APPLICATION FOR ENDORSEMENT OF A MEDICAL LICENSE

The State Medical Board, State of Ohio

FORM I

owing statement regarding my preliminary education. Name KARU IRA SCHAEFFER	2. Place of birth	PITTS BURGH	PA.
Address 634 Jasonway Auf.	Date of birth	6/12/46	
COLUMBUS, OHIO 43214	4. Intended reside	C -1 . 181 0 C) C	, OHIO
PRELIMINARY EDUCATION. Name and Location of Institution Attended and Degree Received. OHIO STATE UNIVERSITY COMM.	BUS, OHÍO PE	ood and Date of Study. 9/64 - 6/6	. B.
Received Ohio Certificate of Preliminary Education No. 1	7328; issued	ь, as-m B	4/14/7
I have made application to the following State Examining VODE as of yet.	and Licensing Bos	ords, and no others (Give names of	States and dates
of application—Reciprocity or Examination.)			·
and received a certificate from each except as follows: (Giva na		of application — Reciprocity	or Examination.)
MEDICAL EDUCATION. Give the date and source of each medical credential, diplo	ma ligana as dage	as which was hold	
Ore the tate and source of each medical credential, diplo	ima, ncense or degr	ee which you hold	•••••
Attendedfull courses of medical lectu	ures as follows, to-	wit:	
1st Course at UNIVERSITY OF RENNSKEY	ANIA 9/6	P 9/69	
2nd Course at U. Of PENUSYLVANIA ,	rom 9/69	. 9/7	0
3rd Course at U. Of PENUSYLVANIA	rom 9/70) to 9/7	<u>']</u>
4th Course at U. of RenusyeuquiA	rom 9/71	. 5/7	EDICINE
. (Nama of Medica)	l College.)	IA SCHOOL UF M	
PHILADELPHIA State of PENNSYLVANIA			
Time of practice Internship at UCL	R MEDICI	al center,	los
ANGELES, Calitornia	June	922 - June	
Has any license entitling you to practice in any foreign of the suspended or revoked?			United States
If so, specify: (State or Country)	(Charge)	Ma (I	Date)
Have you ever been or are you now addicted to narcotic dr	ugs?	(Yes or No)	•••••••
Have you ever been charged with addiction?	(Ye	O s or No)	······································
Specify charge:		No	
Have you ever found it necessary to surrender your narco Have you ever been charged with a violation of a Federal		(Yes or No)	other than -
traffic violation?	la	r a municipal ordinance	
If so, give full particulars:(Offense)		(Dispositio	on)
(Date of Disposition)			
PHYSICAL DESCRIPTION OF APPLICANT		c. '.	
Color of Hair BROWN Color of eyes BROU	Complexic	n taur	/
Height 5'11' Weight (70 Build A	15014 Ma	NONE	

FORM II. *AFFIDAVIT

	0H10	FURM II. TAFFIDA	VII.
TATE OF	FRANKLIN	} ss:	•
OUNTY OF	9TH day of		7.2
On this	······································	JULI	1973, personally appeared before me,
	, ЖІЦШИ А	nd for the County and State rson referred to in the fores	aforesaid, KARL IRA SCHAEFFER
	hio; that the statements		every respect, and that has read and Shoulfer
Signed and su	vorn to hefore me this	9тн day с	JULY (Signature of Applyant. 73
	vois to before me, tins		R. E. famm
(Seal.)	to bedom an amount with		(Official designation of officer administering oath.)
arust be sworn	to before an omicer authorize	d to administer oaths, or a Fede	eral officer. R. E. LAMM, ATTY, AND C FOR THE STATE OF OHIO
		WITH LIFETIM	E COMMISSION
	CERTIFIED CO	FORM III. PY OF- STATE LICENSI	- or certificate.
	N	ATIONAL BOARD OF MEDIC.	
*	14	OF THE	AL EXAMINERS
		United States of A Karl Ira Schaeffer	
	having satisfied all the is hereby declared a	requirements and having s	nuccessfully passed the examinations and Board of Medical Examiners.
	Attest: J. D. Myers Chairman of the		
7 · *		SEAL	John P. Hubbard
	Philadelphia, Pa. July 2, 1973.	Cert. #	President of the Board
I hereby cert	ify that the above is a ve	certificat	e ₁₃₃₁₇₄ , issued to Dr. Karl Ira Schaeffer
the Nationa	l Board of Medical	Examiners 2nd	day of July 19.73
(Seal.)			MS Turned M.D.
		FORM IV.	Associate Director
	CERTIFICATE		OF SEXTREMENTS ASSOCIATE DIRECTO
	DAIL OF the	1 Board of Medical	
lo hereby certi	fy that Dr. Karl Ira	Schaeffer was on th	(Name of Stata Board.) 2nd July eday of
		1	F261
the basis of	written examina	tion	
the following	State box	90(75), Physiology	sa of graduation.) 540(83), Biochemistry 405(75),
			rmacology 520(82), Medicine 585(86),
Surgery	475(81), Obstetri	cs 510(82), Public !	Health and Prev. Med. 385(76),
Pediatr	ics 455(80), Psych	iatry β55(75), Prac	tical, clinical (Part III) 405(78.6)
whichhe	received an average of	78.2 per cent, and from	evidence on file in this office, I do hereby certify
•	-	_	, and recommend to
	_	oper person for medical lic	
The applican	t must satisfy the Board	l of	Danad in afficial
	e-standing-and-moral cha	racter before seal of said.	
			Mitema
(Seal.)		. ,	Associate Director

(Date)

