STATE MEDICAL BOARD OF OHIO
PRE-APPLICATION SCREENING FORM

72-30

App sent 5/28/87

PLEASE TYPE THIS FORM TO AVOID DELAYS IN PROCESSING

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

MD

NAME: Krishen, (LAST (Surname)) Adarsh (FIRST) Edwin (MIDDLE) (SUFFIX (Jr.,II))

ADDRESS: 113 Westmoreland Terrace (STREET & NUMBER) Akron, (CITY) Ohio (STATE) 44302 (ZIP) U.S.A. (COUNTRY)

TELEPHONE: BUSINESS: (216) 375-3584 (AREA CODE & NUMBER) HOME: (216) 535-8804 (AREA CODE & NUMBER)

BIRTH DATE: 09 / 17 / 60 (MO/DAY/YR) BIRTH PLACE: Cleveland, Ohio (CITY) (STATE) U.S.A. (COUNTRY)

MEDICAL EDUCATION

E-

MEDICAL SCHOOL OF GRADUATION: Northeastern Ohio Universities College of Medicine (SCHOOL NAME) (STREET ADDRESS) Rootstown, Ohio (CITY) (STATE) U.S.A. (COUNTRY)

09 / / 82 (FROM (date)) TO 05 / 31 / 86 (date) M.D. (DEGREE RECEIVED) 05 / 31 / 86 (DATE RECEIVED)

Adarsh

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)

KRISHEN,

'87 MAY 27 AM 9:3

E.C.F.M.G. CERTIFICATE: YES _____ NO XX NUMBER _____ DATE ISSUED / /

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: NONE (HOSPITAL OR INSTITUTION) (IF "NONE", ENTER "NONE") 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.

HOSPITAL: Akron City Hospital (NAME) 525 E. Market St. (STREET ADDRESS) Akron, (CITY) Ohio (STATE)

POSITION: Intern (PGY I) DEPARTMENT: Family Practice DATE: 07 /01 /86 (FROM) 06/30 /87 (TO)

HOSPITAL: (NAME) (STREET ADDRESS) (CITY) (STATE)

POSITION: DEPARTMENT: DATE: / / (FROM) / / (TO)

HOSPITAL: (NAME) (STREET ADDRESS) (CITY) (STATE)

POSITION: DEPARTMENT: DATE: / / (FROM) / / (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.

STATE: Ohio ISSUE DATE: 07/01/86 TEMPORARY LICENSE #:0020730 CURRENT:YES XX NO__

BASIS OF LICENSURE: Temporary Certificate for internship (expires 6/30/87)

STATE: _____ ISSUE DATE: __/__/__ LICENSE #: _____ CURRENT:YES__NO__

BASIS OF LICENSURE: _____

STATE: _____ ISSUE DATE: __/__/__ LICENSE #: _____ CURRENT:YES__NO__

BASIS OF LICENSURE: _____

FLEX EXAMINATIONS

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

STATE: _____ DATE TAKEN: _____ PASS: ____ 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 XX NO ___ DATE 06/30/87

DIPLOMATE OF THE NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS? YES___ NO XX DATE __/__

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

A U.S. CITIZEN? YES XX NO ___ BASIS OF CITIZENSHIP Birth DATE: 09/17/60

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

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

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

IF YES, GIVE FULL ADDRESS AT THAT TIME:

1654 Twenty-fourth Street	Cuyahoga Falls,	Ohio	44223
STREET ADDRESS	CITY	STATE	ZIP

CERTIFICATION

I, Adarsh Edwin Krishen, 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.

Adarsh E Krishen 5/22/87

SIGNATURE DATE

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

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

'87 JUL 17 P1:46

ALL RESPONSES MUST BE TYPED

1. SOCIAL SECURITY NUMBER [Redacted]

2. FULL NAME (Use no initials) Krishen, Adarsh Edwin
LAST (Surname) FIRST MIDDLE SUFFIX (Jr., II)

3. NAME (As you prefer it inscribed on your Ohio license) Krishen, Adarsh Edwin
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" 145# Brown Green None
HEIGHT WEIGHT HAIR COLOR COLOR OF EYES IDENTIFYING MARKS

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

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

PLANS OF PRACTICE: Residency in Family Practice

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

NAME OF SPECIALTY BOARD	BOARD CERTIFIED YES	NO	YEAR CERTIFIED	COUNTRY
	[ ]	[ ]		
	[ ]	[ ]		
	[ ]	[ ]		
	[ ]	[ ]		

FOR OFFICE USE ONLY 34 MD 35

1-4
12-30-8 7-21-87 185.00 gm 5-11

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.

