which resulted in no formal action? (Answer "Yes" if you have ever been contacted by an investigator or Board agent to review a complaint or report filed against you.)

If yes, provide an explanation of the inquiry, including dates, state, charges, final outcome and a copy of all related official documents

20. Has any jurisdiction of the U.S. or other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked or filed charges against any license you held?

If yes, provide an explanation and a copy of all related official documents.

21. Are you in violation of any child support order or written agreement to pay child support?

If yes, provide an explanation.

22. Have any professional liability suits ever been filed against you?

If yes, complete the attached Professional Liability Suit Information form along with a copy of the requested legal documents listed on that form.

23. Have any judgments or settlements been paid on your behalf as a result of a professional liability case?

If yes, complete the attached Professional Liability Suit Information form along with a copy of the requested legal documents listed on that form.

Applicant Name: CARHART

LeROY

HARRISON

Section 13— Affidavit of Applicant

Enter the state and county in which the affidavit is being notarized. Sign the affidavit in the presence of a notary. The notary must supply the jurisdiction at the beginning of the affidavit, sign, enter the date of the notarization, and the expiration date of his/her commission. Attach a recent photo of yourself that has been taken within the last 90 days.

State of: NEBRASKA County of: SARPY

I, LEROY HARRISON CARHART, JR.

hereby swear or affirm, under penalty of perjury, that I am the person described and identified; that the attached photo is a true likeness of myself; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

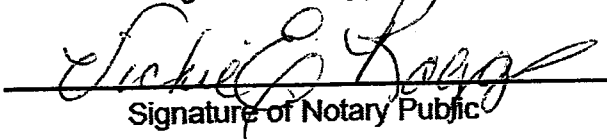
I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted with this application if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally, in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer and take full responsibility for all answers contained in this application.



Signature of Applicant



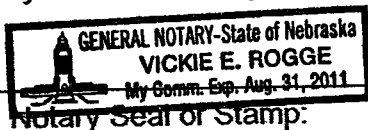
Signature of Notary Public

MARCH 16, 2010

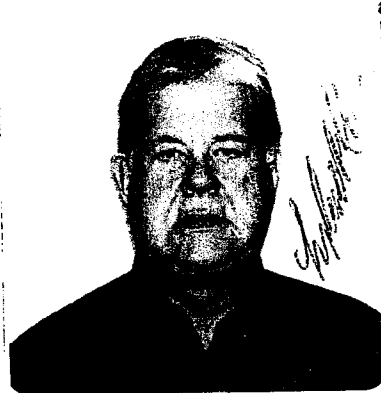
Sworn/Affirmed to before me on

8/31/2011

My commission expires:



Notary Seal or Stamp:

**Office Use Only**

License Number: _____

Issue Date: _____

Expiration Date: _____

Initials: _____

Applicant Name: CARHART

LEROY

HARRISON

Section 14— Authorization for Release of Information

All applicants must sign and date this section.

I, LeRoy Harrison Carhart (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."


Signature of Physician

5/5/2010
Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Applicant Name: CARHART

LeRoy Harrison

KANSAS

BOARD OF HEALING ARTS

Mark Parkinson, Governor
Kathleen Selzler Lippert, Acting Executive Director

www.ksbha.org

03-29-10A11:14 RCVD

March 25, 2010

Iowa Board of Medicine
400 SW 8th Street, Suite C
Des Moines, IA 50309-4686

This is to certify that: Leroy Harrison Carhart, MD has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

License Number: 04-24866
Date of Birth: 10/28/1941
Profession: Medical Doctor (MD)
License Designation: MD Active License
License Status: Current
Original License Date: 12/10/1993
Expiration Date: 06/30/2010

Disciplinary Action: None

Pending Complaints: None

Unless otherwise indicated, this licensee has not been subject to disciplinary proceeding by the Kansas Board of Healing Arts.

