APPLICATION FOR ENDORSEMENT OF A MEDICAL LICENSE

BY

The State Medical Board, State of Ohio

FORM I.

I hereby make application for a license to practice Medicine and Surgery in the State of Ohio, and submit the following statement regarding my preliminary education.

1. Name KARL IRA SCHAEFFER
2. Place of birth PITTSBURGH, PA.
3. Address 634 JASONWAY AVE. COLUMBUS, OHIO 43214
   Date of birth 6/12/46
4. Intended residence COLUMBUS, OHIO
5. PRELIMINARY EDUCATION.
   Name and Location of Institution Attended and Degree Received. OHIO STATE UNIVERSITY, COLUMBUS, OHIO
   Period and Date of Study. 9/64 – 6/68.

   Received Ohio Certificate of Preliminary Education No. 47328; issued by OSMB, 4/16/73 (Date)
6. I have made application to the following State Examining and Licensing Boards, and no others. (Give names of States and dates of application—Reciprocity or Examination.) NONE as of yet.

   and received a certificate from each except as follows: (Give names of States and dates of application — Reciprocity or Examination.)
7. MEDICAL EDUCATION.
   Give the date and source of each medical credential, diploma, license or degree which you hold

   Attended 4 full courses of medical lectures as follows, to-wit:
   1st Course at UNIVERSITY OF PENNSYLVANIA from 9/68 to 9/69
   2nd Course at U. of PENNSYLVANIA from 9/69 to 9/70
   3rd Course at U. of PENNSYLVANIA from 9/70 to 9/71
   4th Course at U. of PENNSYLVANIA from 9/71 to 5/72

   Was granted a diploma by UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE (Name of Medical College.) located at PHILADELPHIA State of PENNSYLVANIA on the 22 day of May, 1973
8. Time of practice Internship at UCLA MEDICAL CENTER, LOS ANGELES, California (Give places and dates) JUNE, 1972 – JUNE, 73
9. Has any license entitling you to practice in any foreign country or in any state or territory of the United States been suspended or revoked? NO (Answer Yes or No)

   If so, specify: (State or Country) (Charge) (Date)

   Have you ever been or are you now addicted to narcotic drugs? NO (Yes or No)

   Have you ever been charged with addiction? NO (Yes or No)

   Specify charge:

   Have you ever found it necessary to surrender your narcotic license? NO (Yes or No)

   Have you ever been charged with a violation of a Federal Law, State Law or a municipal ordinance other than a traffic violation? NO (Yes or No)

   If so, give full particulars: (Offense) (Place) (Disposition)

   (Date of Disposition)
10. PHYSICAL DESCRIPTION OF APPLICANT

    Color of Hair BROWN Color of eyes BROWN Complexion FAIR

    Height 5'11" Weight 170 Build MEDIUM Marks NONE

FORM II. *AFFIDAVIT.

STATE OF OHIO }
COUNTY OF FRANKLIN } ss:

On this 9TH day of JULY 19 73, personally appeared before me, R E. LAMM, within and for the County and State aforesaid, KARL IRA SCHAEFFER who being duly sworn says that he ia the person referred to in the foregoing application for license to practice medicine in the State of Ohio; that the statements therein are strictly true in every respect, and that ..... has read and understands this Affidavit.

Karl Ira Schaeffer
(Signature of Applicant.)

Signed and sworn to before me, this 9TH day of JULY, 19 73

(Seal.)

R. E. Lamm
(Official designation of officer administering oath.)

*Affidavit must be sworn to before an officer authorized to administer oaths, or a Federal officer. R. E. LAMM, ATTY. AND NOTARY PUBLIC FOR THE STATE OF OHIO WITH LIFETIME COMMISSION

FORM III.

CERTIFIED COPY OF ~~STATE LICENSE OR~~ CERTIFICATE.

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Karl Ira Schaeffer, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest: J. D. MYERS
Chairman of the Board

SEAL

JOHN P. HUBBARD
President of the Board

Philadelphia, Pa.
July 2, 1973.

Cert. # 133174

I hereby certify that the above is a verbatim copy of ~~license~~ certificate No. 133174, issued to Dr. Karl Ira Schaeffer by the National Board of Medical Examiners on the 2nd day of July, 19 73

(Seal.)

M. D. Associate Director

FORM IV.