AFFIDAVIT OF PHYSICIANS.
STATE OF
COUNTY
Before me, personally appeared M.D. M. D.
known to me as a reputable practicing physician and surgeon, of good moral character, and on being sworn says that he
has known () Chi 2/13/ M. D., well for years and knows () which we will be the second be to the second be the se
to be of good moral and professional character, thathe is a graduate of
College in the year
as worthy of professional
recognition and that the foregoing physical description is correct. Address YDD Zo Why & & M. D.
Graduate of W.C. V. Certificate No. 1861)
Subscribed and sworn to this 23 day of July 1973
(Seal) NOTARY DECEMBER 18 1991
MY COMMISSION NOTARY Public.
STATE OF COUNTY 58:
Refore me personally appeared Kay I SCHAPFFER M. D.
Detect me, personner, -pp
known to me as a reputable practicing physician and surgeon, of good moral character, and on being sworn says that he
to be of good moral and professional character, that Me he is a graduate of Many. of Rangelbuca
to the
College in the year. that he has been in the practice of Medicine for the last twelve months at
recognition and that the foregoing physical description is correct.
Address 497 E Bon St M. D.
Columbus Thee 43215 Graduate of Court Certificate No. 25891
Subscribed and sworn to this 23 day of July 19 73
(Seal.) PERMICE AS EXPOSED TO THE PROPERTY Public.
NOTARY PUBLIC, ENGINEER COUNTY, ONIO MY COMMISSION EXPIRES NOV. 18, 1975 FORM VI
FORM VI.
CERTIFICATE OF ETHICAL AND MORAL CHARACTER FROM PRESIDENT
OR SECRETARY OF COUNTY, DISTRICT OR STATE MEDICAL SOCIETY:
P. O. Address
I certify that Dr
is a member in good standing of the and that he is an ethical practitioner of good moral character.
guer To the service to the service of the service o
President or Secretary M. D.
(If you are not and have never been a member of a medical society, give a brief explanation of the reason.)
Just moved to Columbus, OHID and an Resident at O.S. U. Hospital. SECTION 4731.29, REVISED CODE Plant to join
Hospital, SECTION 4731.29, REVISED CODE Plante 10 1011
SECTION 4/31.29, REVISED CODE Note of Columbia, or a diplomate of the national board of medical examiners or the national board of examiners for osteo-
pathic physicians and surgeons wishes to remove to this state to practice his profession, the state medical board may, in its discretion, issue to him a certificate to practice medicine or surgery or osteopathic medicine and surgery without requiring the applicant to submit to examination, provided he meets the requirements for entrance as set forth in section 4731.09 of the Revised Code

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JUL 24 1973

OHIO STATE MEDICAL

QUALIFICATION

A certificate of registration showing that an examination has been made by the proper board of any state in which an average grade of not less than 75 per cent was awarded, the holder thereof having been at the time of said examination the legal possessor of a diploma from a medical college in good standing in the state where reciprocal registration is sought, may be accepted, in lieu of examination, as evidence of qualification. Provided, that in case the scope of the said examination was less than that prescribed by the state in which registration is sought, the applicant may be required to submit to a supplemental examination by the board thereof in such subjects as have not yet been covered.

Having failed the Ohio Examination (FLEX licensure method), the applicant cannot endorse from another state unless the endorsement is based on an examination equivalent to or superior to our own (i.e., FLEX or National Boards). "Ohio Examination" means FLEX examination in Ohio or in any other state.

INSTRUCTIONS

- The State Medical Board of Ohio holds regular meetings on the first Tuesday in January, April, July, and October at Columbus.
- 2. Fill out Form I and make the necessary affidavit to Form II. Then obtain the affidavit required by Form V. This must be signed by two reputable physicians residing in the applicant's home state or Ohio; then obtain certification of Form VI.
- 3. Forward to the Administrator of the Medical Board of the State in which the applicant is licensed, or the National Board of Medical Examiners, if a Diplomate. They will fill out Forms III and IV, if justified in doing so, and return the blank to the applicant.
- 4. The application should then be forwarded to the Administrator of the State Medical Board.
- Address all communications to the Administrator of the State Medical Board, Wyandotte Building, 21 West Broad Street, Columbus, Ohio 43215.

obtained on National Board examinations are being reported in terms of standard scores, rather than scale scores. This scoring system was initiated with the Part I examination of June, 1971, and will be applied In accordance with announcements made by the National Board of Medical Examiners, grades to all subsequent examinations in Part I, Part II and Part III.

of the test and scale-score grades for other sections. Therefore, until such time as all three sections of the test can be reported in terms of standard scores for all candidates, both standard-score grades and their Because candidates normally take the various Parts of the National Board examination at different times, it is recognized that for a few years some individuals will have standard-score grades for one section scale-score equivalents are provided for examinations for which the official report is recorded in standard score terms (June, 1971 and later).

The National Board criterion for certification is based upon the candidate's total grade in Part I, Part II and Part III. Scores in individual subjects within each Part (e.g., Anatomy, Physiology, Medicine, Pediatrics, etc.) are not considered in determining whether the candidate has passed the Part. Therefore, official "pass-fail" scores are established for the total grade on each Part, but not for individual subjects within the Part.

th reference to memorandum to all State Medical Examining Boards from Frederick T. Merchant, M.D. dated cember 1, 1970, please note: "The National Board of Medical Examiners is to be regarded as an examining ency with no function in determining the moral character of its Diplomates or their fitness to practice other accordance with the rules and regulations established by the National Board of Medical Examiners."
John P. Hubbard, M.D., President, National Board of Medical Examiners an that related to the completion of educational requirements and successful completion of its examinations

1 Karl & Schaeffer
2 Kaul & Schaeffer
I hereby certify that the photograph on the reverse side to which this slip is pasted is a genuine likeness of
Karl I Schaeffer
who was recommended by me to the State Medical Board for a license to practice in Ohio.
17/23/73 Jun Jun Jun
Signature of First Endorser.
Honge Til lew Sign
Signature of Second Endorser.



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BIOGRAPHICAL DATA ON PHYSICIANS

from the Biographical - Historical files of American Medical Association 535 N. Dearborn St. Chicago, Illinois 60610

6-5-73

This form is provided for your convenience in making routine inquiries regarding physicians seeking medic licensure in your state, hospital staff privileges or faculty positions. Please enter on this form data you wish verified a mail to the Member Services Unit of the AMA.

Full name of M.D. KARL I. SCHAEFFER	
Place of birth Pettsburg, Renna. Date of birth 6-12-9	46
Professional Mailing Address 1385 Kelton Ave. #101 Los Angeles, Calif. 400 vf Medical Education:	
Los anelso Calid. goort	
Medical Education:	
School Name Univ. of Pennsylvania Welval School M.D. Degre	ee 197
	(Year
Internships: Hospital Location Date	
nospital Zotation Zati	
to	·
)
n et este e 15 Hembine	
Residencies and Fellowships: Hospital Location Dat	es
	>
tc	ɔ .
M.D. Licensed to Pactice Medicine in the Following States:	
stional Board	
State Year 1973; State Year; State Year	r
Inquiry Submitted by Title Indorfement	Clerk
(Your Name Here)	
Ohio State Medical Board, 21 W. Broad St. City-State Columbus, 0)hio 43
(Affiliation - Licensing Board, Hospital or Medical School)	
AMA Department of Investigation	YES
MENDER OF AMA	. NO
Our records do not reveal any derogatory information. See attached memo for comments regarding applicant.	
See attached memo to comments regarding approxim.	
A check mark (/) indicates that the data given corresponds to that listed in the AMA Master File of Physical Control of the AMA Master File of Physical Control of the Cont	sicians.
discrepancies are as noted.	
Joan alvare	3

Joan Alvarez, Member Services Unit State MEDICAL BOARD State of OHIO 21. West. BROAD St. Columbus, Ohio 43215 Dear-Sir!