KRISHEN

'87 JUL 1

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. %
a. 06 / 86 (month / year) TO 06 / 87 (month / year)	Akron City Hospital Hospital/University/Other 525 East Market Street Akron, Ohio 44309 Street Address City/State Zip	PGY I Family Practice	100	
b. 06 / 87 (month / year) TO (month / year)	Akron City Hospital Hospital/University/Other 525 East Market Street Akron, Ohio 44309 Street Address City/State Zip	PGY II Family Practice	100	
c. (month / year) TO (month / year)	Hospital/University/Other Street Address City/State Zip			
d. (month / year) TO (month / year)	Hospital/University/Other Street Address City/State Zip			
e. (month / year) TO (month / year)	Hospital/University/Other Street Address City/State Zip			

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			

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, Jay C. Williamson, M.D., a licensed and practicing physician in the state of
Name of Recommending Physician

Ohio affirm that Adarsh Edwin Krishen, has been known
Name of Applicant

to me personally and professionally for 2 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: excellent

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

His/her relationship with patients is: very good

Additional comments:

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

Jay C. Williamson M.D.
Signature of Recommending Physician

Jay C. Williamson, M.D.
Name of Recommending Physician
(Please print or type)

75 Arch Street, Suite 002, Akron, Ohio 44304
Address of Recommending Physician
(Include City, State, Zip)

(216) 375-3584
Telephone Number
(Include Area Code)

(SEAL)

Ohio 36437
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 17th day of July, 1987.

Elizabeth Lynn Hawkins
Notary Public

March 30 1989
Date Commission Expires

PHOTO

~ 5/87
Date Photo Taken

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

87 JUL 23 P1:42
RECEIVED
OHIO STATE
MEDICAL BOARD

MB

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, David L. Hoff, M.D., a licensed and practicing physician in the state of
Name of Recommending Physician

Ohio affirm that Adarsh Edwin Krishen, has been known
Name of Applicant

to me personally and professionally for 2 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: excellent

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

His/her relationship with patients is: very good

Additional comments:

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

Signature of Recommending Physician

David L. Hoff, M.D.
Name of Recommending Physician
(Please print or type)

75 Arch Street, Suite 002, Akron, Ohio 44304
Address of Recommending Physician
(Include City, State, Zip)

(216) 375-3584
Telephone Number
(Include Area Code)

(SEAL)

Ohio 30993
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 17th day of July, 1987.

Elizabeth Lynn Hawkins
Notary Public

March 30, 1989
Date Commission Expires

LOR
HOTO

~5/87
Date Photo Taken

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

RECEIVED
OHIO STATE
MEDICAL BOARD
87 JUL 23 P1:42

MB

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 Adarsh Edwin Krishen (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[ ] intern
[X] resident in Family Practice (Department)
[ ] clinical fellow

at Akron City Hospital (Name of Hospital), 525 East Market St, Akron, Ohio (Complete Address of Hospital)

from July 1, 1986 beginning (month/day/year) to still serving residency ending (month/day/year). It is further certified that the above named

[ ] was awarded a certificate on ___/___/___ (month/day/year)
[ ] was not

and that the training

[X] was accredited by ACGME/AOA.
[ ] was not

(SEAL OF HOSPITAL)

Signature of Medical Director or Program Director

David L. Hoff, M.D.
Name (Please print or type)

July 14, 1987
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

RECEIVED
OHIO STATE
MEDICAL BOARD
'87 JUL 23 P1:42

MB

ADDITIONAL INFORMATION

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO FURNISH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON AND DISPOSITION OF THE MATTER. ALL AFFIRMATIVE ANSWERS MUST BE THOROUGHLY EXPLAINED ON A SEPARATE SHEET OF PAPER.