CERTIFICATE ~~AND IDENTIFICATION~~ OF ~~SECRETARY~~ ASSOCIATE DIRECTOR

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

I do hereby certify that Dr. Karl Ira Schaeffer was on the 2nd day of July, 19 73, ~~graduated from a medical college or practiced medicine by the State of~~ ou the basis of written examination (State board examination or medical diploma of graduation.) iu the following subjects Anatomy 390(75), Physiology 540(83), Biochemistry 405(75), Pathology 430(76), Microbiology 365(72), Pharmacology 520(82), Medicine 585(86), Surgery 475(81), Obstetrics 510(82), Public Health and Prev. Med. 385(76), Pediatrics 455(80), Psychiatry 355(75), Practical,clinical (Part III) 405(78.6)

on which he received an average of 78.2 per cent, ~~and from evidence on file in this office, I do hereby certify to the good moral and professional standing of Dr. of ., State of , and recommend to the State Medical Board of Ohio, as a proper person for medical licensure.~~

~~The applicant must satisfy the Board of on the question of standing and moral character before seal of said Board is affixed.~~

(Seal.)

M. D. Associate Director

July 19, 1973.
(Date)

FORM V.

AFFIDAVIT OF PHYSICIANS.

STATE OF Ohio }
Franklin COUNTY } ss:

Before me, personally appeared Karl I. Schaffer 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 Karl Schaffer M. D., well for 1 years and knows him to be of good moral and professional character, that he is a graduate of Univ. of Penn. College in the year 1972, that he has been in the practice of Medicine for the last twelve months at UCLA, and recommended him as worthy of professional recognition and that the foregoing physical description is correct.

Address 1800 Zollinger Rd — William Pagano M. D.

, Graduate of Univ. of Penn., Certificate No. 18611

Subscribed and sworn to this 23 day of July, 1973

(Seal.) NOTARY PUBLIC, FRANKLIN COUNTY, OHIO MY COMMISSION EXPIRES NOV. 18, 1975 — Bernice M. Pagano Notary Public.

STATE OF Ohio }
Franklin COUNTY } ss:

Before me, personally appeared Karl I SCHAEFFER 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 Karl I Schaefer M. D., well for 3 years and knows him to be of good moral and professional character, that he is a graduate of Univ. of Pennsylvania College in the year 1972, that he has been in the practice of Medicine for the last twelve months at UCLA Medical Center, and recommended him as worthy of professional recognition and that the foregoing physical description is correct.

Address 497 E Bron St — George W. Lewis M. D.

Columbus Ohio 43215, Graduate of OSU, Certificate No. 25891

Subscribed and sworn to this 23 day of July, 1973

(Seal.) BERNICE M. PAGANO NOTARY PUBLIC, FRANKLIN COUNTY, OHIO MY COMMISSION EXPIRES NOV. 18, 1975 — Bernice M. Pagano Notary Public.

FORM VI.

CERTIFICATE OF ETHICAL AND MORAL CHARACTER FROM PRESIDENT OR SECRETARY OF COUNTY, DISTRICT OR STATE MEDICAL SOCIETY:

P. O. Address ..... Date ....., 19.....

I certify that Dr. ..... of .....

is a member in good standing of the ..... and that he is an ethical practitioner of good moral character.

....., M. D.
President or Secretary

(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, OHIO and am Resident at O.S.U. Hospital. I Planned to join soon. Karl D. Schaeffer.

SECTION 4731.29, REVISED CODE

When a physician or surgeon licensed by the licensing department of another state, a territory, or the District of Columbia, or a diplomate of the national board of medical examiners or the national board of examiners for osteopathic 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. . .

FOR USE OF SECRETARY ONLY

State Certificate No. 36011

Issued 8/22/73

APPLICATION FOR
ENDORSEMENT OF A
MEDICAL LICENSE
BY STATE MEDICAL BOARD,
STATE OF OHIO

269-6 7-25-73 (Date)

SCHAEFER, KARL E., M. D.
8/15/42

Filed 19 73

Ohio ck

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

1. 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.
5. Address all communications to the Administrator of the State Medical Board, Wyandotte Building, 21 West Broad Street, Columbus, Ohio 43215.

In accordance with announcements made by the National Board of Medical Examiners, grades 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 to all subsequent examinations in Part I, Part II and Part III.

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 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 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.

With reference to memorandum to all State Medical Examining Boards from Frederick T. Merchant, M.D. dated December 1, 1970, please note: "The National Board of Medical Examiners is to be regarded as an examining agency with no function in determining the moral character of its Diplomates or their fitness to practice other than that related to the completion of educational requirements and successful completion of its examinations in 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

1 Karl I. Schaeffer
Signature of Applicant

2 Karl I Schaeffer
Signature of Applicant

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.

7/23/73
Date

Signature of First Endorser.

7/23/73 2
Date

Signature of Second Endorser.

