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MAY 10 2007

KANSAS STATE BOARD OF HEALING ARTS

RENEWAL OF MEDICINE AND SURGERY LICENSE

JULY 1, 2007 to JUNE 30, 2008

The renewal application and fee must be received postmarked by JUNE 30, 2007, to renew your license. A late fee must be paid for renewal applications received postmarked JULY 1, 2007 or later. If no renewal application is received postmarked on or before JULY 31, 2007 the license will be canceled. Any person desiring to reinstate a cancelled license must contact the Board office for the appropriate form. Please note that supplying information appearing in *italics* is completely voluntary. No licensing decision will be made on the basis of the information. All other information is required. A license will not be renewed if the application is not complete. PLEASE PRINT OR TYPE ALL RESPONSES.

1. Name: Dr. Ronald N Yeomans, MD
2. License Number: 04-14015
3. **Mailing Address** (may be a Post Office Box):
   Line 1: 720 Central Ave
   Line 2:
   City, County, State, Zip, Country: Kansas City, Wyandotte, KS, 66101-3546, USA
   Preferred Telephone Number:

Corrections:

Residence Address (may *not* be a Post Office Box).
Line 1: Confidential
Line 2:
City, County, State, Zip, Country: Overland Park, Johnson, KS, 66212 , USA
Telephone / *Fax*: Confidential
Email:
Web site:

Practice Address (may *not* be a Post Office Box; additional practice addresses may be added to the Kansas Health Care Resources Questionnaire, attached):
Line 1: Women SS Health Center
Line 2: 510 Washington St W
City, County, State, Zip, Country: Charleston, WV, 25302 , USA
Telephone / *Fax*: (304) 344-9838
Email:
Web site:

LICENSE STATUS

4. Current License: Active
5. *I would like to change my license to:*

☐ **Active** - Liability insurance certification received - see Part 9 on Page 2.

☐ **Inactive** - This license does not allow the holder to provide professional services in Kansas.

☐ **Federal Active** - This license allows a person who is active military or employed by the federal government to also engage in administrative and charitable services in Kansas; No private practice outside of federal employment is allowed in Kansas.
Employer
Name _____ Address _____

☐ **Exempt** - This allows a person who is no longer regularly engaged in practice to provide some professional services, including administrative and charitable services;

I intend to engage in the following professional activities in Kansas **(Required for Exempt)**: _____

I request that the change in status become effective on the following date: _____

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6. **You must answer the following questions. Attach documentation and an explanation if you answer "Yes" to any of the following questions.**

(a) ☐ Yes ☒ No — In the past 12 months have you been a defendant or has any judgment, award or settlement been paid resulting from a professional liability claim?

(b) ☐ Yes ☒ No — Within the last 12 months have you been arrested, charged with or convicted of any felony or class A misdemeanor? This includes a plea to a felony or class A misdemeanor.

(c) ☐ Yes ☒ No — In the past 12 months has any disciplinary action been initiated or taken against you by a state licensing agency or other state or government agency, or have you surrendered or consented to limitation of license to practice in any state or country?

(d) ☐ Yes ☒ No — In the past 12 months have you been denied a license to practice the healing arts or other health care profession?

(e) Confidential — In the past 12 months have any hospital privileges been suspended, restricted, limited or voluntarily surrendered or has any peer review or professional association initiated or taken any action against you?

(f) Confidential — In the past 12 months have you suffered from any impairment which might affect your ability to safely practice?

(g) ☐ Yes ☒ No — In the past 12 months do you know of any investigation by or any allegations, complaints or charges concerning you made to any licensing agency or state or government agency?

CONTINUED ON BACK

04-14015# 2008

Ronald N Yeomans
720 Central Ave
Kansas City, KS 66101-3546

✓	080068	2408	08

7 *Are you willing to be included on a registry of potential volunteers to provide your professional services during an emergency? (Please check all that apply)*

Within your county of residence	☒ *Yes*	☐ *No*	*Within 75 miles of your residence*	☒ *Yes*	☐ *No*
Anywhere in the State of Kansas	☐ *Yes*	☐ *No*	*Outside the State of Kansas*	☐ *Yes*	☐ *No*

8 Identify all other authorities that have licensed you to practice Medicine and Surgery (use addition pages if necessary)

State or country:	License No.:	Date Issued:	Status:	State or country:	License No.:	Date Issued:	Status:
Indiana	01059709A	2004	Active	Missouri	114319	? 1997	Active
West Virginia	21411	2003	Active				

☐ I have not been licensed in another state or country.

9. LIABILITY INSURANCE (Active only) -- I certify that I have professional liability insurance as follows

Check one:

☒ I maintain a policy of liability insurance that complies with Kansas statutes, and have paid the annual surcharge to the Health Care Stabilization Fund

Policy Number: KSP0017052 Insurer: KAMMCO Issue Date: 1/31/07 Expiration Date: 1/30/08

☐ I am covered by a qualified self insurance fund and have paid annual surcharges to the Health Care Stabilization Fund.

KANSAS HOSPITAL PRIVILEGES (Active and Federal Active only)

10. Facility Name and county for up to four Kansas Hospitals at which you have privileges

OFFICE-BASED SURGERY

11. "Do you perform any procedure in your office that requires sedation, including: IV sedation of any kind, inhaled agents, parenteral, regional spinal, epidural or general anesthesia? (This does not include minor procedures that can be performed safely and comfortably with any one or combination of the following: a low dose oral sedative that does not affect the patient's level of consciousness, local, topical; or no anesthesia.)" ☒ Yes ☐ No

PRACTICE SPECIALTY

12 Please indicate your primary practice specialty using the appropriate code listed on the instructions 39 Are you Board Certified: ☒ Yes ☐ No

SUPERVISION

13 Do you supervise any physician assistants or athletic trainers? ☐ Yes ☒ No

If Yes, please provide the following information for each:

NAME: _____ LICENSE NUMBER _____

NAME: _____ LICENSE NUMBER _____

NAME: _____ LICENSE NUMBER _____

14. CONTINUING EDUCATION - (Active and Federal Active only) -- **If you have 2007 as the continuing education year in the right-hand corner of the address block on your renewal form, you must certify one of the following:** One-year update (50 hours with a minimum of 20 hours of Category I and a maximum of 30 hours of Category II) for hours earned 01/01/06 thru 06/30/07 Two year update (100 hours with minimum of 40 hours Category I and a maximum of 60 hours of Category II) for hours earned 01/30/05 thru 6/30/07 Three-year update (150 hours with a minimum of 60 hours Category I and a maximum of 90 hours of Category II) for hours earned 01/01/04 thru 06/30/07

I certify that I have met the hours for the following continuing education update:

☐ 50 hours ☐ 100 hours ☐ 150 hours

RENEWAL FEE

Amount: Active, Federal Active: $230.00 ($290.00 if postmarked July 1 or later)
Inactive: $115.00 ($145.00 if postmarked July 1 or later)
Exempt: $130.00 ($160.00 if postmarked July 1 or later)

PAYMENT METHOD:

☒ A check is enclosed Please make your check payable to the KANSAS STATE BOARD OF HEALING ARTS

☒ Payment is by a facility paying for multiple licenses. Payor name: _____

Check no. and date. _____

___ Payment by credit card. **Please complete and return the enclosed credit card authorization form.**

I hereby certify, under penalty of perjury, that the foregoing is true and correct to the best of my knowledge.

Ronald K. Yeomans MD 5/9/07

SIGNATURE DATE