

RECEIVED  
OHIO STATE  
MEDICAL BOARD

'84 AUG 29 P2:18

STATE MEDICAL BOARD OF OHIO

APPLICATION FOR MEDICAL OR OSTEOPATHIC LICENSURE  
(ALL RESPONSES MUST BE TYPED)

1-4 28-39-17  
8-30-84  
1807.00 paid  
45-0

SECTION 1: Identification Information- Answer All Questions

1. Present Legal Name: PATEL NARESHKUMAR G.  
last first middle maiden (if applicable)
2. Address: 1902, GORDON COOPER DRIVE,  
street & number  
SHAWNEE OKLAHOMA 74801 U.S.A.  
city state zip code country
- Intended place of practice: UNDECIDED  
city state country
- Telephone: Business (405) 275-2824 Home: (405) 275-3986  
(area code) (area code)
4. Place of Birth: PANAR, GUJARAT INDIA Date of Birth: 11/19/52  
city state country mo. day year
5. \*Sex: Male (☒) Female ( ) \*Optional: For statistical purposes only.
6. Physical description:  
Color of Hair BLACK Color of Eyes BLACK Height 5'6"  
Build NORMAL Marks NONE Weight 135 Lbs.

7. Immigration or citizenship status:

Indicate which of the following documents you currently possess.

- ☐ U.S. Birth Certificate
- ☒ Certificate of Naturalization  
Number 10972068 Date Issued July 3, 1984 City/State Newark, N.J.
- ☐ Declaration of Intention (issued by the U.S. District Court)  
Number \_\_\_\_\_ Date Issued \_\_\_\_\_ City/State \_\_\_\_\_
- ☐ Alien Registration Receipt Card (issued by Dept. of Immigration & Naturalization)  
Number \_\_\_\_\_ Date Issued \_\_\_\_\_ City/State \_\_\_\_\_
- ☐ Approved Petition for Immigrant Visa (issued by Dept. of Immigration & Naturalization)  
Number \_\_\_\_\_ Date Issued \_\_\_\_\_ City/State \_\_\_\_\_
- ☐ Other, specify \_\_\_\_\_

8. List all names other than the name given above that you have used. Also indicate the time period during which you used the names. Be sure to include all names. Failure to do so may result in denial. You must supply the appropriate legal document which authorizes the name change. This may be a court decree or a marriage certificate. Any document in a foreign language must be accompanied by an official, certified translation (original) as outlined in Paragraph (A)(8), Page 1 of General Instructions above.

NOTE: Individuals who retain their maiden name or hyphenate their maiden and married name are requested to be consistent in such usage.

NOT APPLICABLE

Name	used from: mo./yr.	to	mo./yr.
Name	used from: mo./yr.	to	mo./yr.

SECTION 2: Educational Background

1. Preliminary Education- Census Blank  
You must complete the enclosed census blank in order to apply for your preliminary education number as required by Ohio law.
2. List the names of all medical schools attended, the complete addresses, your date of graduation, and the degree that you received. Give the exact degree that appears on your diploma (M.D., D.O.,

3. You must submit a copy of your original language diploma whether you are an American or foreign graduate.

If it is not in English, you must supply an original certified official translation of your medical diploma which will be returned to you. The translation must be on letterhead stationery, notarized and bear both the official seal and signature of the notary. The translation should be made by one of the following individuals or institutions:

- a) a professor of languages in that language
- b) a priest or cleric only in the case of Latin documents
- c) a recognized translation service, in the United States, e.g., Berlitz
- d) a foreign embassy or consulate authorized to certify translations
- e) your medical school of graduation only in the case of your medical diploma

The translator must attest to the translation, sign, and date the translation in the presence of a notary or officer authorized to administer oaths. This translation must be submitted in addition to the notarized photocopy of your diploma in its original language.

4. Standard E.C.F.M.G. Certificate

Graduates of foreign medical schools who were not American citizens prior to entering medical school should possess a valid standard E.C.F.M.G. Certificate if they graduated after 1957. Give the number and date of your certificate if applicable.

Number 233-127-0 Date Sept. 10, 1980

5. Submit a copy of E.C.F.M.G. Certificate, if applicable.

SECTION 3: Postgraduate Training

All applicants are required to complete the chart below indicating the dates and hospitals of all postgraduate training in the U.S. Give the complete address of the hospital where you were employed. Give your position and department in which you served. Account for the percentage of your time spent in clinical and administrative duties. These two numbers should add up to 100 percent.

Date mo/yr-mo/yr	Hospital	Complete Address	Position & Department	% Clin.	% Admin.
7/1/80 to 6/30/84	University Hospital	100, Bergen Street, Newark, N.J. 07103	RESIDENT, OB-GYN	90	10

Total Number of Months in Approved\* Training: 48 months

\*Approved by LCME, AOA, or in Canada.

SECTION 4: Licensure Information- Answer All Questions

1. a) Are you a diplomate of the National Board of Medical Examiners?  
Yes ( ) No (✓) If so, specify year \_\_\_\_\_  
Are you a diplomate of the National Board of Examiners for Osteopathic Physicians and Surgeons?  
Yes ( ) No (✓) If so, specify year \_\_\_\_\_  
Are you a licentiate of the Medical Council of Canada?  
Yes ( ) No (✓) If so, specify year \_\_\_\_\_
- b) List all FLEX exams which you have taken. Indicate whether you took all three days (place an "X" next to Full) or whether you took only part of the exam (place an "X" next to Partial).

STATE

DATE (Mo/Yr.)

- c) List all other State Board exams taken. Indicate whether you took a full (place an "X" next to Full) or whether you took only part of the exam (place an "X" next to Partial). Also give the month and year you took the exam.

STATE DATE (Mo/Yr.)

NONE

FULL ( ) PARTIAL ( ) PASS ( ) FAIL ( )

FULL ( ) PARTIAL ( ) PASS ( ) FAIL ( )

FULL ( ) PARTIAL ( ) PASS ( ) FAIL ( )

2. List ALL states in which you are or have been fully licensed to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number and the date it was issued. If the license is properly renewed, check YES under current. If the license was not renewed, check NO.

State	Date of Issuance	License Number	Current
Oklahoma	May 1984	14640	YES (✓) NO ( )
New Jersey	Feb. 1982	40132	YES (✓) NO ( )
			YES ( ) NO ( )
			YES ( ) NO ( )
			YES ( ) NO ( )

3. List all foreign countries in which you hold a full right to practice medicine and surgery.

Country	Date Conferred	Is Right Currently Held? (Yes or No)
INDIA	Jan '76	Yes ( ) No (✓)
		Yes ( ) No ( )

4. Field of Specialization

List the field in which you have specialized (Family Medicine, Internal Medicine, Surgery, etc.). Indicate if you are Board Certified and the countries in which you are so certified.

Field	Board Certified	Year Certified	Country
OB-GYN	YES ( ) NO (✓)	1984	U.S.A.
	YES ( ) NO ( )		

#### SECTION 5: General Information- Answer All Questions

Each of the following questions must be answered with a yes or a no answer. Be sure to read each question carefully. All affirmative answers must be thoroughly explained. Attach a separate sheet of paper if necessary.

1. Has any license entitling you to practice in any foreign country or in any state or territory of the United States been suspended, surrendered, or revoked? YES ( ) NO (✓) If so, give:

STATE \_\_\_\_\_ DATE \_\_\_\_\_ CHARGE \_\_\_\_\_

2. Have you ever been denied licensure or application for licensure in any other state or territory for any reason? YES ( ) NO (✓)

If so, specify: \_\_\_\_\_  
State or country Reason Date

3. Have you ever been or are you now addicted to the use of drugs or alcohol? YES ( ) NO (✓)

4. Have you ever been convicted of a violation of a federal law, state law, or municipal ordinance other than a minor traffic violation? YES ( ) NO (✓)

5. Has your narcotic license ever been suspended, surrendered, or revoked? YES ( ) NO (✓)

If so, specify:

ReasonDate

6. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? YES ( ) NO (✓)

If so, specify:

School, Hospital or Institution

City/StateCountry

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (✓)

If so, specify:

Hospital or Institution

City/StateCountry

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. 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.

COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF AP- PLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)					
DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	POSITION & DEPARTMENT	% CLIN.	% ADMIN.	
1/76 - 5/78	D-34, E.S.I.S. GOVT. DISPENSARY	INDIA	95	5	
6/78 - 6/80	UNEMPLOYED	PREPARING FOR ECFMG AND FLEX EXAMINATION			
7/80 - 6/84	UNIVERSITY HOSPITAL	100, Bergen Street, Newark, N.J. 07103	90	10	
Since 7/1/84	Mission Hill Hospital	1900, Gordon Cooper Drive, Shawnee, Ok. 74801	85	15	

City/State

Country

## SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. 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.

COMPLETE ADDRESS  
(INCLUDING STREET,  
APARTMENT, (IF AP-  
PLICABLE), CITY, STATE  
ZIP CODE, AND COUNTRY  
(IF NOT IN THE U.S.)