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	[ ]	[XX]
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges for other than reasons of failure to maintain records on a timely basis or failure to attend staff or section meetings?	[ ]	[XX]
3.	Have you ever resigned, withdrawn, or terminated, or have you ever been requested to resign, withdraw, or otherwise terminate your position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	[ ]	[XX]
4.	Have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from a medical school, clinical clerkship, externship, preceptorship, or postdoctoral training program?	[ ]	[XX]
5.	Have you ever transferred from one postdoctoral training program to another?	[ ]	[XX]
6.	Have you ever, for any reason, lost Specialty Board Certification in the U.S. or elsewhere?	[ ]	[XX]
7.	Has any board, bureau, department, agency, or other body limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand against you?	[ ]	[XX]
8.	Have you ever voluntarily surrendered any professional license, certificate, or registration issued to you by a board, bureau, department, agency, or other body?	[ ]	[XX]
9.	Have you ever been requested to appear before any board, bureau, department, agency, or other body concerning allegations against you?	[ ]	[XX]
10.	Have you ever entered into an agreement of any kind with respect to a professional license, whether oral or written, in lieu of formal disciplinary action, with any board, bureau, department, agency or other body?	[ ]	[XX]
11.	Have you ever been notified of any charges or complaints filed against you with any board, bureau, department, agency, or other body with respect to a professional license?	[ ]	[XX]
12.	Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or other drugs affecting the central nervous system, or any drugs which may cause physical or psychological dependence?	[ ]	[XX]

	YES	NO
13. Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[XX]
14. Have you ever been treated but not hospitalized, for emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[XX]
15. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, been requested to appear before or fined by the responsible agency?	[ ]	[XX]
16. Have you ever been convicted or been found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	[ ]	[XX]
17. Have you ever forfeited collateral, bail or bond for breach or violation of any law, police regulation, or ordinance other than for minor traffic violation, been summoned into court as a defendant, or had any lawsuit (other than malpractice suit) filed against you?	[ ]	[XX]
18. Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf or paid such a claim yourself?	[ ]	[XX]
19. Have you ever been denied, or relinquished, participation in any third party reimbursement program, whether governmental or private, or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	[ ]	[XX]
20. Have you ever been denied licensure, application for licensure, or privilege of taking examination, or withdrawn any application, in any state, territory, province, or country for any reasons?	[ ]	[XX]

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 OHIO

COUNTY OF SUMMIT

I, Adarsh Edwin Krishen 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.

Adarsh E Krishen
Signature of Applicant

Subscribed and sworn to before me this 14th day of July 1987.

Elizabeth Lynn Hawkins
Notary Public Signature

(NOTARY SEAL)

March 30, 1989
Date Commission Expires

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Adarsh Edwin Krishen, M.D.

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

Attest L. THOMPSON BOWLES, M.D., PH.D.
Chairman of the Board

SEAL ROBERT E. VOLLE, PH.D.
President of the Board

Philadelphia, Pa.
07/01/87

Certificate # 330107

87 JUL 17 P1:45

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from NORTHEASTERN OHIO UNIVS in MAY 1986 and whose birth date is 09/17/1960. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 09/84		
Anatomy, incl. histology and embryology	410	75
Physiology	400	75
Biochemistry	500	81
Pathology	425	76
Microbiology, incl. immunology	440	77
Pharmacology and Materia Medica	280	67
Behavioral Sciences	480	79
TOTAL TEST (Minimum Passing Score 380/75)	400	75
Part II passed 09/85		
Internal medicine and the medical specialties	415	78
Surgery and the surgical specialties	465	80
Obstetrics and Gynecology	540	84
Public Health and Preventive Medicine	400	77
Pediatrics	435	79
Psychiatry	545	84
TOTAL TEST (Minimum Passing Score 290/75)	455	80
PART III passed 03/87		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	455	80.5
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		78.5

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

SEAL

Melanie Valente
Secretary for Certification
06/02/87
Date

AMG

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

RECEIVED
AUG 28 1987

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

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

KRISHEN, Adarsh Edwin, M.D.
Name

113 Westmoreland Terrace
Address

Akron, OH 44302
City, State and Zip

9/17/60
Date of Birth

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN
AUG 28 1987
Bryant L. Galusha, M.D.
BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE-PRESIDENT