Following graduation from the University of
Pennsylvania School of MEDICINE on MAY 22,
1972, I served as Obstetrics and Gynecology
Intern at UCLA MEDICAL Center, Los
Angeles, (all fornia. I finished my
internship on June 23, 1973, and returned.
to Columbus, Office to start my second.
year of training in Obstetrics & Gynecology
at Office STATE University Hospital.

Sincerely, Kard D. Schaeffer, M.:

RECEIVED

JIJL 24 1973

OHIO STATE MEDICAL

OHIO STATE MEDICAL BOARD 21 West BROAD STREET Columbos, OHIO 43215

Dear Sir,

Please send me an application for OHIO State MEDICAL LICENSE. I graduated University of Mennsylvania School of Medicine in May, 1972 and , became a Diplomat of the NATIONAL BOARD OF MEDICAL EXAMINERS in April, 1973. Finally, Y Iwas born in PITISBURGH, PENNSYlvANIA on June, € 12, 1946, and have been a permanent residente of Columbus, Otto for past 18 years even I though I am serving my internship at VCLA Menical Center, Los Angeles, California. quant you.

Sincerely,
Karl I. Schaeffer, M.D.,
1385 Kelton Ave, #101.
Lus Angeles, California
90024

RECEIVED

MAY 9 1973

OHIO STATE MEDICAL
BOARD

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CTA			INSTRUCTIONS
017	TE OF OHIO STATE MEDICA	L DUMMU	1. DO NOT FOLD OR STAPLE THIS CARD.
	OF SECTION AND A CALLED	W 7000.40	2. REVERSE SIDE MUIST BE COMPLETED. 3. MAKE CHECK OR MONEY ORDER PAYABLE TO:
CERTIFY, UNDER PERSO	THE LOSS OF MY MIGHT TO PROPERTY OF LAST BEHNIUM THE REQUISITE WORLD	IS OF	TREASURER, STATE OF UNIO
NO SURGERY IN THE S	DUCATION CERTIFIED BY THE OHIO STATE MED	ICAL ASSN	4. PUT IDENTIFICATION NUMBER ON CHECK. 5. MARK CORRECT SPECIALTY CODE(S) BELOW.
NO A TOYED IT THE	STATE MEDICAL BOARD AND HEREBY WAKE APPLICATION FOR REMEMAL.		6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO:
	7 . 2 .	1 1 A	TDEASURER STATE OF OHIO
	Karl & D	Last the line	BOX 2438 COLUMBUS, OHIO 43216
	(SIGNATURE OF APPL	CANT) (DATE)	REPORT ANY CHANGE OF ADDRESS OF RECORD
	and order after age to the district and a second a second and a second	IDENTIFICATION	(PLEASE PRINT)
	APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS R	NUMBER 35-03-60 i	I F F CC V T
	DECTOR OF MEDICINE	33 03 00.	DCHARTER KARL L.
	· compresso		LEST NAME FIRST NAME INTO
1	KARL I. SCHAEFFER	3 37 60 1	1120 Windruck Lane
	COLUMBUS OF 43213		CONT CHAINGEN OF HE WAS A
	CICONEGO		SHEET ADDRESS
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	DATE DUE	Blacklick . Cheo 4300
	: MD & DO SPECIAL TO COLLEG	00.00 11./15	
	SPECIALTY CODES CORRESPOND ON DECISION	00.00	Franklin
	IF REGERSARY TO CORRECT, EMPER		CONNEY
	ALL SPECIALTY CODE NUMBERS		
	THE PROPERTY OF THE PROPERTY O	DICT DETURN THIS A	APPLICATION AND FEE BY DUE DATE.
HE ADDRES	RECEIVE YOUR RENEWAL CARD BY DECEMBER S SHOWN ON THE FRONT OF THIS CARD WILL I	BE MAINTAINED AS YO	UR ADDRESS OF RECORD WITH THE BOARD.
HE ADDRES RINCIPAL PI HOWN ON F PLEASE PRII Scha AST NAME 32 INFET ADDRESS COLUMN	S SHOWN ON THE FRONT OF THIS CARD WILL I RACTICE ADDRESS — IF DIFFERENT FROM THAT FRONT NT) EFFET FIRST NAME LYUNGSTON AVE. WHOUS STATE FRANKLIN Redacted	SECTION 4731.281, RESPONSE BE GIVEN MARK THE CORRECT SINCE YOU LAST RI HAVE YOU BEEN CONDERE TO: YES NO DERE TO: YES NO	OHIO REVISED CODE REQUIRES THAT A N TO THE FOLLOWING QUESTION, PLEASE CT BOX. ENEWED YOUR OHIO MEDICAL LICENSE, CONVICTED OF OR PLEAD NOLO CONTENSION, or or of the course of your on, or
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HE ADDRES RINCIPAL PI HOWN ON F PLEASE PRII Se han Se han Se han TY OCIAL SECU	S SHOWN ON THE FRONT OF THIS CARD WILL I RACTICE ADDRESS — IF DIFFERENT FROM THAT FRONT NT) EFFET FIRST NAME LYUNGSTON AVE. WHOUS STATE FRANKLIN Redacted	SECTION 4731.281, RESPONSE BE GIVE MARK THE CORRECT SINCE YOU LAST RI HAVE YOU BEEN CO DERE TO: YES NO Solution in the correction of the c	UR ADDRESS OF RECORD WITH THE BOARD. OHIO REVISED CODE REQUIRES THAT A N TO THE FOLLOWING QUESTION, PLEASE CT BOX. ENEWED YOUR OHIO MEDICAL LICENSE, CONVICTED OF OR PLEAD NOLO CONTENT ONLY, dedenteanor committed in the course of your eral or state law regulating the possession, tion or use of any drug?
HE ADDRES RINCIPAL PI HOWN ON F PLEASE PRII Scha AST NAME 32 INFET ADDRESS COLUMN	S SHOWN ON THE FRONT OF THIS CARD WILL I RACTICE ADDRESS — IF DIFFERENT FROM THAT FRONT NT) FIG. 1 FIRST NAME INTEL LYINGST ON AVE. UM DU S STATE FRANKLIN Redacted AT ANY TIME SINCE THE LAST REI 1). Been addicted to or dependent upon alcohol or any chemical substance?	SECTION 4731.281, RESPONSE BE GIVEN MARK THE CORRECT SINCE YOU LAST RICHARD TO: YES NO SINCE YOU BEEN CONTROL OF YOUR CERTIFIED NEWAL OF YOUR CERTIFIED OF SINCE YOUR CERTIFI	UR ADDRESS OF RECORD WITH THE BOARD. OHIO REVISED CODE REQUIRES THAT A N TO THE FOLLOWING QUESTION, PLEASE CT BOX. ENEWED YOUR OHIO MEDICAL LICENSE, CONVICTED OF OR PLEAD NOLO CONTENT ONLY, dedenteanor committed in the course of your eral or state law regulating the possession, ition or use of any drug?