PATEL, N.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF AP- PLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADMIN.
1/76 - 5/78	D-34, E.S.S.- Govt. DISPENSARY	AHMEDABAD 380008, INDIA	MEDICAL OFFICER	95	5
6/78 - 6/80	UNEMPLOYED	PREPARING FOR ECFMG AND FLEX EXAMINATION 226 Mt. Vernon Place, APT. 4N Newark N.J. 07106		-	-
7/80 - 6/84	UNIVERSITY HOSPITAL	100, Bergen Street, Newark, N.J. 07103	RESIDENT OB-GYN	90	10
Since 7/1/84	Mission Hill Hospital	1900, Gordon Cooper Drive, Shawnee, Ok. 74801	Private Practice OB-GYN	85	15

IX 4/25

FORM 2

CERTIFICATE OF POST-GRADUATE TRAINING

MUST BE COMPLETED FOR APPLICANTS WHO ARE GRADUATES OF FOREIGN MEDICAL SCHOOLS\*

This certifies that NARESHKUMAR PATEL, M.D. has rendered satisfactory  
Name of Applicant

and continuous service as a RESIDENT IN OBSTETRICS AND GYNECOLOGY  
Position/Department

at UNIVERSITY HOSPITAL, 100 BERGEN STREET, NEWARK, N.J.  
Hospital Address of Hospital

from JULY 1, 1980 to JUNE 30, 1984  
Beginning mo/day/yr of Service Ending mo/day/yr of Service

This training was/~~was not~~ AMA approved.

  
Signature

(PLACE HOSPITAL SEAL HERE)

HAROLD A. KAMINETZKY, M.D.  
Name

PROFESSOR AND CHAIRMAN, DEPT. OB/GYN  
Position

JULY 10, 1984  
Date

This form is to be sent to the hospitals at which the above named physician trained. It must be completed by either the director of the training program, the director of the department, the hospital administrator or an individual authorized to verify the requested information. THE HOSPITAL SEAL MUST BE PLACED IN THE APPROPRIATE PLACE.

This information will be used for licensure purposes.

\*Unless the applicant is American-born and holds a full right to practice in a foreign country.

UPON COMPLETION RETURN TO:

STATE MEDICAL BOARD OF OHIO  
65 SOUTH FRONT STREET  
ROOM 510  
COLUMBUS, OHIO 43215

84 AUG 29 P2:18  
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OHIO STATE  
MEDICAL BOARD

## FORM 3

CERTIFICATE OF RECOMMENDATION

MUST BE COMPLETED FOR ALL APPLICANTS

This form is to be completed by a fully licensed physician in the state in which the form is notarized. The recommending physician should be sufficiently acquainted with the applicant for at least a six month period as to be able to evaluate and recommend the applicant. No relatives can serve as recommending physician. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. 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.

I, SHETTY SHASHINDRA P., M.D., a licensed and practicing physician in the state of  
Oklahoma, affirm that Nareshkumar G. Patel, MD has been known  
 to me personally and professionally for 2 years and that he/she is of good moral and ethical  
 character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as good  
 His/her command of the English language is good  
 I rate his/her ability to work well with peers and medical staff as good  
 His/her relationship with patients is good

In the space below, please add personal comments, evaluation, and recommendation. If more space is required, please attach additional sheets.

I hereby recommend NARESHKUMAR G. PATEL, M.D. for full licensure to practice MEDICINE  
Applicant  
 in Ohio.

Seth G S Medical College, Bombay, India  
Medical School of Graduation of  
Recommending Physician

Signature of Recommending Physician

OKLAHOMA  
State of Licensure of Recommending Physician

11139  
License No. of Recommending Physician

SHETTY SHASHINDRA P., M.D.  
Name of Recommending Physician (Please print)

1902, Gordon Cooper Drive,  
Shawnee, Oklahoma 74501  
Address of Recommending Physician

(405) 275-6902  
Telephone Number (Include area code)

Subscribed and sworn to this 20<sup>th</sup> day of August, 1984.

(SEAL)

Elaine S. Kieffer  
Notary Public

5-3-87  
Date Commission Expires

UPON COMPLETION, RETURN TO:

STATE MEDICAL BOARD OF OHIO  
 65 SOUTH FRONT STREET  
 ROOM 510  
 COLUMBUS, OHIO 43215

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I, WIT CHAINAKUL, M.D., a licensed and practicing physician in the state of  
OKLA., affirm that NARESHKUMAR G. PATEL has been known  
 to me personally and professionally for 1/2 years and that he/she is of good moral and ethical  
 character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as good  
 His/her command of the English language is good  
 I rate his/her ability to work well with peers and medical staff as good  
 His/her relationship with patients is good.

In the space below, please add personal comments, evaluation, and recommendation. If more space is required, please attach additional sheets.

I hereby recommend NARESHKUMAR G. PATEL, M.D. for full licensure to practice MEDICINE  
 Applicant  
 in Ohio.

CHULALONGKORN UNIVERSITY - BANGKOK  
 Medical School of Graduation of THAILAND.  
 Recommending Physician

OKLA.  
 State of Licensure of Recommending Physician

12549  
 License No. of Recommending Physician

Wit Chainakul, M.D.  
 Signature of Recommending Physician

WIT CHAINAKUL, M.D.  
 Name of Recommending Physician (Please print)

Wit Chainakul, M.D.  
1902 Gordon Cooper Dr  
 Address of Recommending Physician

(405) 275-555  
 Telephone Number (Include area code)

Subscribed and sworn to this 20<sup>th</sup> day of August, 1984.

(SEAL)

Gimmie L. Tjapi  
 Notary Public

12-9-85  
 Date Commission Expires

UPON COMPLETION, RETURN TO:

STATE MEDICAL BOARD OF OHIO  
 65 SOUTH FRONT STREET  
 ROOM 510  
 COLUMBUS, OHIO 43215



CERTIFIED COPY OF STATE LICENSE OR CERTIFICATE

MUST BE COMPLETED FOR APPLICANTS WHO ARE APPLYING FOR ENDORSEMENT  
OF ANOTHER STATE LICENSE

(TO ALL STATE MEDICAL BOARDS OR OSTEOPATHIC BOARDS:  
DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED)

(A verbatim copy or wording to follow here, over Seal of State Licensing Board,  
certified to by the Secretary, President, or Executive Secretary thereof.)

## NEW JERSEY BOARD OF MEDICAL EXAMINERS

Certifies that Nareshkumar G. Patel M.D.  
has passed a satisfactory examination before this Board and is  
hereby licensed to practice Medicine and Surgery in the State of  
New Jersey.

No. 40132 Trenton, New Jersey 2/8/82.

I hereby certify that the above is a verbatim copy or wording of license no. 40132,  
issued to Dr. Nareshkumar G. Patel by the NJ St. Bd. of Med. Examiners on the 8th  
day of February, 19 82.  
(Name of State Board)

(Seal)

Charles A. Janousek KMC  
~~Secretary, President, or Executive Secretary~~  
Charles A. Janousek

B CERTIFICATE AND RECOMMENDATION OF SECRETARY, PRESIDENT, OR EXECUTIVE SECRETARY  
(DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED)

Acting in behalf of the NJ State Board of Medical Examiners  
(Name of State Board)

I do hereby certify that Dr. N.G. Patel was on the 8th day of February  
19 82, granted a license to practice medicine & surgery in the State of New Jersey  
on the basis of FLEX examination  
(State Board examination, National Board of Examiners,  
or reciprocity/endorsement)

(Include all grades as well as average score)

To be provided by FLEX  
KMC

and received an average of      percent.

I do hereby certify that the applicant does hold a current, valid license in this state.

(Seal)

8/15/84

(Date)

Charles A. Janousek KMC  
~~Secretary, President, or Executive Secretary~~  
Original signature only, name stamps will not be  
accepted Charles A. Janousek

UPON COMPLETION, RETURN TO:

STATE MEDICAL BOARD OF OHIO  
65 SOUTH FRONT STREET  
ROOM 510  
COLUMBUS, OHIO 43215

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MEDICAL BOARD  
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FORM 4

**CERTIFIED COPY OF STATE LICENSE OR CERTIFICATE**  
**MUST BE COMPLETED FOR APPLICANTS WHO ARE APPLYING FOR ENDORSEMENT**  
**OF ANOTHER STATE LICENSE**

A

**(TO ALL STATE MEDICAL BOARDS OR OSTEOPATHIC BOARDS:**  
**DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED)**

(A verbatim copy or wording to follow here, over Seal of State Licensing Board,  
 certified to by the Secretary, President, or Executive Secretary thereof.)