Verified by:

Sandra Fienhage

Sandra Fienhage
Senior Administrative Assistant

BOARD MEMBERS: MICHAEL J. BEEZLEY, MD, PRESIDENT, Lenexa • M. MYRON LEINWETTER, DO, VICE PRESIDENT, Rossville
RAY N. CONLEY, DC, Overland Park • GARY L. COUNSELMAN, DC, Topeka • FRANK K. GALBRAITH, DPM, Wichita • MERLE J. "BOO" HODGES, MD, Salina
SUE ICE, Public Member, Newton • BETTY MCBRIDE, Public Member, Columbus • GAROLD O. MINNS, MD, Bel Aire • BRENDA R. SHARPE, Public Member, Overland Park
CAROLINA M. SORIA, DO, Wichita • KIMBERLY J. TEMPLETON, MD, Leawood • TERRY L. WEBB, DC, Hutchinson • NANCY J. WELSH, MD, Topeka • RONALD N. WHITMER, DO, Ellsworth

235 S.W. Topeka Blvd., Topeka, KS 66603-3068 • (785)-296-7413 • 1-888-886-7205 • Fax: 785-296-0852
TTY (Hearing Impaired) 711 or 1-800-766-3777 voice/TTY • e-mail: healingarts@ksbha.ks.gov

Jim Doyle
Governor

Celia M. Jackson
Secretary

WISCONSIN DEPARTMENT OF
REGULATION & LICENSING



1400 E Washington Ave
PO Box 8935
Madison WI 53708-8935
Email: web@drl.state.wi.us
Voice: 608-266-2112
FAX: 608-267-0644
TTY: 608-267-2416

CERTIFICATION

03-29-10A11:23 RCVD

DATE: 03/25/2010

I, Cathy Pond, do hereby certify that I am the Division Administrator in the Department of Regulation and Licensing, a department of the government of the State of Wisconsin; that I am the custodian of the records relating to Medicine and Surgery and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT: LEROY H CARHART
WAS ISSUED LICENSED NO: 35028 - 020
ON: 12/15/1993
CREDENTIAL TYPE: MEDICINE AND SURGERY
LICENSE EXPIRATION DATE: 10/31/2011

Credential Holder History

Date	Code	Description
06/07/1973	GRADUATED FROM	HAHNEMANN MED COL-PHILADELPHIA
12/15/1993	ENDORSED FROM	ENDORSED FLEX

According to our records, this credential holder has not been disciplined.

The information above is the only certification information provided by this Department. To expedite the certification process, the above format is the standard format for all professions regulated by this Department.

SEAL

Cathy Pond
Division Administrator



STATE OF INDIANA

MITCHELL E. DANIELS

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Official Proof of Licensure Digitally Certified Record

Personal Information

Name: LEROY HARRISON CARHART
Address: 1002 WEST MISSION AVENUE
BELLEVUE, NE 68005
Date of Birth: 10/28/1941

License Information

Number Issued: 01040632A
License Type: Physician
Status: Active
Issue date: 07/30/1992
Expiration Date: 06/30/2011
Obtained By: Endorsement
Disciplinary Action: None

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams.

For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at www.in.gov/pla/boards.htm

Digitally Certified on: Mon Mar 01 02:48:19 PM EST 2010



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

March 2, 2010

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	LEROY HARRISON CARHART
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD035665L
ORIGINAL LICENSURE DATE:	09/27/1974
EXPIRATION DATE:	12/31/2010
STATUS:	Active

The license is in good standing and the records indicate no derogatory information.

SEAL



Commissioner
Bureau of Professional and Occupational Affairs

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: <http://med.ohio.gov/>

VERIFICATION OF LICENSURE

This is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 3/4/2010:

Identification Information

Name and Address:	Dr. LEROY HARRISON CARHART 1002 W MISSION AVENUE BELLEVUE, NE 68005
Date of Birth:	10/28/1941
Place of Birth:	TRENTON, NJ
School of Graduation:	Hahnemann Medical College of Philadelphia
Date of Graduation:	06/07/73

License Information

Type of License:	Doctor of Medicine
License Number:	35. 057427
How Issued:	End Flex
Original Licensure Date:	09/23/1988
Expiration Date:	04/01/2011
Status:	ACTIVE
Formal Disciplinary Action:	No