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 Pittsburg, Penna. Date of birth 6-12-46

Professional Mailing Address 1385 Kelton Ave. #101
Los Angeles, Calif. 90024

Medical Education:

School Name Univ. of Pennsylvania Medical School M.D. Degree 1972 (Year)

Internships:

Hospital	Location	Dates
		to
		to

Residencies and Fellowships:

Hospital	Location	Dates
		to
		to

M.D. Licensed to Practice Medicine in the Following States:

National Board
State Year 1973; State Year ; State Year

Inquiry Submitted by Joan Elsman Title ~~Endorsement Clerk~~
(Your Name Here)

Ohio State Medical Board, 21 W. Broad St. City-State Columbus, Ohio 432
(Affiliation - Licensing Board, Hospital or Medical School)

AMA Department of Investigation

MEMBER OF AMA ..... YES ..... NO

☐ Our records do not reveal any derogatory information.
☐ See attached memo for comments regarding applicant.

A check mark (✓) indicates that the data given corresponds to that listed in the AMA Master File of Physicians. A discrepancies are as noted.

Date

Joan Alvarez
Joan Alvarez,
Member Services Unit

July 23, 1973

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, California. I finished my internship on June 23, 1973, and returned to Columbus, OHIO to start my second year of training in Obstetrics & Gynecology at OHIO STATE University Hospital.

Sincerely,
Karl D. Schaeffer, M.D.

Applic sent 6/5/73 FU
AMA sent 6/5/73 FU

May 6, 1973

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

Dear Sir,

Please send me an application for OHIO STATE MEDICAL LICENSE. I graduated University of Pennsylvania School of Medicine in May, 1972 and became a Diplomat of the NATIONAL BOARD OF MEDICAL EXAMINERS in April, 1973. Finally, I was born in PITTSBURGH, PENNSYLVANIA on June, 12, 1946, and have been a permanent resident of Columbus, OHIO for past 18 years even though I am serving my internship at UCLA Medical Center, Los Angeles, California.

Thank you.

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

SCHAEFFER, KARL

STATE OF OHIO STATE MEDICAL BOARD

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 BIENNIUM 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.

Karl I. Schaeffer 10-10-84
(SIGNATURE OF APPLICANT) (DATE)

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

IDENTIFICATION NUMBER
35-03-6011

1 KARL I. SCHAEFFER
5745 SOUTHBRIDGE LN
COLUMBUS OH 43213

CP-0345-F

MD & DO SPECIALTY CODES
SPECIALTY CODES CURRENTLY ON RECORD → 39
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS → (LIMIT OF 3)
(SEE LIST ON ENCLOSED CARD)

AMOUNT DUE $100.00

DATE DUE 11/15/84

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

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 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

Schaeffer, KARL I.
LAST NAME FIRST NAME INITIAL

6392 Windrush Lane
STREET ADDRESS

Blacklick, Ohio 43004
CITY STATE ZIP CODE

Franklin
COUNTY

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)

Schaeffer, KARL I.
LAST NAME FIRST NAME INITIAL

3255 E. Livingston Ave.
STREET ADDRESS

Columbus, Ohio 43227
CITY STATE ZIP CODE

FRANKLIN
COUNTY

SOCIAL SECURITY NUMBER Redacted

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 CONVICTED OF OR PLEAD NOLO CONTENDERE 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?
☐	☒	2). Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☒	3). Surrendered or consented to limitation of license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☒	4). Had any hospital privileges suspended or revoked?

346-B

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 BIENNIUM 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.

Karl I. Schaeffer 10-10-85
(SIGNATURE OF APPLICANT) (DATE)

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

IDENTIFICATION NUMBER
35-03-6011

KARL I. SCHAEFFER
6372 WINDRUSH LANE
BLACKLICK OH 43004

MD & DO SPECIALTY CODES
ENTER ALL SPECIALTY CODES → 3 9
(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 2408 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 KEEP IF YOUR RENEWAL CARD BY DECEMBER 1ST AFTER THIS APPLICATION AND FEE BY NOVEMBER 1ST

EDM-14949-B

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)

Schaeffer Karl I.
LAST NAME FIRST NAME INITIAL

3255 E. Livingston Ave.
STREET ADDRESS

Columbus, Ohio 43227
CITY STATE ZIP CODE

Franklin
COUNTY

SOCIAL SECURITY NUMBER Redacted

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?
☐	☑	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☑	3.) Surrendered or consented to limitation upon a license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☑	4.) Had any hospital privileges suspended or revoked?

STATE MEDICAL BOARD OF OHIO

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 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Karl I Schaeffer MD 9-23-88

(SIGNAURE OF APPLICANT) (DATE)

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

IDENTIFICATION NUMBER 35-03-6011

OT-00223-OF

KARL I. SCHAEFFER
6372 WINDRUSH LANE
BLACKLICK OH 43004

MD & DO SPECIALTY CODES		AMOUNT DUE	DATE DUE
SPECIALTY CODES CURRENTLY ON RECORD	SP	$100.00	11/01/88
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS (SEE LIFE ON ENCLOSED CARD)	(LIMIT OF 3)		

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. 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

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)

Schaeffer, Karl I,
LAST NAME FIRST NAME INITIAL

5969 E. Broad St. Suite 401
STREET ADDRESS

Columbus, Ohio 43213
CITY STATE ZIP CODE

Franklin

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?