**NEW JERSEY BOARD OF MEDICAL EXAMINERS**

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 (Name of State Board)

(Seal)

Charles A. Janousek  
 Secretary, President, or Executive Secretary  
 Charles A. Janousek

**CERTIFICATE AND RECOMMENDATION OF SECRETARY, PRESIDENT, OR EXECUTIVE SECRETARY**  
**(DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED)**

Acting in behalf of the NJ State Board of Medical Examiners  
 (Name of State Board)

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 19 82, granted a license to practice medicine & surgery in the State of New Jersey  
 on the basis of FLEX examination  
 (State Board examination, National Board of Examiners,  
 or reciprocity/endorsement)

(Include all grades as well as average score) FLEX Weighted Average 78%  
BAS SCI ANAT 68 PHYS 72 BIO 62 PATH 72 MICR 66 PHAR 71 BEH S 75 AVG 69.42  
CLIN SCI MED 82 SURG 82 OB 89 PH 76 PED 82 PSY 77 AVG 81.33 CLIN COMP 80.03

and received an average of 75 percent.

I do hereby certify that the applicant does hold a current, valid license in this state.

(Seal)

8/15/84

(Date)

UPON COMPLETION, RETURN TO:

STATE MEDICAL BOARD OF OHIO  
 65 SOUTH FRONT STREET  
 ROOM 510  
 COLUMBUS, OHIO 43215

Charles A. Janousek  
 Secretary, President, or Executive Secretary  
 Original signature only, name stamps will not be  
 accepted Charles A. Janousek

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State of New Jersey

DEPARTMENT OF LAW AND PUBLIC SAFETY

DIVISION OF CONSUMER AFFAIRS

BOARD OF MEDICAL EXAMINERS

28 WEST STATE STREET  
TRENTON, N.J. 08608  
(609) 292-4843

IRWIN I. KIMMELMAN  
ATTORNEY GENERAL

JAMES J. BARRY, JR.  
DIRECTOR

August 13, 1984


Ohio State Medical Board  
65 S. Front St. #510  
Columbus, Ohio 43215

To Whom It May Concern:

The files of the State Board of Medical Examiners of New Jersey indicate that license number #40132 was issued on 2/8/82 to Nareshkumar G. Patel, M.D. to practice all branches of Medicine & Surgery in the State of New Jersey. Dr. Nareshkumar G. Patel's license is currently registered and our files reveal no derogatory information.

Very truly yours,

NEW JERSEY STATE BOARD  
OF MEDICAL EXAMINERS

  
Charles A. Janousek  
Executive Secretary

Board Seal

CAJ:gg

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CERTIFIED COPY OF STATE LICENSE OR CERTIFICATE

MUST BE COMPLETED FOR APPLICANTS WHO ARE APPLYING FOR ENDORSEMENT  
OF ANOTHER STATE LICENSE

A

(TO ALL STATE MEDICAL BOARDS OR OSTEOPATHIC BOARDS:  
DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED)

(A verbatim copy or wording to follow here, over Seal of State Licensing Board,  
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No. 40132 Trenton, New Jersey 2/8/82.

I hereby certify that the above is a verbatim copy or wording of license no. 40132,  
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(Name of State Board)  
day of February, 19 82.

(Seal)

Charles A. Janousek KMC  
~~Secretary, President, or Executive Secretary~~  
Charles A. Janousek

B CERTIFICATE AND RECOMMENDATION OF SECRETARY, PRESIDENT, OR EXECUTIVE SECRETARY  
(DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED)

Acting in behalf of the NJ State Board of Medical Examiners  
(Name of State Board)

I do hereby certify that Dr. N.G. Patel was on the 8th day of February  
19 82, granted a license to practice medicine & surgery in the State of New Jersey  
on the basis of FLEX examination  
(State Board examination, National Board of Examiners,  
or reciprocity/endorsement)

(Include all grades as well as average score)

To be provided by FLEX  
KMC

and received an average of        percent.

I do hereby certify that the applicant does hold a current, valid license in this state.

(Seal)

8/15/84

(Date)

Charles A. Janousek KMC  
~~Secretary, President, or Executive Secretary~~  
Original signature only, name stamps will not be  
accepted Charles A. Janousek

UPON COMPLETION, RETURN TO:

STATE MEDICAL BOARD OF OHIO  
65 SOUTH FRONT STREET  
ROOM 510  
COLUMBUS, OHIO 43215

84 AUG 20 AM 1:46

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OHIO STATE  
MEDICAL BOARD

ORIGINAL GIVEN TO

DR. PATEL AT HIS REQUEST

8/15/84 CAT KMC

SECTION 7: Examination Scheduling Request (To be completed by applicants for examination only)

1. I wish to apply for the June ( ) December ( ) \_\_\_\_\_ FLEX examination.  
Fill in year

Indicate which FLEX examination you are applying to take by placing an "X" next to the appropriate month and filling in the appropriate year.

SECTION 8: Photograph, Photoslip, and Certificates of Recommendation (Form 3)

1. Certificates of Recommendation (Form 3) must be completed by two fully licensed physicians. The physicians must be licensed in the state in which the form is notarized. A Form 3 is enclosed for each recommending physician. Each recommending physician must also sign your photoslip as indicated below. The Certificates of Recommendation must be notarized. THE PHYSICIANS MUST HAVE KNOWN THE APPLICANT FOR AT LEAST A SIX MONTH PERIOD. NO RELATIVES CAN SERVE AS RECOMMENDING PHYSICIANS FOR FORM 3.
2. You must submit a recent color photograph. Attach the photoslip enclosed in the application to this photo. Sign and date the back of the photo and print your name. Have each of the physicians who signed your recommendation forms also sign the photoslip.

SECTION 9: Release of Applicant

STATE OF Oklahoma

COUNTY OF Pottawatomie ss:

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the State Medical Board of Ohio any information, files, or records requested by the Board in connection with this application. I further authorize the State Medical Board of Ohio to release to the organizations, individuals, or groups listed above any information which is material to my application.

(Signature of Affiant)

NARESHKUMAR G. PATEL, M.D.

Subscribed and sworn to this 20<sup>th</sup> day of

August, 1984

(Signature of Official Administering Oath)

5-3-87

(Date Commission Expires)

(SEAL)

Must be sworn to before a notary public or other person authorized to administer oaths.

SECTION 10: Affidavit of Applicant

STATE OF Oklahoma ss:

COUNTY OF Pottawatomie

Before me, personally appeared NARESHKUMAR G. PATEL, M.D.  
(Affiant)

who being duly sworn says that he is the person referred to in the foregoing application for license to practice medicine and surgery or osteopathic medicine and surgery in the State of Ohio; that the statements therein and the documents or copies of documents attached thereto are strictly true in every respect and that he has read and understands this Affidavit.

(Signature of Affiant)

Subscribed and sworn to this 20<sup>th</sup> day of

August, 1984

(Signature of Official Administering Oath)

5-3-87

(Date Commission Expires)

(SEAL)

\*Must be sworn to before a notary public or other person authorized to administer oaths.

FOR BOARD USE ONLY

CERTIFICATE OF  
PRELIMINARY EDUCATION

No. 66105

This is to certify that this applicant has met the 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.

R. L. Bengarney

Entrance Examiner

Joseph J. Jenkins

Secretary

11-5-84

Date Issued

FOR BOARD USE ONLY

#100095

NAME: Patel, Nareshkumar S., MD.

CERTIFICATE NO. 51343 DATE ISSUED 11-5-84

FILED 6-20-, 1984

FEE \$175.00

DETERMINATION: Oct Poll Vote

BOARD ACTION: Bnd Approved

BASIS OF LICENSURE:

Revised:



I HEREBY CERTIFY THAT I HAVE RECEIVED MY WALL CERTIFICATE

NUMBER 7343, ON 5/28/85

Name N. G. P. S. S. S.

Street Address \_\_\_\_\_

City \_\_\_\_\_ State/Country \_\_\_\_\_ Zip \_\_\_\_\_

Signature [Signature]

PLEASE CHECK IF THIS IS A CHANGE OF ADDRESS \_\_\_\_\_

REVIEW SHEET FOR FOREIGN MEDICAL GRADUATES

NAME: PATEL, Naresh Kumar G. Audit # 095  
 BIRTHDATE: 11/19/52 BIRTHPLACE: Pansar, Gujarat, India Code # 496  
 SCHOOL CODE: \_\_\_\_\_  
 SCHOOL OF GRADUATION: NHL Municipal Med Coll SCHOOL LOCATION: Ahmedabad, India  
 DATE DEGREE CONFERRED: 3/29/76 DEGREE CONFERRED: MBBS  
 CITIZENSHIP STATUS: Cert of Nat  
 E.C.F.M.G. NUMBER: 233-127-0 DATE ISSUED: 9/10/80  
 INTERNSHIP: \_\_\_\_\_

RESIDENCY: Univ Hosp - OB/GYN Newark, NJ 7/80-6/84

FELLOWSHIP: \_\_\_\_\_

DATE FLEX EXAM TAKEN: 12/81 FOR: NJ

BASIC SCIENCE: 69.42 CLINICAL SCIENCE: 81.33 CLINICAL COMP: 80.03 FLEX WTD. AVG: 78

LICENSED IN: NJ 2/82 BASIS: FLEX

LETTERS OF RECOMMENDATION: Shetty Shasmindra, MD Shawnee, OK  
Wit Chaiwaku, MD "

SPECIALTY: OB/GYN

SPECIALTY BOARDS: ✓

PLANS OF PRACTICE: ?