Social Security Number

Northeastern Ohio Univ
Medical School of Graduation and Branch Location

1986
Date of Graduation

Please mail the response to the following address:

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

ATTENTION: Penny McKenzie
Chief, Licensure

Penny E. McKenzie
Signature

SEP 02 1987

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

AMG

DATE 8/24/87

Dear Doctor:

Dr. Krishen, Adarsh Edwin who is/was Resident 6/86 to 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? 1 SMONTH

(2) What was/is your supervisory capacity? RESIDENCY DIRECTOR

(3) At what hospital? AKRON CITY

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

(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) EXCELLENT

(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,

Penny McKenzie

Penny McKenzie
Chief, Licensure

SEP -8 '87

David L. Hoff MD
Signature of Doctor, please type or print name legibly beneath

DAVID L. HOFF, MD

FAMILY PRACTICE RESIDENCY DIRECTOR
Position

DATE
Telephone No. (216) -375-3584 (Include Area Code)

Northeastern Ohio Universities
College of Medicine

Upon recommendation of the Faculty
and the Board of Trustees
Northeastern Ohio Universities College of Medicine
acting in concert with
University of Akron, Kent State University and Youngstown State University
hereby confers upon

Adarsh Edwin Krishen

the degree of

Doctor of Medicine

with all the rights and privileges pertaining thereto

Given this thirty-first day of May, Nineteen hundred eighty-six.

President, The University of Akron

President, Kent State University

Neil D Humphrey
President, Youngstown State University

James E. Fleming M.D.
Chairman, Board of Trustees
Northeastern Ohio Universities College of Medicine

Robin Campbell
Provost and Dean
Northeastern Ohio Universities College of Medicine

NATIONAL BOARD OF MEDICAL EXAMINERS®

3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

TELEPHONE: AREA CODE 215·349·6400 · · · CABLE ADDRESS: NATBORD

'87 JUL 17 P1:45

RECEIVED
OHIO STATE
MEDICAL BOARD

06/03/87

TO: Adarsh E. Krishen, M.D.
113 West Moreland Terrace
Akron OH 44302

FROM: Certification Department

RE: Endorsement
NBME ID# 330107

In response to your recent request an Endorsement of Certification is enclosed to support your application for licensure in Ohio.

This form should be forwarded with the remainder of your application material to the State Board of Medical Examiners.

407

'87 MAY 14 P3:53

KRISHEN, Adarsh E.

Adarsh Edwin Krishen
113 Westmoreland Terrace
Akron, Ohio 44302

Ohio State Medical Board
65 S. Front Street, #150
Columbus, Ohio 43215

To whom it may concern:

I am a NBME diplomate seeking licensure in the state of Ohio by endorsement of NBME certification. I have taken and passed part III of the Boards on 03/04/87 and am currently in the process of completing the first year of a residency in Family Practice at Akron City Hospital in Akron, Ohio.

Please send the forms necessary to apply for licensure in Ohio to the address above.

S.F.
SENT
5/18/87

Sincerely,

Adarsh Edwin Krishen

Adarsh Edwin Krishen

1-4
72-30-8
7-21-87
185.00

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

PRELIMINARY EDUCATION FORM

My name IN FULL is Krishen, (LAST) Adarsh (FIRST) Edwin (MIDDLE)

High School or Equivalent:

Cuyahoga Falls High School (SCHOOL NAME) Cuyahoga Falls, (CITY) Ohio (STATE) U.S.A. (COUNTRY)

09/ /75 (FROM (DATE)) 06/ /78 (TO (DATE)) High School (DEGREE)

College or Equivalent:

Kent State University (SCHOOL NAME) Kent, (CITY) Ohio (STATE) U.S.A. (COUNTRY)

09/18/78 (FROM (DATE)) 06/ /84 (TO (DATE)) B.S.(Chemistry, Honors) (DEGREE)

71654 9/1/87

University of Akron (SCHOOL NAME) Akron (CITY) Ohio (STATE) U.S.A. (COUNTRY)

