STATE MEDICAL BOARD OF OHIO
PRE-APPLICATION SCREENING FORM

appoint 12/30/81

PLEASE TYPE THIS FORM TO AVOID DELAYS IN PROCESSING

ANSWER EACH QUESTION COMPLETELY; IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH EXTRA SHEETS.

NAME: CARHART (LAST (Surname)) LeROY (FIRST) HARRISON (MIDDLE) SUFFIX (Jr.,II)

ADDRESS: 105 East Mission Avenue (STREET & NUMBER), Bellevue (CITY), Nebraska (STATE), 68005 (ZIP) USA (COUNTRY)

TELEPHONE: BUSINESS: (402) 292-4164 (AREA CODE & NUMBER) HOME: (402) 291-4660 (AREA CODE & NUMBER)

BIRTH DATE: OCT / 28 / 1941 (MO/DAY/YR) BIRTH PLACE: Trenton (CITY), NJ. (STATE) Mercer County (COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: Hahnemann University (SCHOOL NAME) Broad & Vine (STREET ADDRESS) Philadelphia (CITY), Pa. (STATE) COUNTRY

2/16/69 FROM (date) TO 5/23/73 (date) M.D. DEGREE RECEIVED 6 / /73 DATE RECEIVED

OTHER MEDICAL SCHOOLS ATTENDED: (IF "NONE" ENTER "NONE") NONE
SCHOOL NAME STREET ADDRESS CITY STATE COUNTRY

/ / FROM (date) / / TO (date) REASON EDUCATION NOT COMPLETED AT THIS SCHOOL

SCHOOL NAME STREET ADDRESS CITY STATE COUNTRY

/ / FROM (date) / / TO (date) REASON EDUCATION NOT COMPLETED AT THIS SCHOOL

E.C.F.M.G. CERTIFICATE: YES ____ NO ____ NUMBER ________ DATE ISSUED / /

FIFTH PATHWAY

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

ADDRESS: STREET & NUMBER CITY STATE ZIP DATE: / / FROM / / TO

QUALIFYING EXAM TAKEN: ________ DATE: / /

POSTGRADUATE TRAINING

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

RECEIVED MEDICAL BOARD OHIO DEC 1 '87

HOSPITAL: USAF, ANDREWS AFB (NAME), STREET ADDRESS CITY Maryland (STATE)
POSITION: Rotating Internship DEPARTMENT: ________ DATE: July 1/73 (FROM) Jun/30/74 (TO)

HOSPITAL: Hahnemann Hospital (NAME) Broad & Vine (STREET ADDRESS) Philadelphia (CITY), Pa (STATE)
POSITION: Resident DEPARTMENT: Surgery DATE: July 1/1974 (FROM) Jan/26/1976 (TO)

HOSPITAL: Atlantic City Medical Center (NAME), STREET ADDRESS Atlantic City (CITY), New Jersey (STATE)
POSITION: Surgical Resident DEPARTMENT: Surgery DATE: Jan/26/76 (FROM) Jun/30/78 (TO)

HOSPITAL: NAME STREET ADDRESS CITY STATE
POSITION: ________ DEPARTMENT: ________ DATE: / / FROM / / TO

LICENSES IN OTHER COUNTRIES

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

COUNTRY: ________ ISSUE DATE: / / LICENSE # ________ CURRENT: YES__ NO__

COUNTRY ________ ISSUE DATE: / / LICENSE # ________ CURRENT: YES__ NO__

LICENSES IN THE UNITED STATES

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

Dr. called 12/30/87 - is renewing license

STATE: PA ISSUE DATE: Sep 27 1974 LICENSE #: 35665 CURRENT: YES__ NO XX

BASIS OF LICENSURE: FLEX

STATE: Nebraska ISSUE DATE: Oct 17 / 79 LICENSE #: 15162 CURRENT: YES XX NO__

BASIS OF LICENSURE: Reciprocity

STATE: IOWA ISSUE DATE: OCT 15 / 82 LICENSE #: 23312 CURRENT: YES XX NO__

BASIS OF LICENSURE: Reciprocity

FLEX EXAMINATIONS

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

STATE: Pennsylvania DATE TAKEN: May 1974 PASS: XXX FAIL: ____

STATE: ________ DATE TAKEN: ________ PASS: ____ FAIL: ____

STATE: ________ DATE TAKEN: ________ PASS: ____ FAIL: ____

STATE: ________ DATE TAKEN: ________ PASS: ____ FAIL: ____

ADDITIONAL ELIGIBILITY INFORMATION -ANSWER ALL QUESTIONS

DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS? YES ___ NO ___ DATE / /

DIPLOMATE OF THE NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS? YES___ NO___ DATE / /

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

A U.S. CITIZEN? YES xx NO ___ BASIS OF CITIZENSHIP Birth DATE Oct 28 /41

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

DEGREE OBTAINED (CHECK ONLY ONE) ____ ACTA ____ TITULO ____ MEDICO CIRUJANO

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

IF YES, GIVE FULL ADDRESS AT THAT TIME:

STREET ADDRESS CITY STATE ZIP

CERTIFICATION

I, LeROY HARRISON CARHART, HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING SCREENING FORM; THAT THE STATEMENTS THEREIN ARE STRICTLY TRUE IN EVERY RESPECT AND THAT I HAVE READ AND UNDERSTAND THIS CERTIFICATION.

SIGNATURE [signature] DATE November 23, 1987

RETURN TO: STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET ROOM 510
COLUMBUS, OHIO 43266-0315

Ame 7 5-16-88
Feb
Lee-Offutt AFB
Bellevue
5-17-88

APPLICATION FOR MEDICAL & OSTEOPATHIC LICENSURE
(ALL RESPONSES MUST BE TYPED)
STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET ROOM 510
COLUMBUS, OHIO 43266-0315

ALL RESPONSES MUST BE TYPED

1. SOCIAL SECURITY NUMBER Redaction

2. FULL NAME (Use no initials) CARHART LeROY HARRISON
LAST (Surname) FIRST MIDDLE SUFFIX (Jr., II)

3. NAME (As you prefer it inscribed on your Ohio license) XXXXXXX CARHART LeROY Harrison
LAST (Surname) FIRST MIDDLE SUFFIX (Jr., II)

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

5. PHYSICAL DESCRIPTION 6'0" 220 Blond Blue None
HEIGHT WEIGHT HAIR COLOR COLOR OF EYES IDENTIFYING MARKS

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

7. CITY IN OHIO WHERE YOU PLAN TO PRACTICE: Warren
CITY OR COUNTY

PLANS OF PRACTICE: Emergency Medicine

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

NAME OF SPECIALTY BOARD	BOARD CERTIFIED YES	NO	YEAR CERTIFIED	COUNTRY
NONE	[ ]	[ ]		
I am eligible to sit the General Surgery and Emergency Medicine Boards	[ ]	[ ]		
	[ ]	[ ]		
	[ ]	[ ]		

FOR OFFICE USE ONLY 34 dc 35

1-5
45-4-123 4-26-88 1150.00 Rc 6793

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

RESUME

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time you must state on the resume exactly what your activities were, such as "vacation" or "looking for residency program", as well as your permanent address for this period. For any time in which you worked for an "emergency medical group" or did locum tenens you must list all hospitals where you worked. If in private practice, indicate the hospitals where you hold or have held privileges and include complete addresses. Failure to include complete addresses will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

CARHART

	DATES IN CHRONOLOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
a.	7 (month) 73 (year) TO 6 (month) 74 (year)	Malcolm Grow USAF Hospital Andrews AFB, MD (Hospital/University/Other) — (Street Address City/State Zip)	Intern-Rotating Medicine	100	
b.	7 (month) 74 (year) TO 1 (month) 76 (year)	Hahnemann Medical Col & Hos (Hospital/University/Other) — Broad & Vine Streets Philadelphia, Pa 19102-1192 (Street Address City/State Zip)	Surgery	100	
c.	1 76 76 (month year) TO 6- (month) 78 (year)	Atlantic City Med Center (Hospital/University/Other) — Atalntic City, New Jersey (Street Address City/State Zip)	Surgery	100	
d.	7 (month) 78 (year) TO 2 (month) 85 (year)	Offutt AFB Hospital (Hospital/University/Other) — Offutt AFB, Nebraska 68113 (Street Address City/State Zip)	Surgery	75	25
e.	2 (month) 85 (year) TO Present	Bellevue Health & Emergency Center (Hospital/University/Other) — 105 East Missia Ave Bellevue, Nebraska (Street Address City/State Zip)	Emergency Med	85	15