AMA INFORMATION: \_\_\_\_\_ FED INFORMATION: \_\_\_\_\_ REC FORMS: \_\_\_\_\_

STATE BOARD FORMS: NJ, OK

REMARKS:

9/12/84 { ~~AAAA, RECS - Mission Hill, Univ Hosp~~  
~~clears NJ, OK~~

9/12/84 { ~~Resume - full address 6/78-6/80~~  
~~Form 4 - must have FLEX scores~~  
~~FLEX scores~~  
~~training cert - Univ Hosp~~



THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.  
2630 WEST FREEWAY, #138, FORT WORTH, TEXAS 76102-7199

TO: CFIC

SUBJECT: FLEX Examination Grades For:

PATEL, NARESIKUNAR G  
1962 GORION COOPER DR  
SEASIDE CA  
74211

FIN [REDACTED]  
Birthdate 11-19-62  
Date of Certification 08-30-84

It is certified that the named physician took the Federation Licensing Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following grades.

EXAMINATION DATE ..... 12-31-80-81  
FOR STATE ..... 131 131  
STATE ID # ..... 00193 00138

BASIC SCIENCE

Anatomy .....	65	67
Physiology .....	72	69
Biochemistry .....	39	37
Pathology .....	72	74
Microbiology .....	63	65
Pharmacology .....	71	73
Behavioral Science .....	75	62

BASIC SCIENCE AVERAGE ..... 60.42 53.92

CLINICAL SCIENCE

Medicine .....	82	71
Surgery .....	82	72
Obstetrics .....	80	81
Public Health .....	73	73
Pediatrics .....	82	77
Psychiatry .....	77	62

CLINICAL SCIENCE AVERAGE ..... 71.33 72.66

CLINICAL COMPETENCE AVERAGE ..... 66.83 75.66

FLEX WEIGHTED AVERAGE ..... 70.82 73.32

84 SEP -4 P2:28

RECEIVED  
OHIO STATE  
MEDICAL BOARD

WE HAVE NO UNFAVORABLE  
INFORMATION REGARDING  
THE ABOVE NAMED PHYSICIAN

*Bryant L. Galusha, M.D.*  
BRYANT L. GALUSHA, M.D.  
EXECUTIVE VICE PRESIDENT

STATE OF OHIO  
THE STATE MEDICAL BOARD  
Suite 510  
65 South Front Street  
Columbus, Ohio 43215

PM

DATE September 12, 1984

Dear Doctor,

Dr. Nareshkumar G. Patel who is/was OB/GYN private practice 7/1/84-present is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

- (1) How long have you known the doctor? Approx 4 months
- (2) What was/is your supervisory capacity? Hospital Administrator/CEO
- (3) At what hospital? Mission Hill Memorial Hospital
- (4) How would you rate this doctor's medical knowledge and techniques? Above Average.
- (5) In your opinion, is this doctor a person of good moral and ethical character? yes.
- (6) Does this doctor work well with peers and medical staff? yes
- (7) Does he/she relate well to patients? yes
- (8) How is his/her command of the English language? (If applicable) Has good command of English language.
- (9) Would you recommend this doctor for licensure? yes

Additional comments, please: (If needed, an extra sheet of paper may be used)

Seems to have good rapport with hospital personnel, patients, and members of the medical staff. Seems to be well trained, performs well in delivery and surgery.

Please return this form to the Ohio State Medical Board at the above address,  
Sincerely,

Penny McKenzie

Penny McKenzie  
Licensure Assistant

Bennie Witzke Admin/CEO.  
Signature of Doctor, please type or print name legibly beneath

Bennie Witzke  
Administrator  
Position

DATE 10-5-84

Telephone No. 405-273-2240 (Include Area Code)

84 OCT -9 AM 1:57

OHIO  
MEDICAL  
BOARD

STATE OF OHIO  
THE STATE MEDICAL BOARD  
Suite 510  
65 South Front Street  
Columbus, Ohio 43215

PM

DATE September 12, 1984

Dear Doctor,

Dr. Nareshkumar Patel who is/was Resident-OB/GYN 7/80-6/84  
is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out  
the following evaluation so that we can process his/her papers for licensure. Your immediate  
attention to this matter will be greatly appreciated by the doctor as well as by us. Information  
provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you  
for your time and assistance.

- (1) How long have you known the doctor? 5 years
- (2) What was/is your supervisory capacity? Director of Division of Obstetrics
- (3) At what hospital? University Hospital, Newark, New Jersey
- (4) How would you rate this doctor's medical knowledge and techniques? Very good
- (5) In your opinion, is this doctor a person of good moral and ethical character? Yes
- (6) Does this doctor work well with peers and medical staff? Yes
- (7) Does he/she relate well to patients? Yes
- (8) How is his/her command of the English language? (If applicable) Very good
- (9) Would you recommend this doctor for licensure? Yes

Additional comments, please: (If needed, an extra sheet of paper may be used)

Very competent and reliable physician. He has good clinical judgment and very  
satisfactory surgical skills.

Please return this form to the Ohio State Medical  
Board at the above address,  
Sincerely,

*Penny McKenzie*

Penny McKenzie  
Licensure Assistant

*Nareshkumar Patel*

Signature of Doctor, please type or print  
name legibly beneath

Professor of Obstetrics/Gynecology

Position

DATE September 20, 1984

Telephone No. (201) 456-5838 (Include Area Code)

84 SEP 24 P3:17

RECEIVED  
OHIO STATE  
MEDICAL BOARD

OHIO  
MEDICAL BOARD  
SEP 28 PM 3:12

STATE OF OHIO  
THE STATE MEDICAL BOARD  
Suite 510  
65 South Front Street  
Columbus, Ohio 43215

85

PM

TO: New Jersey  
FROM: Penny McKenzie, Licensure Assistant

The following physician has applied for licensure in Ohio. Our files indicate that he is licensed to practice in your state. Please complete the form below, and return it to this office as soon as possible since licensure or eligibility for examination is dependent upon receipt. Thank you for your cooperation.

Name Nareshkumar G. Patel

Date of Birth 11/19/52 License Number 40132 Issued Feb., 1982 (2/8/82)

Is the license current? Yes If not, please explain \_\_\_\_\_

What is basis of license? FLEX (X) Written Exam ( ) National Boards ( )  
Examination  
Endorsement/Reciprocity ( ) Other ( )

Has license been revoked, suspended, or surrendered? No

Reason: \_\_\_\_\_  
\_\_\_\_\_

Derogatory Information: None  
\_\_\_\_\_  
\_\_\_\_\_

Remarks: None  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Board Seal

Signed Charles A. Janousek  
Charles A. Janousek  
Title Executive Secretary

Date 9/17/84

STATE OF OHIO  
THE STATE MEDICAL BOARD  
Suite 510  
65 South Front Street  
Columbus, Ohio 43215

RECEIVED

SEP 21 1984

STATE BOARD  
MEDICAL EXAMINERS

TO: Oklahoma

FROM: Penny McKenzie, Licensure Assistant

The following physician has applied for licensure in Ohio. Our files indicate that he is licensed to practice in your state. Please complete the form below, and return it to this office as soon as possible since licensure or eligibility for examination is dependent upon receipt. Thank you for your cooperation.

Name Nareshkumar G. Patel

Date of Birth 11/19/52 License Number 14640 Issued May, 1984

Is the license current? yes If not, please explain \_\_\_\_\_

What is basis of license? FLEX ( ) Written Exam ( ) National Boards ( )

Endorsement/Reciprocity ( ☒ ) Other ( )

Has license been revoked, suspended, or surrendered? no

Reason: \_\_\_\_\_

Derogatory Information: none

Remarks: \_\_\_\_\_

Signed Barbara A. Smith

Title Administrator

Date 9-17-84



the Chancellor, Vice-Chancellor and Members  
of the Court of the University certify

[Signature]

that the within signed

RECEIVED  
OHIO STATE  
MEDICAL BOARD

'84 AUG 29 P2:21

Nareshkumar Gandhalal Patel of

M. G. L. M. Medical College, having been examined  
for the Degree of Bachelor of Medicine and  
Bachelor of Surgery and having undergone the  
prescribed period of housemanship and found qualified  
for the same, the Degree of

**Bachelor of Medicine & Bachelor of Surgery**

has been conferred on him at Ahmedabad, on the  
twenty ninth day of the month of March in the  
year one thousand nine hundred and seventy six.

In Testimony whereof are set the Seal of the  
said University and the Signature of the said  
Vice Chancellor.

[Signature]

Vice Chancellor.

# EDUCATIONAL COMMISSION for

## FOREIGN MEDICAL GRADUATES

RECEIVED  
OHIO STATE  
MEDICAL BOARD

'84 AUG 29 P2:19

CERTIFICATE

PATEL NARISHKUMAR GANDAJAL

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,

SUCCESSFULLY PASSED ITS EXAMINATIONS

AND HAS BEEN AWARDED THIS CERTIFICATE.

