

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF ECONOMIC DEVELOPMENT
OFFICE OF LICENSES AND PERMITS
OCCUPATIONAL AND PROFESSIONAL LICENSING DIVISION
614 ~~MARKET~~ OF COLUMBIA
Washington, D.C. 20001

Commission on Licensure to Practice The Healing Art



(C) ATION TO PRACTICE THE HEALING ART
IN THE DISTRICT OF COLUMBIA

- [] Examination
[] Endorsement of FLEX
[] Endorsement of National Board Diploma
☒ Reciprocity
(Check One)

FOR OFFICIAL USE ONLY

APPL. NO. 72-92-142
EXAM DATE _____
LICENSE NO. 348
DATE ISSUED 6/7/72
DENIED _____
REMARKS _____

METHOD OF HEALING (Check one): [] Osteopathy & Surgery ☒ Medicine & Surgery [] Chiropractic [] Other (Explain)

1. NAME: First <u>VEENAN</u>	Middle <u>RAMKISSOON</u>	Maiden	Last <u>MATHURA</u>
2. BIRTHDAY: Month <u>1</u>	Day <u>1</u>	Year <u>1942</u>	3. BIRTHPLACE: City <u>5</u> County State
4. CURRENT ADDRESS: Number <u>1</u> Street <u>1st</u> City <u>1</u> State <u>1</u> Zip Code Phone No.			
Duration of residence at above address: <u>4 YRS</u>		From <u>JULY 1, 1968</u>	To <u>PRESENT</u>

5. EDUCATION (including Pre-Medical)		Dates Attended		Degree Received
Name of College or University	Location	From	To	
<u>HOWARD UNIVERSITY</u>	<u>6TH & BRYANT ST. N.W. WASH. DC</u>	<u>9/59</u>	<u>6/63</u>	<u>B.S.</u>
<u>HOWARD</u>	<u>"</u>	<u>7/63</u>	<u>6/67</u>	<u>M.D.</u>

6. TRAINING AND PRACTICE since date of graduation to the present. Include periods of unemployment and other employment.			
Employer	Address	From	To
<u>FREEDMEN'S HOSPITAL</u>	<u>6TH & BRYANT ST. N.W. WASH. DC</u>	<u>7/67</u>	<u>6/30/68</u>
<u>HARLEM HOSPITAL</u>	<u>136th & LENOX AVE. N.Y. N.Y. 10037</u>	<u>7/68</u>	<u>present</u>

7. REFERENCES: List the names and full mailing addresses of 3 personal acquaintances, not relatives, who have knowledge of your character and professional practice; or give the name and address of the chartered State or County Medical Society or other Society nearest your residence.

NAME	ADDRESS
ALFRED J. WILLIAMS M.D.	1090 AMSTERDAM AVE. N.Y. N.Y. 10025
NOEL O. MOHAMMED M.D.	2 BRAR LANE, DIX HILLS, LONG ISLAND, N.Y.
HIROKO T. FELTON M.D.	CENTURY ROAD PALISADES N.Y. 10964

8. PREVIOUS LICENSURE: Give the following information concerning the license on which reciprocity is requested. (If no previous licensure, indicate "none".)

Jurisdiction of Issuance	License Number	Date of Issue	Basis
MARYLAND	D 04828	JAN. 22, 1970	EXAMINATION

Give complete mailing address of the board which issued the above license:

1211 CATHEDRAL ST. BALTIMORE MARYLAND 21201

9. State specifically the specialty, if any, and the limit of such specialty:

OBSTETRICS AND GYNECOLOGY

10. HAS LICENSE EVER BEEN DENIED BY ANY BOARD, OR SUSPENDED, REVOKED, OR SURRENDERED FOR ANY REASON? NO If "Yes", give full details on an attached sheet.

11. DECLARATION OF INTENT: As a part of my application for a reciprocal license to practice the Healing Art in the District of Columbia, I hereby declare that it is my intention, if issued a license, to practice the Healing Art in the District of Columbia, in accordance with Section 2-121, D.C. Code, 1967 Edition.

12. If endorsement of FLEX certificate is requested, give date and place of examination:

13. HAVE YOU EVER BEEN ARRESTED, INDICTED, OR CONVICTED OF ANY CRIME (other than minor traffic violations)? NO
If "Yes", give full details on attached sheet.

14. HAVE YOU EVER TAKEN AN EXAMINATION IN THE BASIC SCIENCES OR ANY EXAMINATION IN THE HEALING ART UNDER THE AUTHORITY OF THE COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART IN THE DISTRICT OF COLUMBIA? NO If "Yes", give date and type of examination:

15. APPLICANT'S CERTIFICATION

I hereby certify that the statements contained in the foregoing application are true and that I am the identical person whose history of education, practice of medicine, or otherwise, is contained herein.