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
f. month year TO month year	Hospital/University/Other Street Address City/State Zip			
g. month year TO month year	Hospital/University/Other Street Address City/State Zip			
h. month year TO month year	Hospital/University/Other Street Address City/State Zip			
i. month year TO month year	Hospital/University/Other Street Address City/State Zip			
j. month year TO month year	Hospital/University/other Street Address City/State Zip			
k. month year TO month year	Hospital/University/Other Street Address City/State Zip			
l. month year TO month year	Hospital/University/Other Street Address City/State Zip			

AMG

FORM 1

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, Steven M. Osborn, a licensed and practicing physician in the state of
Name of Recommending Physician
Nebraska affirm that Lee Carhart, has been known
Name of Applicant
to me personally and professionally for 1 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

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

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

[signature]
Signature of Recommending Physician

Steven M. Osborn
Name of Recommending Physician
(Please print or type)

UNMC, 42nd + Dewey, Omaha NE 68105
Address of Recommending Physician
(Include City, State, Zip)

402- 559- 7200
Telephone Number
(Include Area Code)

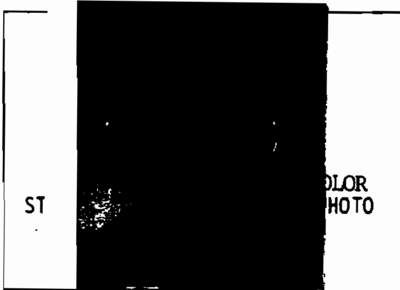
(SEAL)

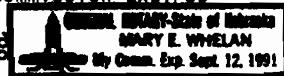
Nebraska 17344
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 22nd day of April, 1988.

[signature]
Notary Public

9/12/91
Date Commission Expires





Upon completion return to:
STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET, ROOM 510
COLUMBUS, OHIO 43266-0315

[signature]
Signature of Applicant

3-1-88
Date Photo Taken

FORM 1

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, ENRIQUE de la GUARDIA, a licensed and practicing physician in the state of
Name of Recommending Physician

NEBRASKA affirm that LeRoy H. Carhart, has been known
Name of Applicant

to me personally and professionally for 3 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Good

His/her command of the English language is: Good

I rate his/her ability to work well with peers and medical staff as: Good

His/her relationship with patients is: Good

Additional comments:

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

[signature]
Signature of Recommending Physician

6408 South 100 Circle
Address of Recommending Physician
(Include City, State, Zip) Omaha NE

(SEAL)

ENRIQUE DELA GUARDIA MD
Name of Recommending Physician
(Please print or type)

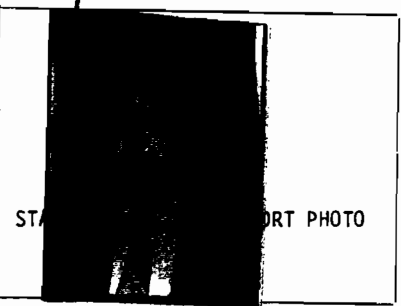
402-3[illegible]3379
Telephone Number
(Include Area Code)

NEBRASKA 16722
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 19 day of July, 1988.

[signature]
Notary Public

4-4-90
Date Commission Expires



Upon completion return to:
STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET, ROOM 510
COLUMBUS, OHIO 43266-0315

[signature]
Signature of Applicant

1 April 1988
Date Photo Taken

AMG

'88 MAR 21 P3:32

RECEIVED
OHIO STATE
MEDICAL BOARD

FORM 2

CERTIFICATE OF POST-GRADUATE TRAINING

MAIL TO HOSPITAL OR INSTITUTION OF POSTGRADUATE TRAINING IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice medicine in the State of Ohio. The State Medical Board of Ohio requires that my postgraduate training be certified. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

This certifies that LeROY HARRISON CARHART has rendered satisfactory
(Name of Applicant)

and continuous service as a(n) [ ] intern [X] resident [ ] clinical fellow in General Surgery
(Department)

at Atlantic City Medical Center, ______
(Name of Hospital) (Complete Address of Hospital)

from January 31, 1976 (1976) to June 30, 1978. It is
beginning (month/day/year) ending (month/day/year)

further certified that the above named [X] was [ ] was not awarded a certificate on June 30 /1978
(month/day/year)

and that the training [ ] was [ ] was not accredited by ACGME/AOA.

[signature]
Signature of Medical Director or Program Director

(SEAL OF HOSPITAL)

Alfred A. Rosenblatt, M.D.
Name (Please print or type)

3/16/88
Date

If the hospital has no seal, please indicate and have form notarized.

Upon completion return to: STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET, ROOM 510
COLUMBUS, OHIO 43266-0315

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P.O. BOX 2649
HARRISBURG, PA 17105-2649

'88 MAR 15 P4:23

LEROY HARRISON CARHART
105 EAST MISSION AVE
BELLEVUE NE 68005

MARCH 7, 1988

STATE BOARD OF MEDICINE

LEROY HARRISON CARHART

MEDICAL PHYSICIAN AND SURGEON

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON IS LICENSED AND CURRENTLY REGISTERED IN THE COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF STATE, STATE BOARD OF MEDICINE.

THE RECORDS OF THE PENNSYLVANIA STATE BOARD OF MEDICINE SHOW NO DEROGATORY INFORMATION AGAINST THIS PERSON.

ORIGINAL LICENSURE DATE: SEPTEMBER 27, 1974
EXPIRATION DATE: DECEMBER 31, 1988
LICENSE NUMBER: MD-035665-L

George L. Shevlin

George L. Shevlin
Commissioner

FORM 3 MB

CERTIFICATE OF STATE BOARD

TO ALL STATE BOARDS-DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED

This form must be completed for applicants who are applying for endorsement of another state license based upon examination in that state.

'88 MAR 15 P4:23

Acting on behalf of the Pennsylvania Medical Board
Name of State Board

I do hereby certify that Dr. LeROY HARRISON CARHART
Name of Licensee

was on the 27th day of September 1974, granted a license to practice Medicine & Surgery in the State of Pennsylvania based upon written examination of:

[x] FLEX Examination administered in this state

[ ] Written examination prepared by this state

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

[ ] Other (Please specify) ____________

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

SUBJECT	PERCENTAGE	SUBJECT	PERCENTAGE

or a Component I score of _______ on ______/______ (month/year) and Component II score of __________ on ______/______ (month/year).

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

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

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

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

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

Upon completion, return to:

STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET, ROOM 510
COLUMBUS, OHIO 43266-0315

____
Date

FORM 4 AMG

VERIFICATION OF LICENSE

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

'88 MAR 15 P4:23

TO BE COMPLETED BY APPLICANTS

LeROY HARRISON CARHART, M.D. — Name in Full

MD-035665-L — License Number

Sept 27, 1974 — Issue Date

105 East Mission Ave
Bellevue, Nebraska 68005 — Complete Address (Include zip code)

October 28, 1941 — Date of Birth

Hahnemann Medical College and Hospital
Philadelphia, Pa. — Medical School Graduation

June 3, 1973

I hereby authorize the licensing agency of the state or province of Pennsylvania to furnish the information below to the State Medical Board of Ohio.

[signature] — Signature of Applicant

2 Mar 88 — Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province ____________ Name of Licensee ____________

License Number ____________ Date Issued ____________

Is license current? ______

If not, please explain ____________

What is the basis of the license?

[ ] 1. Flex examination in ____________
[ ] 2. Written examination prepared by this state or province
[ ] 3. National Boards
[ ] 4. LMCC
[ ] 5. Endorsement from ______ State/Province
[ ] 6. Other (Please Specify) ______

s the applicant currently the subject of a pending investigation by a licensing or isciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE AW _____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

ave formal disciplinary proceedings been initiated against applicant or applicant's license by disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT TATE LAW _____
If yes, please attach details.

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

)TE: If any portion of the above certification is deleted or modified, please attach an planation.