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CONTINUING	BS SOUTH FRONT ST. SUITE STO COLUMBUS, OHRO 43 UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE ERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST DIENNIUM THE REQUISITE HOUR IN MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL OVED IN THE STATE MEDICAL BOARD AND HEREBY MAXE APPLICATION: FOR RENEWAL. SIGNATURE OF APPLICANT	12.15 IS OF	INDITATIONS L DO NOT PLUE OF STATE THIS CORD. E REVERSE SIZE MUST BE CONVICTED. MAKE CHECK OF MONEY ORDER PAYABLE TON TREASURER. STATE OF OHIO 4. PUT IDENTIFICATION NUMBER ON CHECK. 5. MARK CORRECT SPECIALTY CODE(S) SELOW. 6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438 COLUMBUE, OHIO 43216
	APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A DECTOR OF MEDICINE 3	IDENTIFICATI NUMBER 15-03-60	(PLEASE PRINT)
ž	KARL 1. SCHAEFFER 6372 WINDRUSH LANE BLACKLICK DH 43004		LAST NAME FIRST NAME INITIAL
			STREET ADDRESS
	MD & DO SPECIALTY CODES AMOUNT DO	UE DATE	DUE -
	SPECIALTY CODES 39		
	ISEE LIST ON ENCLOSED CARD) (LIMIT OF 37		The state of the s
	TO THOS IF YOUR REMEWAL CARD BY DECRAPTE AND BUT	THE THE AD	COUNTY AND FEE BY HOVEMBER **
	THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THAT SHOWN ON FRONT (PLEASE PRINT) Schaeffer Karl I. LAST NO AE INSTITUTE ADDRESS COLUMBUS CHILD YOUR AVE. ST EET ADDRESS COLUMBUS CHILD YER CODE FRANKLIN ZIP CODE	MAINTAINED SECTION 4: RESPONSE MARK THE SINCE YOU HAVE YOU OR NO CON YES NO	AS YOUR ADDRESS OF RECORD WITH THE BOARD. 731.281, OHIO REVISED CODE REQUIRES THAT A BE GIVEN TO THE FOLLOWING QUESTION. PLEAS CORRECT BOX. LAST RENEWED YOUR OHIO MEDICAL LICENSE, BEEN FOUND GUILTY OR PLEAD GUILTY ITEST TO: a.) a felony. b.) a misdemeanor committed in the course of your practice, or
	THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THAT SHOWN ON FRONT (PLEASE PRINT) Schaeffer Karl I. LAST N. 4E 3255 E. LIVINGS FON AVE ST EET ADDRESS COLUMBUS CHIEF TANK! STATE TANK! IN THE TOTAL TO THE TOTAL	MAINTAINED SECTION 4 RESPONSE MARK THE SINCE YOU HAVE YOU OR NO CON YES NO	AS YOUR ADDRESS OF RECORD WITH THE BOARD. 731.281, OHIO REVISED CODE REQUIRES THAT A BE GIVEN TO THE FOLLOWING QUESTION. PLEAS CORRECT BOX. LAST RENEWED YOUR OHIO MEDICAL LICENSE, BEEN FOUND GUILTY OR PLEAD GUILTY ITEST TO: 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?
14040-B	THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THAT SHOWN ON FRONT (PLEASE PRINT) SCHAPFOR KAN I LAST NA AE STATE STATE ZIP CODE REGARDED Redacted	MAINTAINED SECTION 4 RESPONSE MARK THE SINCE YOU HAVE YOU OR NO CON YES NO	AS YOUR ADDRESS OF RECORD WITH THE BOARD. 731.281, OHIO REVISED CODE REQUIRES THAT A BE GIVEN TO THE FOLLOWING QUESTION. PLEAS CORRECT BOX. LAST RENEWED YOUR OHIO MEDICAL LICENSE, BEEN FOUND GUILTY OR PLEAD GUILTY ITEST TO: 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?
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STATE MEDICAL BOARD C 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 BIENNIUM TO CONTY JING A "DICAL EDUCATION CERTIFIED BY THE AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL (SIGNAURE OF APPLICATION OF APPLICATION FOR PROPERTY OF APPLICATION	2. REVERSE SIDE MUST BE COMPLETED. 3. MARE CHECK OR MONEY GROER PAYABLE TO: THEASURER, STATE OF OHIO 4. PUT IDENTIFICATION NUMBER ON CHECK 5. UPDATE SPECIALTY IF NEEDED. 6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438, COLUMBUS, OHIO 43216
APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A ;	REPORT ANY CHANGE OF ADDRESS OF RECORD (PLEASE PRINT)
KARL I. SCHAEFFER 6 B72 WINDRUSH LANE 6 LACKLICK DH 43004	LAST NAME FIRST NAME INITIAL
	STREET ADDRESS
MD & DO SPECIALIT CODES	AMOUNT DUE DATE DUE
SPECIALTY CODES CURRENTLY ON RECORD IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS	0 .00 11/01/88 CITY STATE ZIP CODE
(SEE LIFE ON ENCLOSED CARD) (LIMIT OF 3)	COUNTY
PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT (PLEASE PRINT)	BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD. SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.
LAST NAME SCHOOL INTEREST NAME (NETTAL	SINCE YOU LAST RENEWED YOUR CHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:
STREET ADDRESS E. Broad St. JUITE 40	
COLUMBUS, OLIO 43213 CITY STATE Franklin	b.) a lederal or state law regulating the possession.
SOCIAL SECURITY NUMBER Redacted	TION FOR DESIGNAL OF YOUR ORDER
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	YES NO 3.) Surrendered or consented to smitation upon a license to practice med if a d state or federal privileges to prescribe controlled
quirements as contained in Section 4731.224, O.R.C., and related provisions; or are currently enrolled in a Board approved program.	 4.) Had any clinical privileges auspended or revoked for other than failure to maintain records or attend staff meetings.
Had any disciplinary action taken or initiated against you by a state licensing agency?	OT MAN OR

MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315 39 OBSTETRICS & GYNECOLOGY CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO. THAT I HAVE COMPLETED DURING THE LAST BIENNIUM
THE REQUISITE HOURS OF CONTINUING MEDICAL EQUICATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION SPECIALTY CODE(S) CORRECT AS LISTED PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN IF THE SPECIALTY CODE(S) ARE IN ERROR EVERY RESPECT. ENTER ALL SPECIALTY CODE NUMBERS. CODET CODE2 CODE3 CHANGE OF ADDRESS (SIGNATURE OF APPLICANT) (DATE) IDENTIFICATION NUMBER: AMOUNT DUE DATE DUE 11/01/90 35-03-6011 \$160.00 KARL I. SCHAEFFER, M.D. 6372 WINDRUSH LANE STATE BLACKLICK OH 43004 1:9696969621 3503501 possession, distribution or use of any drug? or revoked for reasons other than failure to maintain records or attend staff meetings? 3.) Surrendered, or consented to limitation have subsequently adhered to all statutory at a program approved by this board and 4.) Had any clinical privileges suspended E. BROAD STREET 1.) Been addicted to or dependent upon alcohol or any chemical substance? You 4731.224, O.R.C., and related provisions, upon: a) A license to practice medicine; or you are currently enrolled in a board B.) A federal or state law regulating the may answer "no" to this question if you 71 Code have successfully completed treatment concerning approval can be directed to the board offices. requirements as contained in section PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: 2.) Had any disciplinary action taken or initiated against you by any state HAVE YOU BEEN FOUND GUILTY OF, OR PLEAD GUILTY OR NO CONTEST TO : OR b) State or federal privileges to prescribe controlled substances? AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU: approved program. Any questions Redacted Optional for purposes of identificat licensing board? A.) A felony Street 2. OFUM NO ON 90 YES ES, (ES

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STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR. COLUMBUS, OHIO 43266 - 0315 CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT. (SIGNATURE OF APPLICANT) (DATE) IDENTIFICATION NUMBER AMOUNT DUE DATE DUE 35-03-6011 \$160.00 07/01/92 KARL I. SCHAEFFER, M.D. 6372 WINDRUSH LANE BLACKLICK OH 43004	imd & do specialty codes currently on record 39 OBSTETRICS & GYNECOLOGY SPECIALTY CODE(S) CORRECT AS LISTED IF THE SPECIALTY CODE(S) ARE IN ERROR, CODE1 CODE2 CODE3
PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FROM: Street Street State	reatment 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 YES NO

STATE MEDICAL BOARD OF OHIO OBG OBSTETRICS & GYNECOLOGY LOOR, COLUMBUS, OHIO 43266 - 0315 CERTIFICATION CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, PLEASE CODE ENTER ALL SPECIALTY CODES. CODE2 cODE3 RESPECT. REPORT ANY CHANGE OF ADDRESS (SIGNATURE OF APPLICANT) (DATE) DATE DUE IDENTIFICATION NUMBER AMOUNT DUE 05/01/94 \$250.00 35-03-6011 KARL I. SCHAEFFER, M.D. 6372 WINDRUSH LANE BLACKLICK OH 43004 1:969:6969621 3503601 #'00000 25000#' suffering from, drug or alcohol dependency or abuse? You may answer "no" to this AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION 2.) Been found guilty of, or pled guilty or no question if you have successfully completed 1.) Been found guilty of, or pled guilty or no sections 4731,224 and 4731.25 O.R.C., and enrolled in a board approved program. Any contest to a federal or state law regulating 6.) Surrendered, or consented to limitation 8.) After January 14, 1993, referred a patient, or Spire 491 initiated against you by any state licensing board other than the State Medical the possession, distribution or use of any all statutory requirements as contained in you or a member of your immediate family has board and have subsequently adhered to 7.) Had any clinical privileges suspended, than failure to maintain records or attend treatment at a program approved by this 4.) Had malpractice insurance cancelled 3.) Been addicted to or dependent upon 41312113 been treated for, or been diagnosed as upon: a) A license to practice medicine; participated in an arrangement or scheme for services to a person or facility in which either FOR PENEWAL OF YOUR CERTIFICATE HAVE YOU: related provisions, or you are currently restricted or revoked for reasons other alcohol or any chemical substance; or questions concerning approval can be Had any disciplinary action taken or an ownership or investment interest, or any or limited for other than fallure to pay referral of a patient, for clinical laboratory PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: contest to a fetony or misdemeanor ÓR b) State or federal privileges to prescribe controlled substances? SOCIAL SECURITY NUMBER BO Contional for numboses of identification directed to the board offices. compensation arrangement? Brogg Board of Ohio? staff meetings? premiums? 0 GUMBUS FIRATING LIIN drug? ACCOUNT # 20 20 NO 8 20 80 >) ES ES YES. /ES /ES /ES ÉS

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MD & DO SPECIALTY CODES CURRENTLY ON RECORD