SOCIAL SECURITY NUMBER Redacted

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?
☐	☒	3.) Surrendered or consented to limitation upon a license to practice medicine 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-OB

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Karl I Schaeffer, MD 9-30-90

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35-03-6011	$160.00	11/01/90

KARL I. SCHAEFFER, M.D.
6372 WINDRUSH LANE
BLACKLICK OH 43004

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

SPECIALTY CODE(S) CORRECT AS LISTED

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

CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

:96969696 2: 0935036011 :00000 16000:

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

5969 E. Broad Street
Street

Street

Columbus OH 43213
City State Zip Code

County

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

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

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

	YES	NO
1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.		X
2.) Had any disciplinary action taken or initiated against you by any state licensing board?		X
3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?		X
4.) Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?		X

Redacted

(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Karl I. Schaeffer, MD 6-4-92
(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

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

[X] 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

:969696962: 0935036011 "00000160000"

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

2669 E. BROAD STREET
Street
Street
COLUMBUS OH 43203
City State Zip Code
FRANKLIN
County

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

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

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

	YES	NO
1.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.		X
2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?		X
3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?		X
4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?		X

93503601 ACCOUNT #

Redacted

(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Karl I Schaeffer MD 3-30-94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-6011	$250.00	05/01/94

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 ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935036011 :00000 25000:

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

Street 6372 Windrush Ln
Street
City Blacklick State OH Zip Code 43004
County FRANKLIN

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

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES ☐ NO ☒

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES ☐ NO ☒

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 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 ☒

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)
Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 9-10-96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-6011	$250.00	05/01/96

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 ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935036011 :00000 25000:

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

Street
Street
City State Zip Code
County

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

	YES	NO
1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.		☑
2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?		☑
3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.		☑
4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?		☑
5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?		☑
6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?		☑
7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?		☑
8.) 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?		☑

[redacted] SOCIAL SECURITY NUMBER

Redacted

AMOUNT BATCH/DATE 935036011 ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Karl I Schaeffer, M.D. 3-7-98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-6011-S	$179.00	05/01/98

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 ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 093503601 1 " "00000 17900"

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

Street 5761 E BROAD ST
Street
City COLUMBUS State OH Zip Code 43213
County FRANKLIN

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

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES ☐ NO ☒

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES ☐ NO ☒

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 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 ☒

Redacted

995036011 ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-1999 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Karl I. Schaeffer, MD 7-12-99
(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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969698 2: 0935036011 :0000030500:

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

Street
Street
City OH State 43215 Zip Code
FRANKLIN County

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

	YES	NO
1.) Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor?	☐	☒
2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?	☐	☒
3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.	☐	☒
4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?	☐	☒
5.) 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?	☐	☒
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?	☐	☒
7.) Had any clinical privileges or other authority to practice suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?	☐	☒

Redacted

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 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 Karl I Schaeffer, MD 7-28-01
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE 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 ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935036011 :00000305 00:

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principal Practice address.

5769 E. BROAD STREET
Street
Street
City COLUMBUS State OH Zip Code 43213
County FRANKLIN

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

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

YES ☐ NO ☑ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question if** you have successfully completed treatment at 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 ☑ 3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

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

YES ☐ NO ☑ 5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☐ NO ☑ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

REQUIRED:

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2001 - 2003 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Karl I Schaeffer, MD 8-6-03
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE 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
BLACKLICK OH 43004

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.

6372 WINDRUSH LANE
STREET
STREET
BLACKLICK OH 43004
CITY STATE ZIP CODE
FRANKLIN
COUNTY

0935036011 30500

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 ☒

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 ☒

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

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

5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board. YES ☐ NO ☒

6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?** YES ☐ NO ☒

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

5769 E. BROAD STREET
Street
Street
COLUMBUS OH 43213
City State Zip Code
FRANKLIN
County

REQUIRED:

Redacted

08072003 711700
1 0045 023
036011
1 SE 000030500

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}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 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}*

CME-Physicians

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

Discipline

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

reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse CollaborationInfo

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: 8/24/2009 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?
   ..... YES

Discipline

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

healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

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

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged

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

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

Date Posted: 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.

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 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

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 10-14

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 5-9

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hoursper week spent in "Other".

. 1-4

Workforce Counties

1. Enter the first zip code:

. 43213

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS 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 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

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License Information

License Number	35.036011
License Name	KARL SCHAEFFER

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

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. . . . . YES

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

. . . . . *{not Answered}*

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CME-Physicians

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

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

. . . . . NO

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

. . . . . NO

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

occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 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.

. 0

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

. 0

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

. 1-4

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 25-29

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 5-9

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 43213

2. Enter the first county:

. . . . . Franklin

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

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

. . . . . AS5663528

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.