(BOARD SEAL)

Signed: ____________

Title: ____________

Date: ____________

ORIGINALS SIGNATURES ONLY. NAME STAMPS WILL NOT BE ACCEPTED.

ease return to: STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET, ROOM 510
COLUMBUS, OHIO 43266-0315

MAR 7

FORM 4 AMG

VERIFICATION OF LICENSE

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

TO BE COMPLETED BY APPLICANTS

LeROY HARRISON CARHART, M.D. — Name in Full

ML-15162 — License Number

Oct 17, 1979 — Issue Date

105 East Mission Ave
Bellevue, Nebraska 68005 — Complete Address (Include zip code)

October 28, 1941 — Date of Birth

Hahnemann Medical College and Hospital
Philadelphia, Pa.
June 3, 1973 — Medical School Graduation

I hereby authorize the licensing agency of the state or province of Nebraska to furnish the information below to the State Medical Board of Ohio.

[signature] — Signature of Applicant

2 Mar 88 — Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/~~Province~~ Nebraska   Name of Licensee LeRoy Harrison Carhart, M.D.

License Number 15162   Date Issued October 17, 1979

Is license current? Yes

If not, please explain

Reciprocity with the State of Pennsylvania

What is the basis of the license?

[X] 1. Flex examination in Pennsylvania
[ ] 2. Written examination prepared by this state or province
[ ] 3. National Boards
[ ] 4. LMCC
[ ] 5. Endorsement from State/Province
[ ] 6. Other (Please specify)

'88 MAR 14 PM ... RECEIVED OHIO STATE MEDICAL BOARD

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES ____ NO X CANNOT ANSWER UNDER CURRENT STATE LAW ____

If yes, please attach details. Include information as to whether licensee is aware of investigation.

Have formal disciplinary proceedings been initiated against applicant or applicant's license by disciplinary authority in your state? YES ____ NO X CANNOT ANSWER UNDER CURRENT STATE LAW ____

If yes, please attach details.

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state? YES ____ NO X CANNOT ANSWER UNDER CURRENT STATE LAW ____

If yes, please attach details.

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

(BOARD SEAL)

Signed: x Helen L. Meeks [signature]

Title: Helen L. Meeks, Director

Date: March 8, 1988

ORIGINALS SIGNATURES ONLY. NAME STAMPS WILL NOT BE ACCEPTED.

Please return to: STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET, ROOM 510
COLUMBUS, OHIO 43266-0315

FORM 4 AMG

VERIFICATION OF LICENSE

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

TO BE COMPLETED BY APPLICANTS

LeROY HARRISON CARHART, M.D.
Name in Full

MI 23312 — Oct 15, 1982
License Number — Issue Date

105 East Mission Ave
Bellevue, Nebraska 68005
Complete Address (Include zip code)

October 28, 1941
Date of Birth

Hahnemann Medical College and Hospital
Philadelphia, Pa.
Medical School Graduation

June 3, 1973

I hereby authorize the licensing agency of the state or province of IOWA to furnish the information below to the State Medical Board of Ohio.

[signature] — 2 mar 88
Signature of Applicant — Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province Iowa Name of Licensee Leroy Harrison Carhart

License Number 23312 Date Issued 10-15-82

Is license current? yes

If not, please explain

What is the basis of the license?

[ ] 1. Flex examination in

[ ] 2. Written examination prepared by this state or province

[ ] 3. National Boards

[ ] 4. LMCC

[X] 5. Endorsement from PA State/Province

[ ] 6. Other (Please Specify)

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES ____ NO X CANNOT ANSWER UNDER CURRENT STATE LAW ____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state? YES ____ NO X CANNOT ANSWER UNDER CURRENT STATE LAW ____
If yes, please attach details.

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

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

(BOARD SEAL)

Signed: Cheryl Brinkman
Title: Secretary
Date: 3-9-88

ORIGINALS SIGNATURES ONLY. NAME STAMPS WILL NOT BE ACCEPTED.

Please return to: STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET, ROOM 510
COLUMBUS, OHIO 43266-0315

AFFIDAVIT AND RELEASE

AFFIDAVIT AND
RELEASE OF
APPLICANT

The affidavit and release below must be completed by ALL applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being returned to you.

ss STATE OF NEBRASKA

COUNTY OF SARPY

I, LeROY HARRISON CARHART hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and the Routes to Licensure and I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable or transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that failure to complete this application as requested by the Board within six months can be considered as abandonment of any request for licensure and that any fee I submitted is not refundable or transferable.

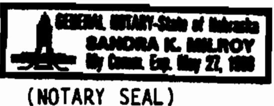
I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives, and any person furnishing information, any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization, or similar institution; or to any professional association.

I further understand that a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained therein or to be furnished, which if false, can subject me to permanent denial of said certificate.

[signature] MD.
Signature of Applicant

Subscribed and sworn to before me this 11 day of April 1988.



(NOTARY SEAL)

Sandra K. Milroy
Notary Public Signature

May 27, 1990
Date Commission Expires

000060

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO ____________

This is to certify that this applicant has met preliminary education requirements for the study of medicine in conformity with the statutes of Ohio and the regulations of the State Medical Board of Ohio.

Ray L. Bumgarner
Entrance Examiner

Henry G. Cramblett M.D.
Secretary

Date Issued

FOR BOARD USE ONLY

NAME: CARHART, Jerry Harrison

CERTIFICATE #: 57427 DATE ISSUED 9-23-88

FILED 12/30, 19 87

FEE ____________

DETERMINATION:

BOARD ACTION:

BASIS OF LICENSURE:

1-5
45-4-123
4-26-88

State of Ohio
THE STATE MEDICAL BOARD
Suite 510
Columbus, Ohio 43266-0315

PRELIMINARY EDUCATION FORM

My name IN FULL is CARHART LeROY HARRISON
LAST FIRST MIDDLE

High School or Equivalent: Hamilton High School - EAST Hamilton Twp. New Jersey USA
SCHOOL NAME CITY STATE COUNTRY

Sep/ /57 Jun/ /60 YES
FROM (DATE) TO (DATE) DEGREE

College or Equivalent: RUTGERS . The State University New-Brunswick, New Jersey USA
SCHOOL NAME CITY STATE COUNTRY

9/1/88
72678

Sep/ /60 Jun/ /64 BA Business Adm
FROM (DATE) TO (DATE) DEGREE

Saint Mary's University, San Antonio Texas USA
SCHOOL NAME CITY STATE COUNTRY

Sep/ /77 Jan/ /67
FROM (DATE) TO (DATE) DEGREE

Hahnemann Univ, Phila, PA 8/69-5/73 -MD

'87 DEC -1 PM 2:41
OHIO STATE MEDICAL BOARD

The Federation of State Medical Boards
of the United States
INCORPORATED

BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE PRESIDENT

2630 WEST FREEWAY, SUITE #138
FORT WORTH, TEXAS 76102-7199
(817) 335-1141

DALE G. BREADEN
ASSOCIATE EXECUTIVE VICE PRESIDENT

RECEIVED
OHIO STATE
MEDICAL BOARD
'88 MAR 31 P3:41

To: Ohio State Medical Board.

Subject: FLEX Scores

LEROY H CARHART
105 EAST MISSION AVE
BELLEVUE, NE
68005

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

FIN: 411028502 Date of Certification: 03/30/88

EXAMINATION DATE: 06/74
FOR INSTITUTION: 139

BASIC SCIENCE

Anatomy:	67.00
Physiology:	75.00
Biochemistry:	65.00
Pathology:	65.00
Microbiolgy:	65.00
Pharmacology:	78.00
Behavioral Science:	.00

BASIC SCIENCE AVE.: 69.20

CLINICAL SCIENCE

Medicine:	71.00
Surgery:	75.00
Obstetrics:	83.00
Public Health:	79.00
Pediatrics:	75.00
Psychiatry:	78.00

CLINICAL SCIENCE AVG.: 76.80

CLINICAL COMPETENCE AVG.: 80.90

FLEX WEIGHTED AVG.: 77.60

* * * * * * * * * * * * * * *

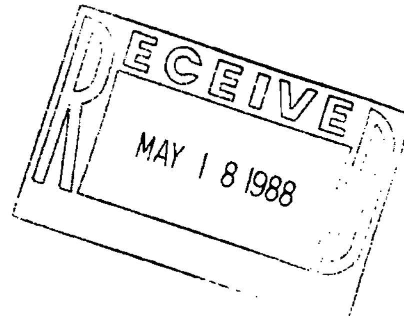
Furthermore: A search of the Federation's Disciplinary Data Bank reveals no reported disciplinary information on the above named physician.