CERTIFICATE NUMBER 233-127-0

MEDICAL EXAMINATION

JANUARY 24, 1979

ENGLISH EXAMINATION

JANUARY 23, 1980

DATE ISSUED

September 10, 1980

VALID THROUGH

English Examination

February 15, 1980

Valid Indefinitely



*Harold J. Gentry, Jr.*  
PRESIDENT

*Ray L. Gentry, Jr.*  
EXECUTIVE DIRECTOR

# State of New Jersey



Robert Wood Johnson Medical School

New Jersey

certify that

G. PATEL, M.D.

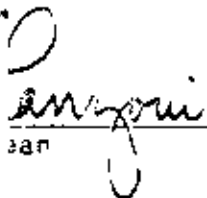
satisfactorily as

RICS and GYNECOLOGY

, June 30, 1988

hospitals program

University Hospital  
Medical Center

  
\_\_\_\_\_  
Patel

  
\_\_\_\_\_  
Program Director



'84 SEP 20 PM 7:54

# University of Medicine and Dentistry of New Jersey

Newark, New Jersey

This is to

**NARESH KUMAR**

has served as

**RESIDENT in OBSTETRICS**

July 1, 1980 to

in the affiliated

UMDNJ-UM  
Hackensack



*Harold A. Kennedy*  
Department Chairman

*James*

# University of Medicine and Dentistry of New Jersey

For Training of

Newark, N.J.

'84 SEP 20 PM 7:54

This is to

**NARESHKUMAR**

has served as

**CHIEF RESIDENT in OBS**

July 1, 1987 to

in the affiliated-

UMDNJ- Uni

Hockensack



*James J. Trinchese*  
Department Chairman

*James J. Trinchese*

State of New Jersey  
84 SEP 20 1984

Office of the  
New Jersey

certify that

G. PATEL, M.D.

satisfactorily as

OBSTETRICS and GYNECOLOGY

June 30, 1984

hospital's program

University Hospital  
Medical Center

*[Signature]*

*[Signature]*  
Program Director



Ref. No.

Smt. Nathiba Hargovandas Lakhmichand  
**MUNICIPAL MEDICAL COLLEGE.**  
OHIO STATE  
MEDICAL BOARD

78: 75  
Tele. No. 3447 X  
Ellis Bridge,  
AHMEDABAD-380006

84 AUG 29 P2:21

Date 4 - 9 -1979

CERTIFICATE

This is to certify that

Mr./~~Miss~~ Patel Nareshkumar G.

is a bonafide student of Smt. N. H. L. Municipal Medical College,  
Ahmedabad which is affiliated to Gujarat University and is recognised by  
Medical Council of India.

He/~~She~~ has passed final M. B. B. S. Degree examination in October,  
1974 held by Gujarat University.

He/She has successfully undergone the compulsory rotating  
housemanship ( internship training ) of one year from 1st Jan., 1975  
to 31st Dec. 1975 , as under :

	<u>Period</u>		<u>Subject</u>	<u>Name of the institution / hospital.</u>
	<u>From</u>	<u>To</u>		
(1)	1/1/1975	31/3/1975		V.S.General Hospital, Ahmedabad.
(2)	1/4/1975	30/6/1975		Rural Health Center, Sabarmati.
(3)	1/7/1975	30/9/1975		Maha Gujarat Hospital, Nadiad.
(4)	1/10/'75	31/12/'75		L.G.General Hospital, Ahmedabad.

He/~~She~~ bears a good moral character.

  
DEAN  
N. H. L. Municipal Medical College  
Ahmedabad-380006.

Tele. No. { 78375  
77080

Smt. Nathiba Hargovandas Lakhmichand

**MUNICIPAL MEDICAL COLLEGE**  
MEDICAL BOARD

Ellis Bridge,  
AHMEDABAD-6.

Ref. No. '84 AUG 29 P2:21

Date 4 - 9 -1979

C E R T I F I C A T E

This is to certify that Dr. Patel Nareshkumar G. was a bonafide student of this college from June 1970 to October 1974. He has passed final M.B.B.S. examination in October 1974, held by Gujarat University.

After having passed the final M.B.B.S. he was posted for one year's compulsory rotating housemanship from 1-1-1975 to 31-12-1975. He is now eligible for full registration after satisfactory completion of his compulsory rotating housemanship.


During the study here as an undergraduate student the following hours of work are required to be put in by a medical student in different subjects. After his admission the attendance of Mr. Patel Nareshkumar G. was regular during the period of his study at this Medical College.

The course pursued during the study at this college:

	Subjects	Hours
I M.B.B.S.	(1) Anatomy, Embryology	982
	(2) Physiology, Biochemistry, Histology	700
II M.B.B.S.	(1) Pharmacology	416
	(2) Pharmacodynamics and Therapeutics	354
	(3) Forensic Medicine	54
	(4) Pathology, Bacteriology	354
III M.B.B.S.	(1) Surgery including Ophthalmology, E.N.T., Orthopaedics, Anaesthesia and Radiology.	850
	(2) Medicine including Paediatrics, Preventive & Social Medicine.	910
	(3) Obstetrics & Gynaecology	530

His conduct and behaviour during the period of study were satisfactory.

He bears a good moral character.

  
D E A N

# UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

100 BERGEN STREET / NEWARK, NEW JERSEY 07103

July 10, 1984

State Medical Board of Ohio  
65 South Front Street  
Room 510  
Columbus, Ohio 43215

In re: Nareshkumar Patel, M.D.

To Whom It May Concern:

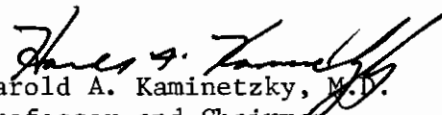
I write on behalf of the above mentioned physician who is applying for licensure in the State of Ohio.

I have known Dr. Patel since July, 1980 when he joined our Department as a first year resident in Obstetrics and Gynecology. Dr. Patel completed his residency training on June 30, 1984. During the time that I have known Dr. Patel he has demonstrated above average skills and knowledge of our specialty. He is extremely hardworking, conscientious and highly motivated. He is very thorough in the treatment of his patients and uses sound medical judgement in their diagnosis and treatment.

Dr. Patel is a very pleasant and personable young man and is well liked by our Attending Staff and his fellow house officers.

For the aforementioned reasons it is without hesitation that I support his application for licensure in the State of Ohio.

Sincerely,

  
Harold A. Kaminetzky, M.D.  
Professor and Chairman  
Department of Obstetrics and Gynecology

HAK:sdw

RECEIVED  
OHIO STATE  
MEDICAL BOARD  
84 AUG 29 P2:19

PATEL, NARESH KUMAR G.

M.D.

Physician Staffing Inc.

app. sent  
6-20-84 JB

To,

Ohio State Medical Board  
65 South Front Street #510  
Columbus, Ohio 43215

'84 JUN 18 P3:50

(614) 466-3934

From,

NARESHKUMAR G. PATEL, M.D.  
220, MT. VERNON PLACE  
APT-4N  
NEWARK, N.J. 07106

Dear Sir,

I hereby request you to send me an applications form for the license to practice medicine in Ohio state. At present I am licensed in State of New Jersey.

Thanking you and waiting for your earliest favourable reply,

Yours Sincerely,

Naresh G. Patel, M.D.

ADDRESS —

NARESHKUMAR G. PATEL, M.D.  
220, MT VERNON PL  
APT-4N

NEWARK, N.J. 07106

(201) 334-2925

9/12/84

STATE OF OHIO  
THE STATE MEDICAL BOARD  
Suite 510  
65 South Front Street  
Columbus, Ohio 43215

614-466-3434

Dear Doctor: N. Patel

SEP 20 PM 2:53

Your credentials and application for licensure have been reviewed. However, to complete the processing of your credentials for the Board:

\_\_\_\_ Submit a notarized copy of your actual medical school diploma in its original language, which conferred the degree of Doctor of Medicine. Documents not in English must be accompanied by an original, certified, official translation.

\_\_\_\_ Submit an original, certified, official translation of your medical school diploma. The translation must be on letterhead stationary, notarized, and bear both the official seal and signature of the notary. The translator must attest to the translation, sign and date the translation in the presence of a notary or officer authorized to administer oaths. This translation must be submitted in addition to the photocopy of your diploma in its original language. The translation should be made by one of the following individuals or institutions:

- a) a professor of languages in that language
  - b) a priest or cleric only in the case of Latin documents
  - c) a recognized translation service, in the United States, e.g., Berlitz
  - d) a foreign embassy or consulate authorized to perform translations
  - e) your medical school of graduation only in the case of your medical diploma
- (Certificates of graduation are not acceptable in lieu of a translation or diploma)

\_\_\_\_ Submit a notarized copy of your standard ECFMG certificate.