09/ /77 (FROM (DATE)) 06/ /78 (TO (DATE)) none (DEGREE)

'87 MAY 27 A9:37
RECEIVED
OHIO STATE
MEDICAL BOARD

STATE MEDICAL BOARD OF OHIO

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

Adarsh E Krishen 10/14/88
(SIGNAURE OF APPLICANT) (DATE)

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

IDENTIFICATION NUMBER 35-05-5906

ADARSH EDWIN KRISHEN
421 MERRIMAN ROAD
AKRON OH 44303

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS (SEE LIFE ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00 DATE DUE 11/01/88

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

INSTRUCTIONS

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

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

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

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

KRISHEN, ADARSH, E
LAST NAME, FIRST NAME, INITIAL

75 ARCH 4002
STREET ADDRESS

AKRON, OHIO, 44304
CITY, STATE, ZIP CODE

Summit

SOCIAL SECURITY NUMBER Redacted

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

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

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

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

YES	NO	
☐	☒	1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer no to this question if you have successfully completed treatment at a program approved by this Board and have subsequently adhered to all statuatory requirements as contained in Section 4731.224, O.R.C., and related provisions; or are currently enrolled in a Board approved program.
☐	☒	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☒	3.) Surrendered or consented to limitation upon a license to practice medicine by any state or federal privileges to prescribe controlled substances?
☐	☒	4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

QT-00224-03

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 Adarsh E Krishen, MD 10/15/20

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35-05-5906	$160.00	11/01/90

ADARSH EDWIN KRISHEN, M.D.
421 MERRIMAN ROAD
AKRON OH 44303

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

15 FAMILY 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

:96969696 21: 0935055906 ' 00000 16000 '

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

Street

Street

City State Zip Code

County

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

YES NO

A.) A felony

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

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

YES NO

1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO

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

YES NO

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

YES NO

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

[redacted] Redacted

SOCIAL SECURITY NUMBER

(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 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 Adarsh E Krishen, MD 6/2/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-5906	$160.00	07/01/92

ADARSH EDWIN KRISHEN,M.D.
421 MERRIMAN ROAD
AKRON OH 44303

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

15 FAMILY 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

:96969696 21: 0935055906" "00000160000"

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

75 ARCH STREET SITE 002
Street

Street

AKRON | OH | 44304
City | State | Zip Code

SUMMIT
County

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

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

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

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

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

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 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 Adarsh E Krishen. MD 4/14/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-5906	$250.00	05/01/94

ADARSH EDWIN KRISHEN,M.D.
421 MERRIMAN ROAD
AKRON OH 44303

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

FP FAMILY PRACTICE

☑ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

75 ARCH STREET SUITE 1012
STREET
STREET
AKRON OH 44304
CITY STATE ZIP CODE
SUMMIT
COUNTY

:969696962: 0935055906 :00000250000:

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

75 ARCH STREET STE 902
Street

Street

AKRON | OH | 44304
City | State | Zip Code

SUMMIT
County

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

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

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

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

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

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

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

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

YES ☐ NO ☑ 8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

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 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 Adarsh E Krishen, MD 3/8/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-5906	$250.00	05/01/96

ADARSH EDWIN KRISHEN,M.D.
75 ARCH STREET
SUITE 002
AKRON OH 44304

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

FP FAMILY 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

:96969696 2: 0935055906 :00000 25000:

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

Street

Street

City | State | Zip Code

County

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

YES NO

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

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 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 Adarsh E Krishen MD 3/3/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-5906-K	$275.00	05/01/98

ADARSH EDWIN KRISHEN,M.D.
75 ARCH STREET
SUITE 002
AKRON OH 44304

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

FP FAMILY 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

:96969696 2: 0935055906 " "00000 27500 "

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 Adarsh E Krishen 7/7/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-05-5906-K	$305.00	07/01/2000

ADARSH EDWIN KRISHEN,M.D.
75 ARCH STREET
SUITE 002
AKRON OH 44304

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

FP FAMILY 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.