PJW

59

AMG

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio ~~43215~~ 43266-0315



DISCIPLINARY INQUIRIES
Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

The OHIO STATE MEDICAL BOARD requests a disciplinary search concerning the following individual:

CARHART, Leroy Harrison, MD
Name

105 E. Mission Ave.
Address

Bellevue, NE 68005
City, State and Zip

10/28/41
Date of Birth

Redaction
Social Security Number

Hahnemann Univ
Medical School of Graduation and Branch Location

1973
Date of Graduation

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAY 20 1988

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

Please mail the response to the following address:

Ohio State Medical Board
65 S. Front Street, Suite 510
Columbus, OH 43266-0315

ATTENTION: Dawn Cales
Licensure Assistant

Dawn Cales
Signature

Bel ue

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

DATE May 17, 1988

Dear Doctor:

Dr. CARHART, Leroy H. who is/was Emergency Medicine 2/85-present is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 6 months

(2) What was/is your supervisory capacity? Acting Medical Director of Bellevue Clinic

(3) At what hospital? Lutheran Hospital

(4) How would you rate this doctor's medical knowledge and techniques? good

(5) In your opinion, is this doctor a person of good moral and ethical character? yes

(6) Does this doctor work well with peers and medical staff? yes

(7) Does he/she relate well to patients? yes

(8) How is his/her command of the English language? (if applicable) native

(9) Would you recommend this doctor for licensure? yes

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

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

Dawn Cales
Dawn Cales
Licensure Assistant

R. Fleming, M.D.
Signature of Doctor, please type or print name legibly beneath

Richard Max Fleming, MD

Acting Medical Director
Position

DATE: 5/26/88

Telephone No. 402-292-4164 (Include Area Code)

'88 ... P1:09

Offutt AFB Hosp

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

DATE May 17, 1988

Dear Doctor:

Dr. CARHART, Leroy H. who is/was Surgery 7/78-2/85 is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 4 years

(2) What was/is your supervisory capacity? No Supervisory Capacity

(3) At what hospital? Ehrling Bergquist Strategic Hospital

(4) How would you rate this doctor's medical knowledge and techniques? Good

(5) In your opinion, is this doctor a person of good moral and ethical character? Yes

(6) Does this doctor work well with peers and medical staff? Yes

(7) Does he/she relate well to patients? Yes

(8) How is his/her command of the English language? (if applicable) Yes

(9) Would you recommend this doctor for licensure? Yes

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

JUN - 7 1988

Signature of Doctor, please type or print name legibly beneath

Joseph J. Roh, Major, USAF, MC
Chairman, Dept. of Surgery
505-72-9373 R9416 SGHS/BBA
E.B. Strategic Hospital
Offutt AFB, NE 68113-5300

Position

DATE: 1-June 88

Telephone No. 402-294-7412 (Include Area Code)

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

Sincerely,

Dawn Cales

Dawn Cales
Licensure Assistant

AFFIDAVIT AND RELEASE

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below must be completed by ALL applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being returned to you.

ss STATE OF NEBRASKA

COUNTY OF SARPY

I, LeRCY HARRISON CARHART hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and the Routes to Licensure and I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable or transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that failure to complete this application as requested by the Board within six months can be considered as abandonment of any request for licensure and that any fee I submitted is not refundable or transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

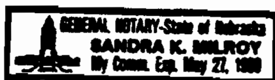
I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives, and any person furnishing information, any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization, or similar institution; or to any professional association.

I further understand that a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained therein or to be furnished, which if false, can subject me to permanent denial of said certificate.

Signature of Applicant

Subscribed and sworn to before me this 11 day of April 1988.

Notary Public Signature



(NOTARY SEAL)

May 27, 1990

Date Commission Expires

Bellevue Health Center
105 East Mission Avenue
Bellevue, Nebraska 68005

12 Sept 1988

Dear Penny:

As per our telephone conversation enclosed is a copy of my license to practice.

Sincerely:

LeRoy Carhart M.D.

SEP 20 1988

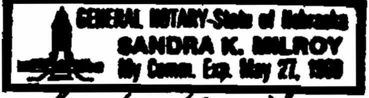
Certified true copy
September 12, 1988

[signature]

Hahnemanniani Medicinae Collegium et Nosocomii Philadelphiae

OMNIBUS HAS LITERAS PRÆSENTES VISURIS

Salutem



9-12-88

SEP 2 0 1988

Sandra K. Milroy

Cum Academiae ubique gentium institutae viros Philosophia Scientiis Medicina Litterisve Humanioribus exultos aut de Republica bene meritos titulo justo et congruente condecorare solitae sint:
Nos igitur Curatores Collegii et Nosocomii Hahnemanniani Philadelphiae auctoritate reipublicae Pennsylvaniensis nobis commissa

LeRoy Harrison Earhart

bona indole praeditum omnibus muneribus atque officiis quae hujus Academiae legibus ei imposita sunt constanter et fideliter expletis ad gradum

Medicinae Doctoris

rite admisimus eique omnia jura honores privilegia ad hunc gradum pertinentia libenter concessimus.
Cujus rei testimonio huic diplomati nomina nostra hoc die Ante Idus Junias
Anno Domini millesimo nongentesimo septuagesimo tertio Philadelphiae scripsimus et quo major sit fides auctoritasque Curatores consentientes Collegii nostri sigillum apponi jusserunt

Whiston Shober
Praeses

Joseph R. Di Palma, M.D.
Praesidis Vice Gerens Et Decanus

[signature]
Secretarius Curatoribus

THE HAHNEMANN MEDICAL COLLEGE & HOSPITAL OF PHILADELPHIA 88 MAR 17 P3:53

TWO-THIRTY NORTH BROAD STREET PHILADELPHIA, PENNSYLVANIA 19102

DIPLOMA TRANSLATION

The Hahnemann Medical College and Hospital of Philadelphia

To all about to examine these presents

Greeting

Since Academies, established throughout the world, are accustomed to recognize men skilled in Philosophy, the Sciences, Medicine, the Humane Letters, or well deserving on account of the Common Wealth by lawful and appropriate degrees Therefore we, the Trustees of the Hahnemann Medical College and Hospital of Philadelphia, by authority granted to us by the Commonwealth of Pennsylvania have admitted in due form to the degree of *Doctor of Medicine, LeRoy H. Carhart* who is gifted with good natural ability and has fulfilled steadily and faithfully all the requirements and duties imposed by the statutes of the Academy, and have freely granted to him all the rights, honors, and privileges appertaining to this degree. In testimony thereof we have written our signatures on this day, the *7th* day of *June* in the year of Our Lord one thousand nine hundred *seventy-three*, and, that the faith and authority may be greater, the Trustees consenting have ordered the seal of our College affixed.

Wharton Shober
President

Joseph R. DiPalma, M.D.
Senior Vice President and Dean

Charles B. Hollis, M.D.
Secretary of the Board

[signature]
Registrar
3/10/88

STATE OF NEBRASKA

DEPARTMENT OF HEALTH

KAY A. ORR
GOVERNOR

GREGG F. WRIGHT, M.D., M.ED.
DIRECTOR

THIS IS TO CERTIFY THAT LeRoy Harrison Carhart, M.D., was issued License No. 15162, dated October 17th 1979, to practice Medicine and Surgery in the State of Nebraska on the basis of Reciprocity with the State of Pennsylvania.

SAID LICENSE has been maintained and in good standing up to and including the present date.

SAID LICENSE shall expire on October 1st, 1988.

DATED AT LINCOLN, Lancaster County, Nebraska this 21st day of June, 1988.

Helen L. Meeks By KLC
Helen L. Meeks, Director
Bureau of Examining Boards

'88 JUN 28 P1:50
RECEIVED
OHIO STATE
MEDICAL BOARD

(SEAL)

MISSOURI VALLEY ASSOCIATES, P.C.