☒ Your resume: \_\_\_\_\_ is not fully accountable (time period missing \_\_\_\_\_ to \_\_\_\_\_)  
You must account for all time, working and non-working, by month and year in all countries. Explain what you were doing for all non-working time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER.  
☒ must list exact dates (month and year)  
☒ must list complete addresses 6/78-6/80  
☒ must list position and department  
☒ must list hospitals where you hold/held staff privileges

Listed on Resume  
220 Mt. Vernon Pl.  
# 42,  
Newark, N.J. 07106

\_\_\_\_ Complete the enclosed affidavit form. This must be notarized.

\_\_\_\_ Submit a Certificate of Post-Graduate Training (Form 2) from \_\_\_\_\_  
This form must be completed by either the director of the training program, the director of the department, the hospital administrator or an individual authorized to verify the requested information. The hospital seal must be placed in the appropriate place. PLEASE USE THE ENCLOSED FORM.

\_\_\_\_ The Certificate of Post-Graduate Training (Form 2) submitted by \_\_\_\_\_  
was not completed properly. Enclosed is a duplicate form.

- \_\_\_\_ must be completed by someone of authority at the hospital who can attest to the exact dates and capacities served.
- \_\_\_\_ must have the hospital seal affixed (if no seal, must state so)
- \_\_\_\_ must list position and department served in
- \_\_\_\_ must list exact dates of service
- \_\_\_\_ must have the original signature

\_\_\_\_ Submit two Certificates of Recommendation (Form 3) from two physicians who have known you at least six months. They must also sign the photoslip. PLEASE USE THE ENCLOSED FORMS.



We have received only one Certificate of Recommendation (Form 3) from \_\_\_\_\_, you must submit one more. He must also sign the enclosed photoslip.

The Certificate of Recommendation (Form 3) submitted by \_\_\_\_\_ was not completed properly. Enclosed is a duplicate form.

- \_\_\_\_\_ the form must be notarized
- \_\_\_\_\_ must give full address of recommending physician
- \_\_\_\_\_ was not completed fully
- \_\_\_\_\_ must be completed by someone who is not related to you in any way
- \_\_\_\_\_ must be completed by someone who has known you at least six months

We did not receive a recent COLOR photograph of yourself. Please submit.

We have not received Form 4, which must be certified by the state in which you were licensed by written examination.

We have not received the Certificate of Fifth Pathway (Form 5). Enclosed is a duplicate form to be completed by the school where you completed your Fifth Pathway training.

We have not received a certified copy of your FLEX scores from the Federation of State Medical Boards.

We have not received a copy of the letter you received from the state in which you passed the FLEX examination in. Please submit a notarized copy.

☒ We do not have a training certificate from Univ. Hosp.. Please submit a copy. This is the certificate the hospital issues to you after you complete your training. If you do not have a certificate, then have the Director of the department you were in submit a letter stating the dates of training, the position and department you were in and the reason why you do not have a certificate. The letter must be an original on the hospitals letterhead stationary and bear the Director's original signature.

Please submit a copy of your \_\_\_\_\_ license.

*Copy Submitted*

Why was there a delay between the time you took your examination and the time you were licensed in \_\_\_\_\_?

Please explain why you were not licensed in \_\_\_\_\_.

Part of your credentials are issued in one name, and part in another name. You must supply the appropriate legal document which authorizes the name change, NOTARIZED COPY, (i.e., Marriage Certificate, Divorce Decree). Any documents in a foreign language must be accompanied by an original, certified, official translation.

☒ Other: The Form 4 completed by the New Jersey Board was not completed properly. The

FLEX scores must be indicated on the form. Enclosed is the Form 4 to be completed properly.

*Form 4 sent to state Board of Med. Examiners, New Jersey on 9/17/84*

ONLY THOSE SECTIONS MARKED WITH AN "X" APPLY TO YOU.

*Penny McKenzie*  
Penny McKenzie  
Licensure Assistant

# GRADUATES OF FOREIGN MEDICAL SCHOOLS REQUESTING ENDORSEMENT

NAME: PATEL, Nareshkumar G.

SCHOOL OF GRADUATION: N.H.L. Municipal Medical College

SCHOOL LOCATION: Ahmedabad, India

DATE DEGREE CONFERRED: 3/29/76

DEGREE CONFERRED: MBBS

E.C.F.M.G. NUMBER: 233-127-0

DATE: 9/10/80

INTERNSHIP: none

RESIDENCY: APPROVED  
Univ. Hosp.

Newark, NJ

7/80-6/84

DATE FLEX EXAM TAKEN: 12/81

FOR: New Jersey

FLEX GRADES RECEIVED AS FOLLOWS FROM THE FEDERATION OF STATE MEDICAL BOARDS:

BASIC SCIENCE: 69.42 CLINICAL SCIENCE: 81.33 CLINICAL COMP: 80.03 FLEX WEIGHTED AVG: 78

LICENSED IN: New Jersey 2/82 BASIS: FLEX

LETTERS OF RECOMMENDATION: Shetty Shasindra, MD

Shawnee, OK

Wit Chainakul, MD

Shawnee, OK

SPECIALTY: OB/GYN

SPECIALTY BOARDS: none

AMA INFORMATION: ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
✓		

OCT 30 1984

TIMOTHY L. STEPHENS JR., M. D.

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. 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.

COMPLETE ADDRESS  
(INCLUDING STREET,  
APARTMENT, (IF AP-  
PLICABLE), CITY, STATE  
ZIP CODE, AND COUNTRY  
(IF NOT IN THE U.S.)

PATEL, N.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF AP- PLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADMIN.
1/76 - 5/78	D-34, E.S.I.S. GOVT. DISPENSARY	AHMEDABAD 380008, INDIA	MEDICAL OFFICER	95	5
6/78 - 6/80	UNEMPLOYED	— PREPARING FOR ECFMG AND FLEX EXAMINATION 220, Mt. Vernon Place, APT. 4N Newark N.J. 07106		-	-
7/80 - 6/84	UNIVERSITY HOSPITAL	100, Bergen Street, Newark, N.J. 07103.	RESIDENT OB-GYN	90	10
Since 7/1/84	Mission Hill Hospital	1900, Gordon Cooper Drive, Shawnee, Ok. 74801	Private Practice OB-GYN	85	15

## GRADUATES OF FOREIGN MEDICAL SCHOOLS REQUESTING ENDORSEMENT

NAME: PATEL, Nareshkumar G.SCHOOL OF  
GRADUATION: N.H.L. Municipal Medical CollegeSCHOOL  
LOCATION: Ahmedabad, IndiaDATE DEGREE  
CONFERRED: 3/29/76DEGREE  
CONFERRED: MBBSE.C.F.M.G. NUMBER: 233-127-0DATE: 9/10/80INTERNSHIP: noneRESIDENCY: APPROVED  
Univ. Hosp. Newark, NJ 7/80-6/84DATE FLEX EXAM TAKEN: 12/81 FOR: New Jersey

FLEX GRADES RECEIVED AS FOLLOWS FROM THE FEDERATION OF STATE MEDICAL BOARDS:

BASIC SCIENCE: 69.42 CLINICAL SCIENCE: 81.33 CLINICAL COMP: 80.03 FLEX WEIGHTED AVG: 78LICENSED IN: New Jersey 2/82 BASIS: FLEXLETTERS OF RECOMMENDATION: Shetty Shasindra, MD Shawnee, OKWit Chainakul, MD Shawnee, OKSPECIALTY: OB/GYNSPECIALTY BOARDS: noneAMA INFORMATION: okFEDERATION INFORMATION: okRECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	RECEIVED	ABSTAIN
<input checked="checked" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

JOHN E. RAUCH, D.O.

OCT 25 1984

OCT 23 1984

Hospital or Institution

SEP 20

Country

City/State

P7:54

## SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. 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.

COMPLETE ADDRESS  
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PLICABLE), CITY, STATE  
ZIP CODE, AND COUNTRY  
(IF NOT IN THE U.S.)

PATEL, N.

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF AP- PLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADMIN.
1/76 - 5/78	D-34, E.S.I.S. Govt. DISPENSARY	AHMEDABAD 380008, INDIA	MEDICAL OFFICER	95	5
6/78 - 6/80	UNEMPLOYED	PREPARING FOR ECFMG AND FLEX EXAMINATION 220, Mt. Vernon Place, APT. 4N Newark N.J. 07106		-	-
7/80 - 6/84	UNIVERSITY HOSPITAL	100, Bergen Street, Newark, N.J. 07103.	RESIDENT OB-GYN	90	10
Since 7/1/84	Mission Hill Hospital	1900, Gordon Cooper Drive, Shawnee, Ok. 74801	Private Practice OB-GYN	85	15

GRADUATES OF FOREIGN MEDICAL SCHOOLS REQUESTING ENDORSEMENT

NAME: PATEL, Nareshkumar G.

SCHOOL OF GRADUATION: N.H.L. Municipal Medical College

SCHOOL LOCATION: Ahmedabad, India

DATE DEGREE CONFERRED: 3/29/76

DEGREE CONFERRED: MBBS

E.C.F.M.G. NUMBER: 233-127-0

DATE: 9/10/80

INTERNSHIP: none

RESIDENCY: APPROVED  
Univ. Hosp.