It is understood and agreed by the applicant that any information contained in this application may be furnished to any State Medical Board or similar organization having an official and legitimate need for same.

Signature of Applicant:

Steven R. Mathern M.D.

Date:

February 22, 1972

SUBSCRIBED AND SWORN TO BEFORE ME THIS

24TH

DAY OF

February

, 19 72

Signature of Notary Public

Hilda L. Warrick

(Seal of Notary Public)

HILDA L. WARRICK
NOTARY PUBLIC, State of New York
No. 41-484008 Qual. In Queens Co.
Comm. filed in New York County
Commission Expires March 30, 1972

BIOGRAPHICAL DATA ON PHYSICIANS

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

RECEIVED

APR 20 1972

April 5, 1972

Department of
INVESTIGATION

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

Full name of M.D. Jeeva Ramkisson Mathura

Place of birth _____ Date of birth _____

Professional Mailing Address Harlem Hospital, 136th & Lenox Avenue New York, New York

Medical Education:

School Name Howard University, Washington, D.C. M.D. Degree 1967
(Year)

Internships:

Hospital	Location	Dates
_____	_____	to _____
_____	_____	to _____

Residencies and Fellowships:

Hospital	Location	Dates
_____	_____	to _____
_____	_____	to _____

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

State md Year 1970; State NY Year 1971; State _____ Year _____

Inquiry Submitted by D.C. Title _____
(Your Name Here)

(Affiliation - Licensing Board, Hospital or Medical School) City-State _____

AMA Department of Investigation

MEMBER OF AMA

..... YES

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

..... NO

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

Date 4-27-72

Joan Alvarez
Joan Alvarez,
Member Services Unit

HEALING ART

PROCESSING CHECKLIST

NAME MATHURA, JEEVAN R.

OCCUPATIONS
AND PROFESSIONS
RECEIVED
FEB 28 1972

DISTRICT OF COLUMBIA

Applications Clerk

1. Is application form signed and notarized
2. Is photograph attached
3. Is internship certificate (or notarized copy) or certified statement from internship hospital (except Reciprocity)
4. Notarized copy of medical diploma or certified copy or medical school transcript (except Reciprocity)
5. Notarized copy of ECFMG Certificate (foreign grads only)
6. Fee attached
7. File folder attached (Re-examination applicants only)

NA

NA

NA

NA

B.N.

(Applications Clerk)

Applications Examiner

1. Applicant is at least 21 years old
2. Applicant has accounted for all practice since M.D. degree or (Reciprocity only) since issue of base license
3. Method of healing
4. Applying for license by
5. (Examination applicant only)
 - a. Applicant asks exemption from Basic Sciences
 - b. Questions have been received directly from other Board
6. (Reciprocity applicant only)
 - a. Written licensing examination by
 - b. Has provided information re base license
 - c. Has practiced at least one year out of the last three years immediately prior to this application and since issue of base license
 - d. Applicant has been previously examined in District of Col.
 - (1) Exam taken and failed here before base license
 - (2) Exam taken and failed here after base license
7. Applicant has submitted proper fee

✓

✓

✓

M+S
(indicate)
Reciprocity
(indicate)

NA

NA

Maryland
(indicate)

✓

✓

NO
(yes or no)

NA

NA

\$6.00
(amount)

M. Medakow

(Applications Examiner)

(OVER)

Disposition

1. Returned to applicant _____ by _____
(date) (initials)

2. Accepted. Form 52 prepared *SM*

(Signature)
(initials)

Applications Clerk

1. Assign application number and enter in journal
2. Process fee
3. Prepare file envelope
4. Forward Form 52
5. File envelope in "pending" file

(Signature)
(Applications Clerk)

Review of Investigation

1. AMA clearance received
2. Police clearances received
3. Satisfactory references received
4. Grades received and approved (National Board and FLEX only)
5. Licensure verified and reciprocity statement received

(Signature)
(Applications Examiner)

EXAMINER COMMENTS:

COMMISSION COMMENTS AND ACTION

DATE:

CERTIFICATE AS TO ISSUE OF LICENSE

TO THE COMMISSION ON LICENSURE, HEALING ART PRACTICE ACT, D.C.