DETACH HERE AND REMIT THIS PORTION WITH FEE MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315 OBG OBSTETRICS & GYNECOLOGY CERTIFICATION CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 cODE3 RESPECT. REPORT ANY CHANGE OF ADDRESS (SIGNATURE OF APPLICANT) (DATE AMOUNT DUE DATE DUE **IDENTIFICATION NUMBER** 35-03-6011 \$250.00 05/01/96 KARL I. SCHAEFFER, M.D. 6372 WINDRUSH LANE BLACKLICK OH 43004 129696969621 0935036011 ".00000 2 5000." question if you have successfully completed ANS TIME SINCE SIGNING YOUR LAST APPLICATION 2.) Been found guilty of, or pled guilty or no suffering from, drug or alcohol dependency 1.) Been found guilty of, or pled guilty or no enrolled in a board approved program. Any sections 4731.224 and 4731.25 O.R.C., and 6.) Surrendered, or consented to limitation arrangement or scheme for referral of a patient, contest to a federal or state law regulating initiated against you by any state licensing the possession, distribution or use of any board and have subsequently adhered to 7.) Had any clinical privileges suspended, all statutory requirements as contained in than failure to maintain records or attend 3.) Been addicted to or dependent upon treatment at a program approved by this Had malpractice insurance cancelled or facility in which either you or a member of been treated for, or been diagnosed as upon: a) A license to practice medicine; STREET 14.312-1.3 Zip Code FOR TRENEWAL OF YOUR CERTIFICATE HAVE YOU : or abuse? You may answer "no" to this questions concerning approval can be directed to the board offices. alcohol or any chemical substance; or related provisions, or vou are currently 5.) Had any disciplinary action taken or restricted or revoked for reasons other 8.) Referred a patient, or participated in an your immediate family has an ownership or for clinical laboratory services to a person or limited for other than failure to pay investment interest, or any compensation contest to a felony or misdemeanor. PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FRO城部HE ADDRESS SHOWN ON FRONT: OR b) State or federal privileges to board other than the State Medical prescribe controlled substances? Redacted BECADE staff meetings? Board of Ohio? premiums? A PORT I LINE drug? YES THUMBER OSIZE BAJOHDATE 3 0 80 4 20 9 935036011 ACCOUNT # ÉS ÆS,

DETACH HERE AND REMIT THIS PORTION WITH FEE MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315 OBG OBSTETRICS & GYNECOLOGY CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE ON IO 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 SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, CODE2 CODE3 RESPECT. ENTER ALL SPECIALTY CODES. CODE1 Schae REPORT ANY CHANGE OF ADDRESS (SIGNATURE OF APPLICANT) (DATE) AMOUNT DUE DATE DUE IDENTIFICATION NUMBER 05/01/98 \$179.00 35-03-6011-S I. SCHAEFFER, M.D. KARL WINDRUSH LANE 6372 ZIP CODE BLACKLICK OH 43004 1:9696969621 0935036011 #0000017900# suffering from, drug or alcohol dependency question if you have successfully completed AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU : 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 enrolled in a board approved program. Any 1.) Been found guilty of, or pled guilty or no sections 4731.224 and 4731.25 O.R.C., and arrangement or scheme for referral of a patient, 6.) Surrendered, or consented to limitation board and have subsequently adhered to initiated against you by any state licensing 7.) Had any clinical privileges suspended, all statutory requirements as contained in 4.) Had malpractice insurance cancelled than failure to maintain records or attend or facility in which either you or a member of treatment at a program approved by this Been addicted to or dependent upon upon: a) A license to practice medicine; been treated for, or been diagnosed as or abuse? You may answer "no" to this questions concerning approval can be restricted or revoked for reasons other your immediate family has an ownership or investment interest, or any compensation related provisions, or you are currently Had any disciplinary action taken or 8.) Referred a patient, or participated in an alcohol or any chemical substance; or for clinical laboratory services to a person or limited for other than failure to pay contest to a felony or misdemeanor. PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT OR b) State or federal privileges to board other than the State Medical prescribe controlled substances? Redacted FROM THE ADDRESS SHOWN ON FRONT. directed to the board offices. staff meetings? Board of Ohio? premiums? ORDINAUT. drug? County NO 8 8 NO 200 8 031 BATC

ACCOUNT #

STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315 CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO. THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-1999 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT. X (SIGNATURE OF APPLICANT) (DATE) IDENTIFICATION NUMBER AMOUNT DUE DATE DUE 35-03-6011-S \$305.00 10/01/99 KARL I. SCHAEFFER, M.D. 6372 WINDRUSH LANE BLACKLICK OH 43004	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
::53696963c	0935036011" "0000030500"
PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: THIS ADDRESS MIJST BE ENTERED AT EACH RENEWAL. Street CLASS MIJST BE ENTERED AT EACH RENEWAL. STREET BY THE THIS BY THE AND ATST. LEG OF AND	

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) IDENTIFICATION NUMBER AMOUNT DUE 35-03-6011-S \$305.00 10/01/01 KARL I. SCHAEFFER, M.D. 6372 WINDRUSH LANE BLACKLICK OH 43004	MD & DO SPECIALTY CODES CURRENTLY ON RECORD OBG OBSTETRICS & GYNECOLOGY SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, PLEASE CODET CODE2 CODE3 RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL. STREET STREET CITY STATE ZIP CODE
pal f, or pled received lieu of felony? d to or chemical or been drug or chemical or been drug or statutory sections and have statutory sections questions rected to	spartment, from acts of the acts of those in filed any complaints with the controlled sy over the controlled sy ov
MUST BE ENTERED AT EACH RENEWAL. Check this Box if you have NO principal Practice address. Street County AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION OF RENEWAL OF YOUR CERTIFICATE: YES NO Conviction of, a misdemeanor or felony? YES NO 2. Have you been found guilty of, or pled treatment or intervention in lieu of conviction of, a misdemeanor or felony? YES NO 2. Have you been found guilty of, or pled treatment upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependent won alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependently 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 a board approved program. Any questions or the board approved concerning approved can be directed to the board offices.	alpractice awe on your behal state other than traff body, including a this board, ations or concerned or concerned or consent was any clinical or institutional tricted or remark basis or mery basis or concerned or

STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127 OBG OBSTETRICS & GYNECOLOGY CERTIFICATION CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2001 - 2003 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT. SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES CODE1 CODE2 CODE3 8-6-03 RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL (SIGNATURE OF APPLICANT) (DATE) DATE DUE IDENTIFICATION NUMBER AMOUNT DUE \$50 Late Fee Due After 35-03-6011-S \$305.00 10/01/03 01/01/04 KARL I. SCHAEFFER, M.D. 6372 WINDRUSH LANE 430014 ZIP CODE BLACKLICK OH 43004 0935036011 30500 APPLICATION FOR RENEWAL OF YOUR prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent found guilty of, or pled guilty or no contest to, or received treatment or intervention in Have you been addicted to or dependent upon alcohol or been treated for, or been drug or alcohol dependency or abuse? You may answer ó other body, including those in Ohio, <u>other than</u> this board, filed any charges, allegations or 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons other than fallure to maintain records on a timely basis or to attend staff meetings? any chemical substance; or "NO" to this question if you have successfully completed enrolled in, a program approved by this Board and have adhered to all statutory requirements if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the bλ or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to diagnosed as suffering from you or on your behalf for acts occurring in any and subsequent to treatment. You must answer "YES treatment at, or are currently lieu of conviction of, misdemeanor or felony? 5.) Have you surrendered, or consented 4.) Has any board, bureau, department, agency, 3.) Have any malpractice awards been paid S.T.R. 66T. 4.3.3 (13) PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS 1.) Have you been Check this Box if you have NO principal Redacted MUST BE ENTERED AT EACH RENEWAL. O. H. REQUIRED: complaints against you? was given to this board. Eil A KILI (I.W) I I I I County CERTIFICATE: state other than Ohio? 59.69 G. BROAD 200 X 9 limitation of, Practice address. 2003 71 0045 1700 823

board offices.