Newark, NJ

7/80-6/84

DATE FLEX EXAM TAKEN: 12/81

FOR: New Jersey

FLEX GRADES RECEIVED AS FOLLOWS FROM THE FEDERATION OF STATE MEDICAL BOARDS:

BASIC SCIENCE: 69.42 CLINICAL SCIENCE: 81.33 CLINICAL COMP: 80.03 FLEX WEIGHTED AVG: 78

LICENSED IN: New Jersey 2/82

BASIS: FLEX

LETTERS OF RECOMMENDATION: Shetty Shasindra, MD

Shawnee, OK

Wit Chainakul, MD

Shawnee, OK

SPECIALTY: OB/GYN

SPECIALTY BOARDS: none

AMA INFORMATION: ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DECLINED	ABSTAIN
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

JOHN H. BUCHAN, D.P.M.

OCT 25 1984

## SECTION 6: Resume

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DEGREE CONFERRED: MBBS

E.C.F.M.G. NUMBER: 233-127-0

DATE: 9/10/80

INTERNSHIP: none

RESIDENCY: APPROVED  
Univ. Hosp.

Newark, NJ

7/80-6/84

OCT 23 1984

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BASIS: FLEX

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Shawnee, OK

Wit Chainakul, MD

Shawnee, OK

SPECIALTY: OB/GYN

SPECIALTY BOARDS: none

AMA INFORMATION: ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
X		

LEONARD L. LOVSHIN, M.D.



## SECTION 6: Resume

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SCHOOL OF GRADUATION: N.H.L. Municipal Medical College

SCHOOL LOCATION: Ahmedabad, India

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DEGREE CONFERRED: MBBS

E.C.F.M.G. NUMBER: 233-127-0

DATE: 9/10/80

INTERNSHIP: none

RESIDENCY: APPROVED Univ. Hosp.

Newark, NJ

7/80-6/84

OCT 23 1984

DATE FLEX EXAM TAKEN: 12/81

FOR: New Jersey

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LICENSED IN: New Jersey 2/82

BASIS: FLEX

LETTERS OF RECOMMENDATION: Shetty Shasindra, MD

Shawnee, OK

Wit Chainakul, MD

Shawnee, OK

SPECIALTY: OB/GYN

SPECIALTY BOARDS: none

AMA INFORMATION: ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	REVIEWED	ABANDON
✓		

CAROL ROLTES

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. 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.

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PATEL, N.

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GRADUATES OF FOREIGN MEDICAL SCHOOLS REQUESTING ENDORSEMENT

NAME: PATEL, Nareshkumar G.

SCHOOL OF GRADUATION: N.H.L. Municipal Medical College SCHOOL LOCATION: Ahmedabad, India

DATE DEGREE CONFERRED: 3/29/76 DEGREE CONFERRED: MBBS

E.C.F.M.G. NUMBER: 233-127-0 DATE: 9/10/80

INTERNSHIP: none

RESIDENCY: APPROVED  
Univ. Hosp. Newark, NJ 7/80-6/84

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LICENSED IN: New Jersey 2/82 BASIS: FLEX

LETTERS OF RECOMMENDATION: Shetty Shasindra, MD Shawnee, OK  
Wit Chainakul, MD Shawnee, OK

SPECIALTY: OB/GYN

SPECIALTY BOARDS: none

AMA INFORMATION: ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:

**OCT 23 1984**

PLEASE CHECK ONE		
APPROVED	DECLINED	ABSTAIN
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**WILLIAM W. JOHNSTON**

Hospital or Institution

SEP 20

Country

City/State

## SECTION 6: Resume

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PATEL, N.

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# GRADUATES OF FOREIGN MEDICAL SCHOOLS REQUESTING ENDORSEMENT

NAME: PATEL, Nareshkumar G.

SCHOOL OF GRADUATION: N.H.L. Municipal Medical College

SCHOOL LOCATION: Ahmedabad, India

DATE DEGREE CONFERRED: 3/29/76

DEGREE CONFERRED: MBBS

E.C.F.M.G. NUMBER: 233-127-0

DATE: 9/10/80

INTERNSHIP: none

RESIDENCY: APPROVED  
Univ. Hosp.

Newark, NJ

7/80-6/84

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FOR: New Jersey

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LICENSED IN: New Jersey 2/82

BASIS: FLEX

LETTERS OF RECOMMENDATION: Shetty Shasindra, MD

Shawnee, OK

Wit Chainakul, MD

Shawnee, OK

SPECIALTY: OB/GYN

SPECIALTY BOARDS: none

AMA INFORMATION: ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:

OCT 23 1984

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
✓		

JOSEPH P. YUT, M. D.

Hospital or Institution

SEP 20

Country

City/State

## SECTION 6: Resume

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Since 7/1/84	Mission Hill Hospital	1900, Gordon Cooper Drive, Shawnee, OK. 74801	Private Practice OB-GYN	85	15

GRADUATES OF FOREIGN MEDICAL SCHOOLS REQUESTING ENDORSEMENT

NAME: PATEL, Nareshkumar G.

SCHOOL OF GRADUATION: N.H.L. Municipal Medical College

SCHOOL LOCATION: Ahmedabad, India

DATE DEGREE CONFERRED: 3/29/76

DEGREE CONFERRED: MBBS

E.C.F.M.G. NUMBER: 233-127-0

DATE: 9/10/80

INTERNSHIP: none

RESIDENCY: APPROVED  
Univ. Hosp.

Newark, NJ

7/80-6/84

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LICENSED IN: New Jersey 2/82

BASIS: FLEX

LETTERS OF RECOMMENDATION: Shetty Shasindra, MD

Shawnee, OK

Wit Chainakul, MD

Shawnee, OK

SPECIALTY: OB/GYN

SPECIALTY BOARDS: none

AMA INFORMATION: ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:

OCT 23 1981

PLEASE CHECK ONE		
APPROVED	DENIED	ABSTAIN
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PETER LANCIONE, M. D.



Hospital or Institution

SEP 20

Country

City/State

## SECTION 6: Resume

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# GRADUATES OF FOREIGN MEDICAL SCHOOLS REQUESTING ENDORSEMENT

NAME: PATEL, Nareshkumar G.

SCHOOL OF GRADUATION: N.H.L. Municipal Medical College ✓ SCHOOL LOCATION: ✓ Ahmedabad, India

DATE DEGREE CONFERRED: 3/29/76 ✓ DEGREE CONFERRED: MBBS ✓

E.C.F.M.G. NUMBER: 233-127-0 ✓ DATE: 9/10/80 ✓

INTERNSHIP: none

RESIDENCY: APPROVED Univ. Hosp. Newark, NJ 7/80-6/84 ✓

DATE FLEX EXAM TAKEN: 12/81 ✓ FOR: New Jersey ✓

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LETTERS OF RECOMMENDATION: Shetty Shasindra, MD Shawnee, OK

Wit Chainakul, MD Shawnee, OK

SPECIALTY: OB/GYN

SPECIALTY BOARDS: none

AMA INFORMATION: ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:

PLEASE CHECK ONE		
APPROVED	RENEWAL	ABSTAIN
✓		

OCT 22 1984

LUCY OXLEY M. D.

Hospital or Institution

SEP 20

City/State

Country

P7:54

## SECTION 6: Resume

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DATE: 9/10/80

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Newark, NJ

7/80-6/84

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Shawnee, OK

Wit Chainakul, MD

Shawnee, OK

SPECIALTY: OB/GYN

SPECIALTY BOARDS: none

AMA INFORMATION: ok

FEDERATION INFORMATION: ok

RECOMMENDATION FORMS: ok

(SEE ATTACHED RESUME)

REMARKS:

OCT 30 1984

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
✓		

DEIRDRE O'CONNOR, M. D.

Hospital or Institution

SEP 20

City/State

Country

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Since 7/1/84	Mission Hill Hospital	1900, Gordon Cooper Drive, Shawnee, OK. 74801	Private Practice OB-GYN	85	15

AF-39-17  
8-30-84  
185 ss and  
460

CENSUS BLANK

My name IN FULL is TEL NARESHKUMAR G.  
Last Name First Middle  
Place of birth PANJAR, INDIA Date of birth 11 / 19 / 52  
Month Day Year  
Permanent or home address 101, Ken Del Dr #26, SHAWNEE, OK. 74801  
Number Street City State Zip  
Present mailing address 1912, Gordon Cooper Dr. Shawnee, OK. 74801  
Number Street City State Zip

I have attended school as follows: (State name, location, and whether high school, undergraduate school or college)

C U SHAN SCIENCE COLLEGE, Ahmedabad, INDIA for 2 years, from 68 to 70  
Year Year Year  
N H L MUN MED COLLEGE, Ahmedabad, INDIA for 5 1/2 years, from 70 to 75  
Year Year Year  
for \_\_\_ years, from \_\_\_ Year to \_\_\_ Year

I was graduated from Gujarat University N H L Mun Med Coll  
College, University, etc  
located at Ahmedabad, INDIA in 1976 Degree M.B.B.S.  
Town State Zip Year

(Signed by applicant)

Dated

(OVER)

August 20, 1984

10/5/84

RDB  
66105

# STATE MEDICAL BOARD OF OHIO

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE **MEDICINE** AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIAL THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSN** AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

(SIGNATURE OF APPLICANT)

(DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A  
**DOCTOR OF MEDICINE**

IDENTIFICATION

NUMBER

**35-05-1343**

**3**

**NARESHKUMAR G. PATEL**  
**1902 GORDON COOPER DR.**  
**SHAWNEE OK 74801**

## MD & DO SPECIALTY CODES

ENTER ALL  
SPECIALTY CODES

**39**

(SEE LIST ON ENCLOSED CARD)

(LIMIT OF 3)

AMOUNT DUE  
**\$100.00**

DATE DUE  
**11/15/86**

## INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO:  
TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS  
APPLICATION IN ENCLOSED ENVELOPE TO:

TREASURER, STATE OF OHIO  
BOX 2438 COLUMBUS, OHIO 43218

## REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 15

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.  
PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THAT SHOWN ON FRONT  
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES NO

☐ ☒

a.) a felony.