105 EAST MISSION AVENUE • BELLEVUE, NEBRASKA 68005 • (402) 292-4164

LEROY H. CARHART, M.D.
GENERAL SURGEON

October 30, 1987

OHIO STATE MEDICAL BOARD
65 South Front Street
Room 510
Columbus, Ohio 43215

Dear Sir:

Please send me an application for Medical Licensure for the state of Ohio.

Sincerely;

LeRoy H. Carhart, M.D.

Carhart, LeRoy H

RECEIVED
OHIO STATE
MEDICAL BOARD
'87 NOV -3 P2:37

8/11/5/87

242 OR

CERTIFICATION LOG OF CONTINUING MEDICAL EDUCATION FOR THE PERIOD OF JULY 1, 1992 - JUNE 30, 1994

I certify the following to be true and correct. This form must be completed, signed and returned.

[signature] SIGNATURE — 4/20/95 DATE — 35-05-7427 OHIO CERTIFICATE NUMBER

NAME: CARHART (Last) LeRoy (First) HARRISON (Middle) (Suffix, Jr., II)

ADDRESS: 1002 WEST MISSION AVE (Number & street) Bellevue (City) NE (State) 68005 (Zip code)

CATEGORY I

ATTACH DOCUMENTATION

100 CREDIT REQUIREMENT
At least ***40 credits*** must be earned in Category I. Please list Category II credits on reverse side.

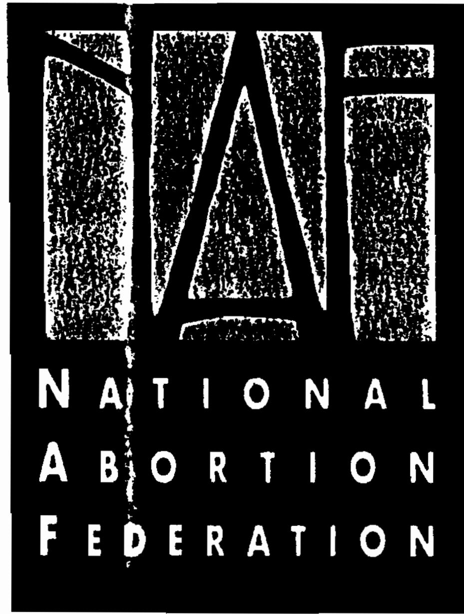
Name of Sponsor	Location (City & State)	Description	Date	Credits
Examples: Ohio State University Hosp.	Columbus, Ohio	Pediatric Grand Rounds	12/01/93 thru 12/31/93	4
Christ Hospital	Cincinnati, Ohio	Surgery Residency	07/01/92 thru 06/30/93	50
NAF - DAL	DALLAS, TX	2ND TRIMESTER ABORTION	9-13/9-14 92	12
MIDLANDS COMM. HOSP	OMAHA NE	CATARAC SURGERY	9-26-92	1
UNMC	OMAHA NE	DIABETES + CORONARY HEART	01-23-93	1.5
OMAHA MID-WEST CLINICAL	OMAHA NE	ANNUAL POST-GRAD ASSY	11/5-11/7 92	20
AHRP	SAN FRANCISCO CA	STD'S IN THE 90'S	5-21-5-23 93	18.
NAF	WASHINGTON DC	POST GRAD SEMINAR	APR 25 93	6
NAF	WASHINGTON DC	SECURING WOMEN RIGHTS	4-26-4/27 93	11
OMAHA MIDWEST CLINICAL	OMAHA NE	POST GRAD ASSEMBLY	10-6-8-93	19.
NAF	CINCINNATI OH	POST GRAD SEMINAR	4-24-94	6
NAF	CINCINNATI OH	UNITY IN DIVERSITY	4/25-26/94	11
				105.5

CATEGORY II

A Maximum of *60 credits* may be earned in this Category.

Name of Sponsor	Location (City & State)	Description	Date	Credits
Examples: Riverside Hospital	**Toledo, Ohio**	**Internal Medicine Staff Meeting**	**10/21/92**	**8**
Self instruction		**American Journal of Opthalmology**	**01/93 thru 12/93**	**60+**

CERTIFICATE OF ATTENDANCE



This Program has been reviewed and is acceptable for 12 Prescribed Hours by the American Academy of Family Physicians.

"Second Trimester Abortion: From Every Angle"

September 13-14, 1992 ■ Dallas, Texas

This Certifies the Attendance of

LEROY CARHART, MD

NAF is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The National Abortion Federation designates this continuing medical education activity for 12 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

The American College of Obstetricians and Gynecologists has assigned 12 cognates (Formal Learning) to this program.

Barbara Radford
Executive Director
National Abortion Federation

Adele Hughey
President
National Abortion Federation

MIDLANDS COMMUNITY HOSPITAL

Continuing Medical Education Activities
1992

Name of registered attendant: Le Roy Carhart

	PRESENTATION	SPEAKER	DATE	CREDIT	AAFP
	GENERAL STAFF				
☐	Physician Payment Issues	Tom Schnack, CPA K. Lempka, CPA	3/2/92	1 hour	No
☑	Anaphylaxis: What you should know	Linda Ford, M.D.	6/1/92	1 hour	Yes
☐	Risk Analysis of Early Breast Cancer	Margaret Block, M.D. Peter Townley, M.D.	9/14/92	1 hour	Yes
☐	MRI of the Radiated & Operated Brain	John Sherman, M.D.	12/7/92	1 hour	Yes
	COMBINED DEPARTMENT				
☐	Methicillin Resistant Staph Aureus (MRSA)	Phil Smith, M.D.	2/15/92	1 hour	Yes
	DEPARTMENT OF FAMILY PRACTICE				
☐	Gram Negative Sepsis	J. Tim Bourke, R.P.	1/14/92	1 hour	Yes
☐	Neonatal Hepatitis & Hepatitis B Vaccine	Stu Kaufman, M.D.	8/11/92	1 hour	Yes
☐	Nasopharyngoscopy & Endoscopic Sinus Surgery	Barbara Heywood, M.D.	10/13/92	1 hour	Yes
	DEPARTMENT OF MEDICINE				
☐	Basic Life Support	Certified Instructors	1/18/92	3 hours	Yes
☐	Update on Congestive Heart Failure	Vincent Miscia, M.D.	11/21/92	1 hour	No
	DEPARTMENT OF SURGERY/OB-GYN				
☑	No Stitch Cataract Surgery	Gerald Ferenstein, M.D.	9/26/92	1 hour	No
	TUMOR CONFERENCE				
☐	Small Cell Carcinoma	Peter Townley, M.D. Fay Coleman, M.D.	11/30/92	1 hour	No

Each of these offerings met the criteria for credit in Category I of the Physicians Recognition Award of the American Medical Association.

CME.

(402) 559 4152

THE UNIVERSITY OF NEBRASKA MEDICAL CENTER
CENTER FOR CONTINUING EDUCATION
600 SOUTH 42nd STREET OMAHA, NE 68198-5651

CERTIFICATION

THIS COURSE WAS APPROVED FOR CONTINUING EDUCATION CREDIT AS LISTED BELOW. THE REGISTRANT MAY USE THIS CREDIT AS MAY BE REQUIRED BY ASSOCIATIONS, LICENSING BOARDS, OR OTHER AGENCIES.

01/22/93

DIABETES AND CORONARY HEART DISEASE
MA0270193
01/23/93 01/23/93

LeROY H CARHART MD
BELLEVUE HEALTH CLINIC
105 E MISSION
BELLEVUE NE 68005

AMA PHYSICIAN'S RECOGNITION AWARD
CATEGORY I CONTACT HOURS--- 1.50

AMERICAN ACADEMY OF FAMILY PHYSICIANS
PRESCRIBED HOURS--- 1.50

Omaha Mid-West Clinical Society

OMAHA, NEBRASKA

certifies that

LEROY H. CARHART, M.D. , M.D.

was a registered attendant at the 60th Annual Postgraduate Assembly held November 5, 6 and 7, 1992.

This meeting is certified for twenty (20) credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. This meeting is also certified for seventeen prescribed hours by the American Academy of Family Physicians.

, M.D.

Patrick E. Brookhouser, M.D.
President

, M.D.