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MD & DO SPECIALTY CODES CURRENTLY ON RECORD

Date Posted: 9/11/2005 3:40:44 PM

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

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

Address Information

BUSINESS ADDRESS

5969 E BROAD ST SUITE 401 COLUMBUS, OH 43213 Franklin County (614) 868-1160

MAIN

6372 WINDRUSH LANE BLACKLICK, OH 43004 Franklin County (614) 866-4089

License Information

License Number

35.036011

License Name

KARL SCHAEFFER

Email Address

Fees

Relicensure Fee

\$305.00

Total Fees \$305.00

Specialty Codes

1.	Please	select	one	specialty	from	the	field	below
----	--------	--------	-----	-----------	------	-----	-------	-------

..... OBSTETRICS & GYNECOLOGY

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

........ {not Answered}

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

..... {not Answered}

CN	ME-Physicians
1.	Have you met the above CME requirements for your license?
	YES
Di	scipline
1.	Have you been found guilty of, or pled guilty or no contest to, or
	received treatment or intervention in lieu of conviction of, a
	misdemeanor or felony?
	NO
2	Have you surrendered, consented to limitation of, or to suspension,
4.	reprimand or probation concerning, a license to practice any
	healthcare profession or state or federal privileges to prescribe
	controlled substances in any jurisdiction other than Ohio?
	NO
3.	Have any malpractice awards been paid by you or on your behalf for
	acts occurring in any state other than Ohio?
	NO
4	Has any board, bureau, department, agency, or any other body,
••	including those in Ohio other than this board, filed any charges,
	allegations or complaints against you?
	NO
5.	Have you had any clinical privileges or other similar institutional
	authority suspended, restricted or revoked for reasons other than
	failure to maintain records on a timely basis or to attend staff
	meetings?
	NO
6.	Have you been addicted to or dependent upon alcohol or any
	chemical substance; or been treated for, or been diagnosed as
	suffering from, drug or alcohol dependency or abuse?
	NO
So	cial Security Number
1.	
	Redacted

Nurse Collaboration Info

1.	Are you currently in a collaboration agreement with any Clinical
	Nurse Specialists, Certified Nurse-Midwives or Certified Nurse
	Practitioners?
	NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.

..... {not Answered}

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

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

Date Posted: 7/17/2007 2:32:29 PM

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

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

License Information

License Number 35.036011
License Name KARL SCHAEFFER
Email Address tracygilbert76@aol.com

Fees

Relicensure Fee \$305.00

Total Fees \$305.00

Specialty Codes

- 1. Please select one specialty from the field below OBSTETRICS & GYNECOLOGY
- 2. Please select one specialty from the field below, if applicable.
- {not Answered}
- 3. Please select one specialty from the field below, if applicable.

..... {not Answered}

. NO

CME-Physicians

1. Have you met the above CME requirements for your license? YES

Discipline

- 1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
- 2. Have you surrendered, consented to limitation of, or to suspension,

	reprimand or probation concerning, a license to practice healthcare profession or state or federal privileges to pre controlled substances in any jurisdiction other than Ohio	scribe
	January Januar	NO
3.	Have any malpractice awards been paid by you or on you acts occurring in any state other than Ohio?	ur behalf for
		NO
4.	Has any board, bureau, department, agency, or any other including those in Ohio <u>other than this board</u> , filed any allegations or complaints against you?	
		NO
5.	Have you had any clinical privileges or other similar instauthority suspended, restricted or revoked for reasons ot failure to maintain records on a timely basis or to attempt meetings?	<u>her than</u>
		NO
6.	Have you been addicted to or dependent upon alcohol or chemical substance; or been treated for, or been diagnose suffering from, drug or alcohol dependency or abuse?	•
		NO
So 1.	cial Security Number	
••		Redacted
Nυ	ırse CollaborationInfo	
	Are you currently in a collaboration agreement with any Nurse Specialists, Certified Nurse-Midwives or Certified Practitioners?	
		NO
2.	List the name/names and type of licensure for each nurse you are collaborating. For example: Jane Doe, CNP; M. CNS.	
	{no	t Answered}
	·	

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

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

Date Posted: 8/24/2009 9:05:36 AM

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

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

License Information

License Number 35.036011
License Name KARL SCHAEFFER

Fees

Relicensure Fee \$305.00

Total Fees \$305.00

Specialty Codes

- 1. Please select one specialty from the field below
 - OBSTETRICS & GYNECOLOGY
- 2. Please select one specialty from the field below, if applicable.
 - {not Answered}
- 3. Please select one specialty from the field below, if applicable.
 - {not Answered}

CME-Physicians

- 1. Have you met the above CME requirements for your license?
 - \dots YES

Discipline

- 1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
 -NO
- 2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any

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

I understand that submitting a false, fraudulent, or forged

statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

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

Date Posted: 8/8/2011 2:05:48 PM

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

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

Address Information

BUSINESS ADDRESS

5969 E BROAD ST SUITE 401 COLUMBUS, OH 43213 Franklin County (614) 868-1160 mechellebsb@yahoo.com

License Information

License Number 35.036011 License Name KARL SCHAEFFER

Fees

Relicensure Fee \$305.00

Total Fees **\$305.00**

Medical Board Correspondence Email

1. Did you provide a Credential email address? Please note this information is a public record.

. YES

Specialty Codes

- 1. Please select one specialty from the field below
 - OBSTETRICS & GYNECOLOGY
- 2. Please select one specialty from the field below, if applicable.
 - {not Answered}
- 3. Please select one specialty from the field below, if applicable.