Richard A. Whitehouse
Executive Director



CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183, Trenton, NJ 08625-0183



PAULA T. DOW
Attorney General

SHARON M. JOYCE
Acting Director

March 25, 2010

Iowa Board of Medicine
400 Southwest Eighth Street
Suite C
Des Moines, IA 50309

For overnight deliveries:
140 East Front St.
PO Box 183, 3rd Floor
Trenton, NJ 08608
(609) 826-7100
(609) 826-7101 FAX

To Whom It May Concern:

The New Jersey State Board of Medical Examiners has been requested by Leroy H Carhart to forward a letter of good standing regarding the Medical Doctor's license to practice in the State of New Jersey.

A review of the Board's files indicates that Leroy H Carhart was issued a New Jersey license 25MA03654100 on or about 08/08/1979 and is currently Retired-Paid with an expiration date of 06/30/2011. A review of the Board's files further indicates that no public disciplinary action has been taken against this Medical Doctor.

Very truly yours,

BOARD OF MEDICAL EXAMINERS

William V. Roeder
Executive Director

WVR/dd/mac/sh

State of Nebraska

Department of Health and Human Services
Division of Public Health

License Type: Physician

License No. 15162 Status: Active

LeRoy Harrison Carhart, MD
1002 W Mission Avenue
Suite 201
Bellevue NE 68005

Expires: 10/01/2010

John J. Meeks
Administrator / Licensure Unit



STATE MEDICAL BOARD OF OHIO
30 E. Broad St., 3rd Floor, Columbus, Ohio 43215-6127
www.med.ohio.gov

EXPIRES: 04/01/2011

LICENSE NUMBER
35. 057427



Dr. LEROY HARRISON CARHART

Doctor of Medicine

is duly registered and entitled to practice in The State of Ohio
until the expiration date. **AUDIT #: 3270**

KANSAS STATE BOARD OF HEALING ARTS Certificate of Renewal

This is to certify that the individual named below is authorized
to practice as indicated.

LEROY HARRISON CARHART

Profession: Medical Doctor (MD)
Certificate #: 04-24866 Status: ACTIVE
Date Issued: 07/01/2009 Expiration: 06/30/2010
CE Due: 2010

[Signature]
Signature of Practitioner

Commonwealth of Pennsylvania Department of State
Bureau of Professional and Occupational Affairs
Medical Physician and Surgeon

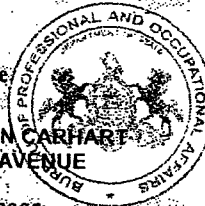
License Number
MD035665L

Registration Code
18120317

Expiration Date
12/31/2010

License Status
Active

LEROY HARRISON CARHART
1002 W MISSION AVENUE
SUITE 201
BELLEVUE NE 68005



New Jersey Office of the Attorney General
Division of Consumer Affairs

THIS IS TO CERTIFY THAT THE
Board of Medical Examiners
HAS REGISTERED
Leroy H. Carhart
Medical Doctor

06/24/2009 TO 06/30/2011

VALID

SIGNATURE

25MA03654100

License/Registration/Certificate #

DIRECTOR

Wisconsin Credential Lookup Credential Summary - Details

Credential Summary for 35028-20

Name:	Carhart, Leroy H
Credential Type:	Medicine and Surgery (20)
Credential Number:	35028-20
Location:	BELLEVUE, NE
License Type:	regular
Status	credential license is current (active)
Eligible To Practice:	credential license is current
First Fee Received:	YES

Details

Requirements

Payments

Details

Orders

Relationships

License current through:	10/31/2011
Granted date:	12/15/1993
Multi-state:	N
Orders:	NONE
Specialties:	SURGERY - GENERAL
Other Names:	NONE

Section 14— Authorization for Release of Information

All applicants must sign and date this section.

I, LeROY HARRISON CARHART, JR (print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."


Signature of Physician

3-3-2010
Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Applicant Name: CARHART

LeROY

HARRISON