Walter W. Huurman, M.D.
Director of Clinics

I hereby certify that I attended 20 hours during the 60th Annual Postgraduate Assembly of the Omaha Mid-West Clinical Society.

, M.D.

(Signature of attendant)

A · R · H · P

ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS

STDs IN THE 90s: MEN, WOMEN AND FAMILIES

CERTIFICATE OF ATTENDANCE

This Certifies the Attendance of

LeRoy Carhart, MD

ARHP is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

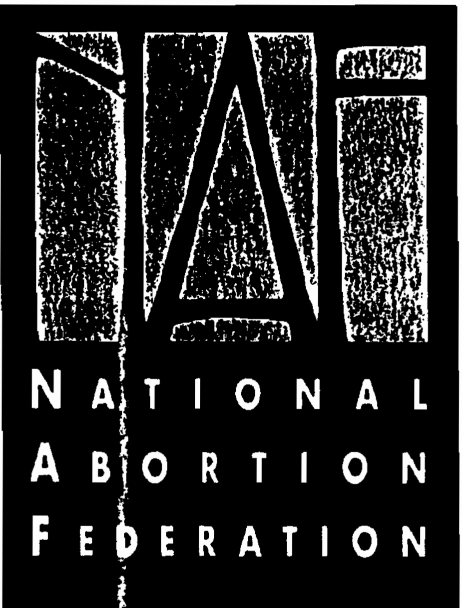
ARHP designates this continuing medical education activity for 18 credit hours in Category 1 of the Physicians' Recognition Award of the American Medical Association.

This course has been approved for 18 cognates, Formal Learning, by the American College of Obstetricians and Gynecologists.

CHAIR,
Association of Reproductive Health Professionals

SAN FRANCISCO, CA
May 21-23, 1993

CERTIFICATE OF ATTENDANCE



Post Graduate Seminar: "On Trial: Minimizing Medical Error"

April 25, 1993 Washington, DC

This Certifies the Attendance of

LEE CARHART, MD

NAF is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

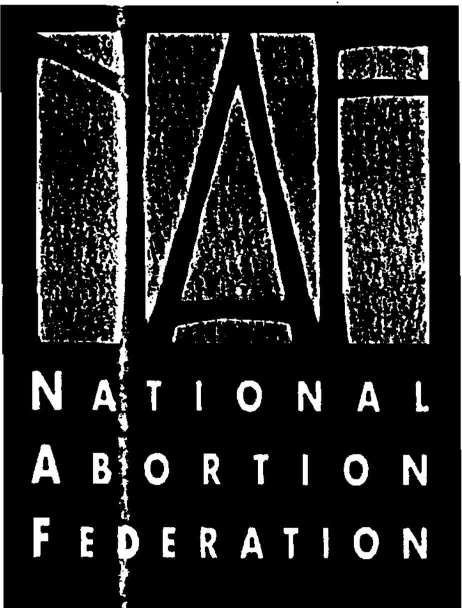
The National Abortion Federation designates this continuing medical education activity for 6 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

The American College of Obstetricians and Gynecologists has assigned 6 cognates (Formal Learning) to this program.

Barbara Radford
Executive Director
National Abortion Federation

Adele Hughey
President
National Abortion Federation

C E R T I F I C A T E   O F   A T T E N D A N C E



17th Annual Meeting: "Abortion: Securing Women's Rights, Ensuring Women's Health"

April 26-27, 1993 Washington, DC

This Certifies the Attendance of

LEE CARHART MD

NAF is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The National Abortion Federation designates this continuing medical education activity for 11 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

The American College of Obstetricians and Gynecologists has assigned 11 cognates (Formal Learning) to this program.

Barbara Radford
Executive Director
National Abortion Federation

Adele Hughey
President
National Abortion Federation

Omaha Mid-West Clinical Society

OMAHA, NEBRASKA

certifies that

LE ROY H. CARHART, M.D.

was a registered attendant at the 61st Annual Postgraduate Assembly held October 6, 7 and 8, 1993.

This meeting is certified for nineteen (19) credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. This meeting is also certified for 18 prescribed hours by the American Academy of Family Physicians.

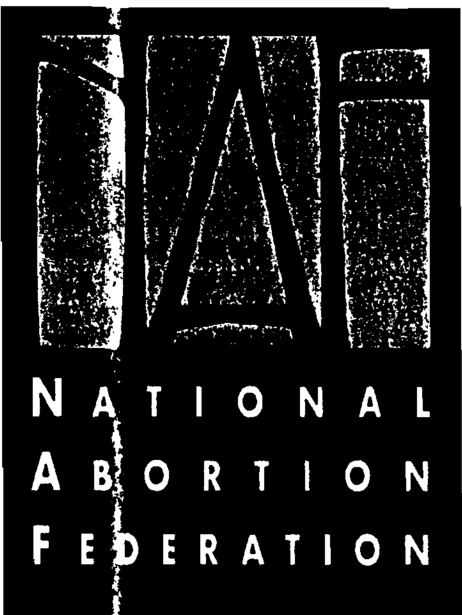
_______________, M.D.
H. Jeoffrey Deeths, M.D.
President

_______________, M.D.
William P. Fitzgibbons, M.D.
Director of Clinics

I hereby certify that I attended 19 hours during the 61st Annual Postgraduate Assembly of the Omaha Mid-West Clinical Society.

_______________, M.D.
(Signature of attendant)

CERTIFICATE OF ATTENDANCE



Post Graduate Seminar: "Managing Troublesome Events: Case Studies in Abortion Care"

April 24, 1994 Cincinnati, OH

This Certifies the Attendance of

LeRoy Carhart, M.D.

NAF is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The National Abortion Federation designates this continuing medical education activity for 6 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

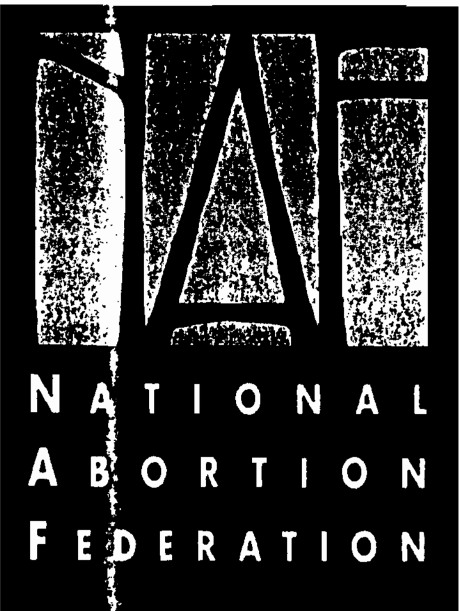
The American College of Obstetricians and Gynecologists has assigned 6 cognates (Formal Learning) to this program.

This program has been reviewed and is acceptable for 6 Prescribed Hours by the American Academy of Family Physicians.

Sylvia Stengle
Executive Director
National Abortion Federation

Adele Hughey
President
National Abortion Federation

CERTIFICATE OF ATTENDANCE



18th Annual Meeting: "Abortion: Unity in Diversity"

April 25-26, 1994 Cincinnati, OH

This Certifies the Attendance of

LeRoy Carhart, M.D.

NAF is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The National Abortion Federation designates this continuing medical education activity for 11 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

The American College of Obstetricians and Gynecologists has assigned 11 cognates (Formal Learning) to this program.

This program has been reviewed and is acceptable for 10.75 Prescribed Hours by the American Academy of Family Physicians.

Sylvia Stengle
Executive Director
National Abortion Federation

Adele Hughey
President
National Abortion Federation

APPENDIX B

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

LEROY HARRISON CARHART
1002 W MISSION AVE
SUITE 101
BELLEVUE NE 68005

Dear Doctor:

Upon renewal of your Ohio license to practice medicine and surgery, you certified that during the last registration period (July 1, 1992 - June 30, 1994) you had completed the requisite hours of Continuing Medical Education as certified by the Ohio State Medical Association and approved by the Board.

At this time, as a result of your being randomly selected for audit, it will be necessary for you to complete the enclosed log of Continuing Medical Education. It will also be necessary for you to provide the Board with documentation that you have actually completed at least 40 hours of Category I CME as certified on your license renewal application. Certificates of attendance, hospital printouts and accredited organization printouts are acceptable documentation, copies of which must be enclosed with your log. Those individuals desiring CME credits for their residency training program must submit either a copy of their certificate or a letter from the training program director giving the dates that they were in the program.