	{no	t Answered}
CN	ME-Physicians	
	Have you met the above CME requirements for your lice	ense?
Di	scipline	
1.	Have you been found guilty of, or pled guilty or no contereceived treatment or intervention in lieu of conviction of misdemeanor or felony?	
		NO
2.	Have you surrendered, consented to limitation of, or to s reprimand or probation concerning, a license to practice healthcare profession or state or federal privileges to pre controlled substances in any jurisdiction other than Ohio	any scribe
		NO
3.	Have any malpractice awards been paid by you or on you acts occurring in any state other than Ohio?	ur behalf for
		NO
4.	Has any board, bureau, department, agency, or any other including those in Ohio <u>other than this board</u> , filed any allegations or complaints against you?	
		NO
5.	Have you had any clinical privileges or other similar instauthority suspended, restricted, revoked or placed on proreasons other than failure to maintain records on a time or to attend staff meetings?	bation for
	OT TO WITH DIWING THE PROPERTY OF THE PROPERTY	NO
6.	Have you been addicted to or dependent upon alcohol or chemical substance; or been treated for, or been diagnose suffering from, drug or alcohol dependency or abuse?	any ed as
		NO
So 1.	cial Security Number	
1.		Redacted

N	irse Conadoration into
1.	Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
	NO
2.	List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.
	{not Answered}
Oł	nio Employment
1.	Do you practice in Ohio?
	YES
	i. Waylefayaa Oyaatiaya
	nio Workforce Questions "Clinical" - direct patient care
1.	30-34
2.	"Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose
	1-4
3.	"Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)
	1-4
4.	"Education" - preceptor, mentor, etc.
	0
5.	"Volunteering" - providing medical and medical-related services at no cost
	0
6.	"Other" - medical professional activities not included in above categories
	5-9
Cli	nical - Practice setting

1.	Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).
	10-14
2.	Enter the number of hours per week spent in "Hospital (in-patient care)".
	5-9
2	
Э.	Enter the number of hours per week spent in "Emergency Room".
1	Enter the number of hours per week spant in "Urgent Care"
4.	Enter the number of hours per week spent in "Urgent Care".
_	0
5.	Enter the number of hoursper week spent in "Other".
	1-4
W	orkforce Counties
1.	Enter the first zip code:
	43213
2.	Enter the first county:
	Franklin
3.	Enter the second zip code:
•	{not Answered}
4	
4.	Enter the second county:
_	{not Answered}
5.	Enter the third zip code:
	{not Answered}
6.	Enter the third county:
	{not Answered}
Pr	actice Arrangement (size)
1.	Solo practitioner
	NO
2.	Single-specialty Group
	2-5
3.	Multi-specialty Group
٠.	N/A

4.	Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)
	NO
W	orkforce Language Question
1.	Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?
	NO
Al	BMS Certified
1.	Are you certified by an ABMS Board? YES
	123
Al	BMS Specialty
1.	Choose specialty from the dropdown list.
	Obstetrics and Gynecology
2.	Choose specialty from the dropdown list.
	{not Answered}
3.	Choose specialty from the dropdown list.
	{not Answered}
I u	inderstand that submitting a false, fraudulent, or forged

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

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

Date Posted: 8/1/2013 12:11:43 PM

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

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

reg	gistration.		
Li	cense Information		
Lie	cense Number	. 3	5.036011
Lie	cense Name	KARL SCH	AEFFER
Fe			¢205.00
Ke	elicensure Fee		\$305.00
		Total Fees	\$305.00
M	edical Board Correspondence Email		
1.	Did you provide a Credential email address? Please not a public record.	te this inform	nation is
	•		YES
_	ecialty Codes		
1.	Please select one specialty from the field below		
	OBSTETRIC	S & GYNEC	COLOGY
2.	Please select one specialty from the field below, if applicable	ole.	
		\dots {not Ar	iswered}
3.	Please select one specialty from the field below, if applicable	ole.	
		{not An	iswered}
	ME Physicians		
	ME-Physicians Have you met the above CME requirements for your licens	20	
1.	Trave you met the above civil requirements for your needs		YES
			125
Di	scipline		
1.	Have you been found guilty of, or pled guilty or no contest treatment or intervention in lieu of conviction of, a misdem	neanor or felo	
2.	Have you surrendered, consented to limitation of, or to sus probation concerning, a license to practice any healthcare prederal privileges to prescribe controlled substances in any than Ohio?	profession or s	state or

6/2/2015

.....NO

3. Have any malpractice awards been paid by you or on your behalf for acts

	occurring in any state other than Ohio?
	NO
4.	Has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u> , filed any charges, allegations or complaints against you?
	agamst you?
5.	Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
	NO
6.	Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
	NO
So	cial Security Number
1.	
Nι	irse Collaboration Info
1.	Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
	NO
2.	List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.
	{not Answered}
Oł	nio Employment
1.	Do you practice in Ohio?
	YES
Oh	nio Workforce Questions
1.	"Clinical" - direct patient care
	35-39
2.	"Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose
	5-9
3.	"Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)
	20-24

4.	"Education" - preceptor, mentor, etc.	
	Face	0
5.	"Volunteering" - providing medical and medical-rela	ted services at no cost
		0
6.	"Other" - medical professional activities not included	l in above categories
		1-4
Cl	linical - Practice setting	
1.	Enter the number of hours per week spent in "Office/	Clinic/Ambulatory
	care" (out-patient care).	25-29
_	7	
2.	Enter the number of hours per week spent in "Hospita	
_		5-9
3.	Enter the number of hours per week spent in "Emerge	•
		0
4.	Enter the number of hours per week spent in "Urgent	
_		0
5.	Enter the number of hours per week spent in "Other".	
		0
	orkforce Counties	
ı.	Enter the first zip code:	43213
•		43213
2.	Enter the first county:	Franklin
•		Franklin
3.	Enter the second zip code:	(, , , , , , , , , , , , , , , , , , ,
		{not Answered}
4.	Enter the second county:	(, , , , , , , , , , , , , , , , , , ,
_		{not Answered}
5.	Enter the third zip code:	Cont Assessment
		{not Answered}
6.	Enter the third county:	
_		{not Answered}
7.	Do you have more than one practice location?	
		NO
n		
	actice Arrangement (size)	
1.	Solo practitioner	NO
•	Simple contribution	NO
Z.	Single-specialty Group	

		2-5
3.	Multi-specialty Group	
		N/A
4.	Employee of a clinical facility or hospital? (Clinical facility is an urgent care, ndustrial clinic or similar entity)	
		NO
W	orkforce Language Question	
1.	o practitioners or staff in your practice communicate in sign language or in a nguage other than spoken English?	
		NO
ABMS Certified		
1.	Are you certified by an ABMS Board?	
		NO
NPI number		
1.	Please enter your current NPI number	
	••••	. 1821066150
DEA number		
1.	Please enter your DEA number	
		Δ \$5663528

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