407 MERRIMAN ROAD
STREET
STREET
AKRON OH 44303
CITY STATE ZIP CODE
SUMMIT
COUNTY

:96969696 2: 0935055906" "0000030500"

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

75 ARCH STREET
Street

SUITE 002
Street

AKRON OH 44304
City *State* *Zip Code*

SUMMIT
County

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

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

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.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?*

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

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

REQUIRED:

[redacted]

SOCIAL SECURITY NUMBER

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 2000 - 2002 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 Adarsh E Krishen 4/9/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-05-5906-K	$305.00	07/01/02	10/01/02

ADARSH EDWIN KRISHEN,M.D.
407 MERRIMAN RD
AKRON OH 44303

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

FP FAMILY 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.

407 MERRIMAN ROAD
STREET
STREET
AKRON OH 44303
CITY STATE ZIP CODE
SUMMIT
COUNTY

0935055906 30500

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

75 ARCH STREET SUITE002
Street

Street

AKRON OH 44304
City State Zip Code

SUMMIT
County

REQUIRED: [redacted] Redacted
SOCIAL SECURITY NUMBER

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 DURING THE 2002 - 2004 CME PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION IN COMPLIANCE WITH O.R.C. 4731.281 AND O.A.C. 4731-10, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Adarsh E Krishen 7/25/2004

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 055906	305.00	7/1/2004	10/1/2004

Dr. ADARSH EDWIN KRISHEN
407 MERRIMAN RD
AKRON OH 44303

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

FP

☑ 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.

407 MERRIMAN ROAD
STREET
STREET
AKRON OH 44303
CITY STATE ZIP CODE
SUMMIT
COUNTY

SELECT ONE ADDRESS FOR MAILINGS FROM THE BOARD.
☐ RESIDENCE ☑ PRINICIPAL PRACTICE ADDRESS

0003660875 30500 35ZZ 055906

APPLICATION FOR LICENSURE / RENEWAL IN OHIO :

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 felony or misdemeanor?

YES NO

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

YES NO

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

YES NO

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

YES NO

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

YES NO

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

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

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

Street

Street

City State Zip Code

County

REQUIRED: [redacted]

SOCIAL SECURITY NUMBER

Date Posted: 5/9/2006 3:18:30 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	55 ARCH ST SUITE 3A AKRON, OH 44304 Summit County United States of America 330-375-3584
CREDENTIAL MAIL ADDRESS	55 Arch Street Suite 3A Akron, OH 44304 Summit County United States of America 330-375-3584

License Information

License Number	35.055906
License Name	ADARSH KRISHEN
Email Address	

Fees

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

Specialty Codes

1. Please select one specialty from the field below

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . YES

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.**

. . . . . Darin Carman, CNP

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: 4/4/2008 4:04:03 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	35.055906
License Name	ADARSH KRISHEN
Email Address	krishena@summa-health.org

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY MEDICINE

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

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. . . . . YES

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. . . . . Darin T. Carman, DNP, NP-C

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

Date Posted: 4/13/2010 2:35:39 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	55 ARCH ST SUITE 3A AKRON, OH 44304 Summit County United States of America 330-375-3584 krishena@summahealth.org

License Information

License Number	35.055906
License Name	ADARSH KRISHEN

Fees

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

Specialty Codes

1. Please select one specialty from the field below

. . . . . FAMILY 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. 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?**

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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

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. . . . . Darin Carman, DNP, NP-C

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

Date Posted: 6/11/2012 8:25:28 AM

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

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

License Information

License Number 35.055906

License Name ADARSH KRISHEN

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

. . . . . FAMILY MEDICINE

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

occurring in any state other than Ohio?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . YES

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.**

. . . . . Darin Carman, DNP, FNP-BC

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 10-14

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 30-34

4. "Education" - preceptor, mentor, etc.

. 30-34

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

. 1-4

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

. 0

Clinical - Practice setting

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

. 5-9

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

. 1-4

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 44304

2. Enter the first county:

. . . . . Summit

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . 10+

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

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

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

Date Posted: 5/2/2014 5:42:38 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

55 Arch Street
Suite 3A
Akron, OH 44304
Summit County
United States of America
330-375-3584
krishena@summahealth.org

License Information

License Number 35.055906
License Name ADARSH KRISHEN

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

. . . . . FAMILY MEDICINE

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . YES

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.**

. . . . . Leanne Myers, CNP,/ Darin Carmin, DNP, NP-C

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 10-14

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 50-54

4. "Education" - preceptor, mentor, etc.