Up to 60 hours of Category II credits may be listed on the reverse side of the log, but no documentation need be provided.

It is important you understand that under Ohio law it is your responsibility to document your CME participation, and, further that a failure to comply with the audit requirements can result in revocation or suspension of your license to practice in Ohio.

Please return the above requested material to the State Medical Board of Ohio within three weeks of receipt of this letter. The result of your audit will be made available to you in the near future.

Thank you for your cooperation.

Sincerely,

Thomas E. Gretter
Secretary
State Medical Board of Ohio

TEG:jdc

Enclosures

CERTIFIED MAIL #
RETURN RECEIPT REQUESTED

Revised 03/07/95

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

June 29, 1995

LeRoy H. Carhart, M.D.
1002 W. Mission Avenue
Bellevue, NE
68005

Dear Doctor:

Thank you for your prompt response to our request for audit material.

The results of this audit confirm that the continuing medical education materials you submitted for relicensure did indeed meet the Board's requirements.

The current and subsequent registration periods will end July 1, 1994, and July 1 of each even numbered year thereafter. It will be necessary to complete 100 credits with 40 being in Category I during each registration period. Licenses will expire on September 30 of each even numbered year. Please keep the Board informed of any address change.

Again, thank you for your cooperation.

Very truly yours,

Thomas E. Gretter, M.D.
Secretary
State Medical Board of Ohio

TEG:jdc

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

May 21, 1992

Leroy H. Carhart, M.D.
105 E. Mission Ave.
Bellevue, NE 68005

Dear Doctor:

Please be advised that your Ohio medical license number 57427 has been reinstated as of 5/20/92. Due to the enactment of House Bill 454, this license will remain current through September 30, 1992.

You will receive in the very near future a renewal application card to renew for the 1992-94 biennium. We are currently in the process of developing booklets containing information on Continuing Medical Education and such will be mailed to you upon their completion.

It is important that you notify the Board immediately of any change of address.

If you should have any questions, please feel free to contact our office at the above address.

Sincerely,

Debra L. Jones

Debra L. Jones, Chief
CME, Records and Renewal

DLJ:bar

Renewed 5/20

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

March 11, 1991

Leroy H. Carhart, MD
105 E. Mission Ave.
Bellevue, NE 68005

CARHART, LEROY

Dear Doctor:

Please be advised that pursuant to operation of Section 4731.281, Ohio Revised Code, your license to practice medicine in Ohio has been suspended effective January 1, 1991, or fifteen days after prior notice by this Board, for the reason(s) checked below:

____ 1. The renewal application and fee were not received.

In order to initiate reinstatement processing, complete the enclosed card and return it with $185.00 in fees ($160.00 renewal fee, plus $25.00 penalty fee for late renewal). Return the completed card and $185.00 directly to the Board at 77 South High Street, 17th Floor, Columbus, Ohio, 43266-0315. You must also complete the enclosed certification of Continuing Medical Education. However, it is not necessary to attach documentation of your CME to the certification.

____ 2. The $160.00 fee was not received.

In order to initiate reinstatement processing, please submit $185.00 in fees ($160.00 renewal fee, plus $25.00 penalty fee for late renewal). Submit the fee directly to the Board at 77 South High Street, 17th Floor, Columbus, Ohio, 43266-0315.

____ 3. The statement on the renewal application card certifying compliance with the continuing medical education requirement was not signed.

If you have completed the requisite hours of continuing medical education but merely neglected to sign the statement on the renewal application card, please complete and sign the enclosed renewal application card and return it to the Medical Board at 77 South High Street, 17th Floor, Columbus, Ohio, 43266-0315 along with one of the following:

____ $25.00 penalty fee for late renewal.

____ $185.00 ($160.00 renewal fee, plus $25.00 penalty fee for late renewal)

If you have not completed the requisite hours of continuing medical education necessary for license renewal, you cannot reinstate your medical license until the CME hours have been completed. There are no provisions under Ohio law for relicensure without completing the continuing medical education requirement. When you have accrued the hours needed for reinstatement, you should complete the enclosed renewal application card and forward it to the Board at 77 South High Street, 17th Floor, Columbus, Ohio, 43266-0315, along with one of the following:

___ $25.00 penalty fee for late renewal. You must also complete the enclosed log of Continuing Medical Education.

___ $185.00 ($160.00 renewal fee, plus $25.00 penalty fee for late renewal)

✓ 4. The $25.00 late renewal penalty fee has not been received.

We are in receipt of your $160.00 license renewal fee. Please submit the $25.00 late renewal fee to the Board at 77 South High Street, 17th Floor, Columbus, Ohio, 43266-0315.

✓ 5. The Certification of Continuing Medical Education has not been received.

Please complete the enclosed certification of Continuing Medical Education and submit it to the above address. It will not be necessary to attach documentation.

As soon as the above requirements have been met, your medical license will be reinstated retroactively to January 1, 1991. However, "... continued practice after the effective date of your suspension shall be considered as practicing without a license..." Section 4731.281, (Ohio Revised Code) and subject to criminal or other disciplinary sanction.

Any continuing medical education undertaken after December 31, 1988, and used for the purpose of reinstatement, cannot then also be used for the purpose of meeting the continuing medical education requirement for the biennium, January 1, 1991 through December 31, 1992.

Sincerely,

Debra L. Jones, Chief
C.M.E., Records & Renewal

DLJ:men

C.M.E. - LeROY HARRISON CARHART, M.D.

92 MAY 19 :38

Continuing Medical Education:

Trauma Update, Creighton University Omaha, Nebraska. May 1981 - 18 hrs.

Liver, Pancreatic, and Biliary Disease, a Multidiciplined Approach. Saint Vincent's Hospital, NY, NY. April 1982 - 22 hours.

Midwest Clinical Society, Omaha, Nebraska. October 1985 - 23 hours.

Midwest Clinical Society, Omaha, Nebraska. October 1986 - 23 hours.

Midwest Clinical Society, Omaha, Nebraska. October 1987- 23 hours.

National Abortion Federation, Minneapolis, Minnesota. Ultrasound update. May 1988 - 6 hours.

Midwest Clinical Society, Omaha, Nebraska. October 1988 - 23 hours.

National Abortion Federation, Ultrasound update. San Francisco, Ca. April 1989 - 6 hours.

National Abortion Federation, General Membership Meeting San Francisco, Ca. April 1989 - 9 hours.

National Abortion Federation, Products of Conception Workshop Toronto, Ontario, Sep. 1989 - 6 hours.

National Abortion Federation, Fall Risk Management Meeting, Progress and Problems In Abortion Practice Toronto, Ontario, Sep.1989 - 9 hours.

Midwest Clinical Society, Omaha, Nebraska. October 1989 - 23 hours.

Midland's Community Hospital, 1990 CME hours - 3 hours.

C.M.E. - LeROY HARRISON CARHART, M.D.

Lutheran General Hospital, 1990 CME hours - 4 hours.

National Abortion Federation, Post Graduate Seminar. Atlanta, Georgia. May 1990 - 6 hours.

National Abortion Federation, Abortion in a Just Society. Atlanta, Georgia. May 1990 - 9 hrs.

National Abortion Federation, Sexually Transmitted Diseases, Vancouver, B.C., Canada. September 1990. 6 hours.

National Abortion Federation, Pain is a Four Letter Word, Vancouver, B.C., Canada. September 1990. - 9 hours.

Midwest Clinical Society, Omaha, Nebraska. October 1990- 23 hours.

Midland's Community Hospital, 1990 CME hours - 5 hours.

1989 + 1990
118 hrs

National Abortion Federation, Post Graduate Seminar. Chicago, IL. May 1991- 6 hours.

National Abortion Federation, Abortion Setting the Standard. Chicago, IL., April 1991 - 9 hrs.

National Abortion Federation, Post Graduate Seminar, Boston, Ma., September 1991 - 6 hours.

National Abortion Federation, B.C., Fall Risk Management Meeting, Boston, Ma., September, 1991. 9 credits.

Midwest Clinical Society, Omaha, Nebraska. October 1991- 23 hours

National Abortion Federation, Post Graduate Seminar, San Deigo, Ca., Post Abortion Complications and Their Management. April 12, 1992 - 6 hours.