☐ ☒

b.) a misdemeanor committed in the course of your practice, or

☐ ☒

c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES NO

☐ ☒

1.) Been addicted to or dependent upon alcohol or any chemical substance?

YES NO

☐ ☒

3.) Surrendered or consented to limitation upon license to practice medicine, or state or federal privileges to prescribe controlled substances?

☐ ☒

2.) Had any disciplinary action taken or initiated against you by a state licensing agency?

☐ ☒

4.) Had any hospital privileges suspended or revoked?

EDM-1494B

EDM-1494B-B

# STATE MEDICAL BOARD OF OHIO

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIAL THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE BOARD AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

(SIGNATURE OF APPLICANT)

(DATE)

12/15/99

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A;  
DOCTOR OF MEDICINE

IDENTIFICATION

NUMBER

35-05-1343

NAKESHKUMAR G. PATEL  
1902 GORDON COOPER DR.  
STANLEE JK 74801

## MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD

IF NECESSARY TO CORRECT, ENTER

ALL SPECIALTY CODE NUMBERS

(SEE LIFE ON ENCLOSED CARD)

(LIMIT OF 3)

AMOUNT DUE

DATE DUE

\$100.00

11/01/98

1446

## INSTRUCTIONS

- DO NOT FOLD OR STAPLE THIS CARD.
- REVERSE SIDE MUST BE COMPLETED
- MAKE CHECK OR MONEY ORDER PAYABLE TO TREASURER, STATE OF OHIO
- PUT IDENTIFICATION NUMBER ON CHECK
- UPDATE SPECIALTY IF NEEDED.
- SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO:  
TREASURER, STATE OF OHIO  
BOX 2438, COLUMBUS, OHIO 43216

## REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME

FIRST NAME

INITIAL

STREET ADDRESS

CITY

STATE

ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 1.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT (PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES NO

☐ ☒ a.) a felony

☐ ☒ b.) a federal or state law regulating the possession, distribution or use of any drug?

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

YES NO

☐ ☒ 1.) Been addicted to or dependent upon alcohol or any chemical substance? 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 are currently enrolled in a Board approved program.

☐ ☒ 2.) Had any disciplinary action taken or initiated against you by a state licensing agency?

YES NO

☐ ☒ 3.) Surrendered or consented to limitation upon a license to practice medical or state or federal privileges to prescribe controlled substances;

☐ ☒ 4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

QT-00224-03



## 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 BIENNIAL 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:

35-05-1343

AMOUNT DUE

\$160.00

DATE DUE

11/01/90

NARESHKUMAR G. PATEL, M.D.

1902 GORDON COOPER DR.

SHAWNEE OK 74801

## MD &amp; DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS &amp; GYNECOLOGY



SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR,

ENTER ALL SPECIALTY CODE NUMBERS: 4 CODE1 CODE2 CODE3

## CHANGE OF ADDRESS

STREET

STREET

CITY

STATE

ZIP CODE

COUNTY

⑈96969696⑈

0935051343⑈ ⑈0000016000⑈

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 PLEAD GUILTY OR NO CONTEST TO:

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

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? 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.

YES NO  
☒ ☐ 2.) Had any disciplinary action taken or initiated against you by any state licensing board?

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

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



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 BIENNIIUM 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

35-05-1343

\$160.00

07/01/92

NARESHKUMAR G. PATEL, M.D.

1902 GORDON COOPER DR.

SHAWNEE OK 74801

## MD &amp; DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS &amp; 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

9696969621

0935051343 0000016000

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.

YES NO

B.) A federal or state law regulating the  
possession, distribution or use of any drug?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.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?

YES NO

3.) Surrendered, or consented to limitation  
upon: a) A license to practice medicine;  
OR b) State or federal privileges to  
prescribe controlled substances?

YES NO

4.) Had any clinical privileges suspended,  
limited or revoked for reasons other than  
failure to maintain records or attend  
staff meetings? *Yes has been*

SOCIAL SECURITY NUMBER

(Optional for purposes of identification)



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 BIENNIAL 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)

5/12/94  
(DATE)

IDENTIFICATION NUMBER

35-05-1343

AMOUNT DUE

\$250.00

DATE DUE

05/01/94

NARESHKUMAR G. PATEL, M.D.

1902 GORDON COOPER DR.

SHAWNEE OK 74801

26  
64-7-4  
7-5-94  
250.00

### MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY



SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE  
ENTER ALL SPECIALTY CODES.

CODE1

CODE2

CODE3

### REPORT ANY CHANGE OF ADDRESS

6112	N.W.	63RD	STREET
STREET			
OKLAHOMA	CITY	OK	73132
CITY	STATE	ZIP CODE	
OKLAHOMA	CITY	COUNTY	

0969696962: 0935051343 0000025000

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT

FROM THE ADDRESS SHOWN ON FRONT:

6112	N.W.	63RD	STREET
STREET			
OKLAHOMA	CITY	OK	73132
CITY	STATE	ZIP CODE	
OKLAHOMA	CITY	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.) 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  
compensation arrangement?

YES NO



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

### CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIAL 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)

3/8/96

(DATE)

IDENTIFICATION NUMBER

35-05-1343

AMOUNT DUE

\$250.00

DATE DUE

05/01/96

NARESHKUMAR G. PATEL, M.D.

6112 NW 63RD ST

OKLAHOMA CITY OK 73132

### MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & 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

19696969621

0935051343 0000025000

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

STREET  
STREET  
CITY  
STATE  
ZIP CODE  
COUNTY

AT THE 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?

YES NO

ACCOUNT #

## MD &amp; DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS &amp; 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

## 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 BIENNIAL 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

35-05-1343-P

## AMOUNT DUE

\$211.00

## DATE DUE

05/01/98

NARESHKUMAR G. PATEL, M.D.

6112 NW 63RD ST

OKLAHOMA CITY OK 73132

96969696 21

0935051343 0000021100

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

Street

Street

City

County

State

Zip Code

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



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 1998-2000 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

(SIGNATURE OF APPLICANT)

10/5/99  
(DATE)

IDENTIFICATION NUMBER

35-05-1343-P

AMOUNT DUE

\$305.00

DATE DUE

01/01/00

NARESHKUMAR G. PATEL, M.D.

6112 NW 63RD ST

OKLAHOMA CITY OK 73132

I wish to apply for Emeritus status: ☐

MD & DO SPECIALTY CODES CURRENTLY ON RECORD  
**OBG OBSTETRICS & 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

9696969621

0935051343 0000030500

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

Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
County \_\_\_\_\_

AT THE 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 4731.22 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

ACCOUNT #  
935051343

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?

YES NO

SOCIAL SECURITY NUMBER



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

(SIGNATURE OF APPLICANT)

(DATE)

IDENTIFICATION NUMBER AMOUNT DUE DATE DUE \$50 Late Fee Due After  
35-05-1343-P \$305.00 01/01/02 04/01/02  
NARESHKUMAR G. PATEL, M.D.  
6112 NW 63RD ST  
OKLAHOMA CITY OK 73132

MD & DO SPECIALTY CODES CURRENTLY ON RECORD  
OBG OBSTETRICS & 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

6213 PLUMTHICKET ROAD  
STREET  
STREET  
OKLAHOMA CITY OK 73162  
CITY STATE ZIP CODE  
OKLAHOMA  
COUNTY

0935051343

30500

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS  
MUST BE ENTERED AT EACH RENEWAL.  
Check this Box if you have NO principal  
Practice address.  
6112 NW 63RD ST  
STREET  
OKLAHOMA CITY OK 73162  
CITY STATE ZIP CODE  
OKLAHOMA  
COUNTY

SOCIAL SECURITY NUMBER

AT ANY TIME SINCE SIGNING YOUR LAST  
APPLICATION FOR RENEWAL OF YOUR  
CERTIFICATE:  
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  
X 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.  
YES NO  
X 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  
X 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  
X 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  
X 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?