. 40-44

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

. 1-4

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

. 1-4

Clinical - Practice setting

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

. 5-9

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

. 5-9

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

. 0

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

. 0

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

. 1-4

Workforce Counties

1. Enter the first zip code:

. 44304

2. Enter the first county:

. . . . . Summit

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . 10+

3. Multi-specialty Group

. . . . . N/A

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

. . . . . NO

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1013924125

DEA number

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

. . . . . BK1747508

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: 6/24/2016 11:39:25 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

CREDENTIAL MAIL ADDRESS

844 Merriman Road
Akron, OH 44303
Summit County
United States
330-375-3584
akrishen@sbcglobal.net

License Information

License Number 35.055906
License Name ADARSH KRISHEN

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

. . . . . FAMILY MEDICINE

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 you been 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?

. . . . . YES

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.**

. . . . . Rebecca A. Bridenthal, CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 10-14

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 1-4

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 30-34

4. "Education" - preceptor, mentor, etc.

. 20-24

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

. 1-4

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

. 0

Clinical - Practice setting

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

. 10-14

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

. 5-9

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

. 0

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

. 0

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

. 0

Workforce Counties

1. Enter the first zip code:

. 43004

2. Enter the first county:

. . . . . Summit

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . 10+

3. Multi-specialty Group

. . . . . N/A

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

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Workforce Language Question

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

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1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Family Medicine

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1013924125

DEA number

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

. . . . . BK1747508

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . YES

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . YES

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

Contact Audit Trail for KRISHEN ADARSH

Date	User	Table	Field	New	Old
5/5/2017 1:45:57 PM	Spencer, T	CONTACTADDRESS	ADDRESSTYPEID	Former Business Address	BUSINESS ADDRESS
6/24/2016 1:50:59 PM	Hawk, L	CONTACTADDRESS	ZIPCODE	44303	44304
6/24/2016 1:50:59 PM	Hawk, L	CONTACTADDRESS	ADDRESS2		Suite 3A
6/24/2016 1:50:59 PM	Hawk, L	CONTACTADDRESS	ADDRESS1	844 Merriman Road	55 Arch Street
9/21/2009 2:11:30 PM	Cammarata, S	CONTACTADDRESS	ADDRESS1	844 Merriman Road	407 MERRIMAN RD
9/21/2009 2:11:30 PM	Cammarata, S	CONTACTADDRESS	ZIPCODE	44303-1748	44303
5/10/2006 7:00:58 AM	Cammarata, S	CONTACTADDRESS	COUNTRYIDNT	United States of America	
5/10/2006 7:00:58 AM	Cammarata, S	CONTACTADDRESS	COUNTRYIDNT	United States of America	
5/10/2006 7:00:58 AM	Cammarata, S	CONTACTADDRESS	ADDRESS2	Suite 3A	Suite 002
5/10/2006 7:00:58 AM	Cammarata, S	CONTACTADDRESS	ADDRESS2	SUITE 3A	SUITE 002
5/10/2006 7:00:58 AM	Cammarata, S	CONTACTADDRESS	PHONE	330-375-3584	
5/10/2006 7:00:58 AM	Cammarata, S	CONTACTADDRESS	PHONE	330-375-3584	
5/10/2006 7:00:58 AM	Cammarata, S	CONTACTADDRESS	ADDRESS1	55 Arch Street	75 Arch Street
5/10/2006 7:00:58 AM	Cammarata, S	CONTACTADDRESS	ADDRESS1	55 ARCH ST	75 ARCH ST
6/24/2004 11:36:18 AM	Cammarata, S	CONTACTADDRESS	ADDRESS1	75 Arch Street	407 MERRIMAN RD
6/24/2004 11:36:18 AM	Cammarata, S	CONTACTADDRESS	ADDRESS2	Suite 002	
6/24/2004 11:36:18 AM	Cammarata, S	CONTACTADDRESS	ZIPCODE	44304	44303