National Abortion Federation,

C.M.E. - LeROY HARRISON CARHART, M.D.

General Membership Meeting, Abortion: Moral Choice and Medical Imperative, San Deigo, Ca., April 13-14, 1992 - 9 hours.

92 MAY 19 [illegible] 9:38

BELLEVUE HEALTH CLINIC

105 EAST MISSION AVENUE • BELLEVUE, NEBRASKA 68005 • (402) 292-4164

LeROY H. CARHART, M.D.

STATE MEDICAL BOARD OF OHIO
93 OCT 29 PM 4:05

NOTICE

EFFECTIVE - OCTOBER 11, 1993

CHANGE OF ADDRESS:

From: 105 E. Mission Avenue
Bellevue, NE 68005

TO: 1002 W. Mission Avenue, Ste. 101
Bellevue, NE 68005

PLEASE CHANGE YOUR RECORDS ACCORDINGLY.

Thank you for your cooperation.

Carhart, LeRoy H.

57427

updated 11-3-93 pc

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X ____________________ (SIGNATURE OF APPLICANT) ____ (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-7427	$160.00	07/01/92

LEROY HARRISON CARHART, M.D.
105 EAST MISSION AVENUE
BELLEVUE NE 68005

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

73 SURGERY, GENERAL
12 EMERGENCY MEDICINE
17 GENERAL PRACTICE

[✓] 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: 0935057427" "0000016000"

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

Street

Street

City State Zip Code

County

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

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

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

YES	NO	
[ ]	[X]	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?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)
Redaction

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 ______________________ (SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-7427	$250.00	05/01/94

LEROY HARRISON CARHART, M.D.
1002 W MISSION AVE
SUITE 101
BELLEVUE NE 68005

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GS GENERAL SURGERY
EM EMERGENCY MEDICINE
GP GENERAL PRACTICE

[X] SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

⑆969696962⑆ 0935057427⑈ ⑈0000025000⑈

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

Street

Street

City State Zip Code

County

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

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES [ ] NO [✓]

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

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

BATCH 00189 042894 01 250.00 935057427
PAY DATE R DATE SC AMOUNT BAL DATE ACCOUNT #

DETACH HERE AND RETAIN THIS PORTION FOR YOUR RECORDS

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 [signature]

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-7427	$250.00	05/01/96

LEROY HARRISON CARHART,M.D.
1002 W MISSION AVE
SUITE 101
BELLEVUE NE 68005

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GS GENERAL SURGERY
EM EMERGENCY MEDICINE
GP GENERAL PRACTICE

☐ **SPECIALTY CODE(S) CORRECT AS LISTED**

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

REPORT ANY CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

⑆9696969621⑆ 09350574271⑈ ⑈0000025000⑈

Y2557

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

Street: 1002 W Mission Ave
Street:
City: Bellevue State: NE Zip Code:
County:

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

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

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

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

SOCIAL SECURITY NUMBER (Optional for purposes of identification) [Redaction]

383 00295 061096 00082 [illegible] 250.00 061096 935057427
ABA BATCH DATE SEQ MC# AMOUNT BATCHDATE 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 [signature] 5/1/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-7427-C	$339.00	05/01/98

LEROY HARRISON CARHART,M.D.
1002 W MISSION AVE
SUITE 101
BELLEVUE NE 68005

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GS GENERAL SURGERY
EM EMERGENCY MEDICINE
GP GENERAL PRACTICE

☐ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

⑆969696962⑆ 09350574270⑈ ⑈0000033900⑈

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.

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

YES ☐ NO ☒ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

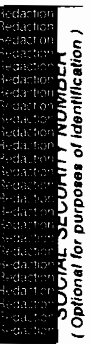
YES ☐ NO ☒ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

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

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

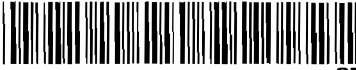
YES ☐ NO ☒ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES ☐ NO ☒ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?



SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

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 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] Feb 1, 99
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-7427-C	$305.00	01/01/2001

LEROY HARRISON CARHART, M.D.
1002 W MISSION AVE
SUITE 101
BELLEVUE NE 68005

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GS GENERAL SURGERY
EM EMERGENCY MEDICINE
GP GENERAL PRACTICE

☐ 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 1002 W Mission Ave
STREET
CITY Bellevue STATE NE ZIP CODE 68005
COUNTY Sarpy

⑆969696962⑆ 0935057427⑈ ⑈0000030500⑈

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

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

Street 1002 W Mission Ave
Street
City Bellevue State NE Zip Code 68005
County Sarpy

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 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:
SOCIAL SECURITY NUMBER [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 [signature]

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-05-7427-C	$305.00	01/01/03	04/01/03

LEROY HARRISON CARHART,M.D.
1002 W MISSION AVE
BELLEVUE NE 68005

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GS GENERAL SURGERY
EM EMERGENCY MEDICINE
GP GENERAL PRACTICE

[X] 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
1002 W Mission Ave
STREET
Bellevue NE 68005
CITY STATE ZIP CODE
Sarpy
COUNTY

0935057427 30500

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

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

YES [ ] NO [X] 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.

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

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

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

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

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

[ ] Check this Box if you have NO principal Practice address.

Street: 1002 West Mission Ave
Street:
City: Bellevue State: NE Zip Code: 68005
County: Sarpy

REQUIRED: [redacted]
SOCIAL SECURITY NUMBER

Date Posted: 3/10/2005 12:34:41 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.

Address Information

BUSINESS ADDRESS	1002 W MISSION AVE BELLEVUE, NE 68005 Out of State County 402-292-4164

License Information

License Number	35.057427
License Name	LEROY CARHART
Email Address	

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   .... GENERAL SURGERY
2. Please select one specialty from the field below, if applicable.
   .... GENERAL PRACTICE
3. Please select one specialty from the field below, if applicable.
   .... EMERGENCY MEDICINE

CME

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.

   .... Redaction

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: 12/27/2006 7:23:58 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	1002 W MISSION AVE BELLEVUE, NE 68005 Out of State County 402-292-4164
CREDENTIAL MAIL ADDRESS	1002 W MISSION AVE BELLEVUE, NE 68005 Out of State County 402-292-2291
MAIN	1002 W MISSION AVE BELLEVUE, NE 68005 Out of State County 402-292-2291

License Information

License Number	35.057427
License Name	LEROY CARHART
Email Address	janine70@aol.com

Fees

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

Specialty Codes

1. Please select one specialty from the field below

   .... GENERAL SURGERY

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

.... GENERAL PRACTICE

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.

. . . . Redaction

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: 10/9/2008 11:02:11 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	35.057427
License Name	LEROY CARHART
Email Address	janine70@aol.com

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   .... GENERAL SURGERY
2. Please select one specialty from the field below, if applicable.
   .... GENERAL PRACTICE
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.

.... Redaction

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.

State Medical Board of Ohio

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

VERIFICATION OF LICENSURE

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

Identification Information

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

License Information

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

Richard A. Whitehouse
Executive Director

Date Posted: 3/28/2011 4:41:59 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 35.057427

License Name LEROY CARHART

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

    .... GENERAL PRACTICE

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

    .... GENERAL SURGERY

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?

. . . . NO

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

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

Date Posted: 3/26/2013 4:48:15 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

CREDENTIAL MAIL ADDRESS	1002 W MISSION AVE BELLEVUE, NE 68005 Out of State County 402-292-2291 admin@drcarhart.com
MAIN	1002 W MISSION AVE BELLEVUE, NE 68005 Out of State County 402-292-2291 admin@drcarhart.com

License Information

License Number	35.057427
License Name	LEROY CARHART

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

. . . . GENERAL PRACTICE

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

. . . . GENERAL SURGERY

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?

. . . . NO

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

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

Date Posted: 3/13/2015 3:12:46 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 35.057427

License Name LEROY CARHART

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

. . . . GENERAL PRACTICE

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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . NO

4. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** 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. **At any time since signing your last application for renewal of your certificate** have youbeen addicted to or dependent upon alcohol or any chemical substance; relapsed, 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?

. . . . NO

NPI number

1. Please enter your current NPI number

. . . . 1902028715

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number. AC2062139

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.