THIS IS TO CERTIFY:

(1) THAT Jeevan Ramkissoon Mathura IS THE HOLDER OF AN OUT-
(Name of Applicant)
STANDING, UNREVOKED LICENSE TO PRACTICE Medicine and surgery
IN THE STATE OF Maryland, SAID LICENSE, NUMBERED
not numbered, ISSUED January 22, 1970
(Date)

(2) THAT SAID LICENSE WAS ISSUED IN ACCORDANCE WITH THE LAWS OF THIS STATE AS
FOLLOWS:



A. WITHOUT EXAMINATION. LICENSE WAS ISSUED ON THE BASIS OF A DIPLOMA
CONFERRING ON THE APPLICANT THE DEGREE OF:
ISSUED BY
(Name and Location of Medical or Other School)
ON
(Date of Diploma)



B. WITHOUT EXAMINATION. LICENSE WAS ISSUED BY VIRTUE OF RECIPROCITY
WITH THE STATE OF ON THE BASIS OF A
LICENSE TO PRACTICE IN SAID STATE, ISSUED
BY THE LICENSING BOARD OF THAT STATE ON
(Date)



C. AFTER SUBMISSION OF DIPLOMA AND AFTER REGULAR WRITTEN EXAMINA-
TION.
LICENSE WAS ISSUED AFTER THE APPLICANT HAD SUBMITTED TO THIS BOARD
A DIPLOMA CONFERRING ON HIM THE DEGREE OF Doctor of Medicine,
ISSUED AFTER 4 (Four) YEARS OF STUDY OF Medicine
AT Howard University, Washington, D.C.
(Name and Location of School or College)
ON June 9, 1967, AND AFTER REGULAR WRITTEN EXAM-
(Date of Graduation)
INATION COVERING THE FOLLOWING SUBJECTS (STRIKE OUT STUDIES WHICH DO
NOT APPLY) :

ANATOMY; PHYSIOLOGY; BACTERIOLOGY; PATHOLOGY; ~~ANEX~~
~~THESIA~~ ~~XX~~
~~XX~~ PRACTICE OF MEDICINE OR
~~XX~~ OBSTETRICS AND GYNECOLOGY; ~~XXXXXXXXXXXXXXXXXXXX~~
SURGERY; ~~XXXXXXXXXXXX~~ ~~XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX~~

HEALING, IN WHICH EXAMINATION THE APPLICANT ATTAINED A GENERAL
AVERAGE OF OUT OF A POSSIBLE 100.

Chemistry, Therapeutics & Pharmacology

(ADD STUDIES NOT LISTED ABOVE)

(3) THAT A PERSON HOLDING AN OUTSTANDING, UNREVOKED LICENSE TO PRACTICE THE
HEALING ART IN THE DISTRICT OF COLUMBIA, ISSUED UNDER CONDITIONS CORRESPON-
DING TO THOSE SET FORTH IN THE PRECEDING PARAGRAPHS, AS HAVING FORMED THE

(3) (CONT.D)

BASIS OF THE ISSUE OF THE LICENSE THEREIN DESCRIBED, WILL UPON PRESENTATION
TO THE BOARD. of Medical Examiners of Maryland
(Name of Board Certifying this License)
OF SATISFACTORY EVIDENCE OF GOOD MORAL CHARACTER, AND UPON PAYMENT OF
THE PROPER FEE, BE LICENSED WITHOUT EXAMINATION TO PRACTICE THE HEALING
ART IN THE STATE OF District of Columbia

(4) REMARKS: _____

(BOARD SEAL)

BOARD OF
MEDICAL
EXAMINERS
OF MARYLAND

Karl F. Mech, M.D.
(PRESIDENT)

Elmer G. Linhardt, M.D.
(SECRETARY)

Karl F. Mech, M.D., PERSONALLY KNOWN TO ME, BEING DULY SWORN,
DEPOSES AND SAYS THAT HE IS THE PRESIDENT OF Board of Medical Examiners of Maryland
(Name of Licensing Board)
AND THAT THE FOREGOING CERTIFICATION IS TRUE TO THE BEST OF HIS KNOWLEDGE AND
BELIEF.

James H. Moore
(NOTARY PUBLIC)

(SEAL)

April 24, 1972
(DATE)

Elmer G. Linhardt, M.D., PERSONALLY KNOWN TO ME, BEING DULY SWORN,
DEPOSES AND SAYS THAT HE IS THE SECRETARY OF Board of Medical Examiners of Maryland
(Name of Licensing Board)
AND THAT THE FOREGOING CERTIFICATE IS TRUE TO THE BEST OF HIS KNOWLEDGE AND
BELIEF.

James H. Moore
(NOTARY PUBLIC)

(SEAL)

April 24, 1972
(DATE)

INVESTIGATOR.....

E.F.—Ejects to Forfeit; Ft. in Ct.—Forfeit in Court; P.B.—Personal Bond; P.R.—Personal Recognizance; Prob.—Probation; S.S.—Suspended Sentence; E.S.S.—Execution of Sentence Suspended; I.S.S.—Imposition of Sentence Suspended; \$15 or 3 days—Susp.—\$15 or 3 days Suspended

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF ECONOMIC DEVELOPMENT

OFFICE OF SPECIAL OPERATIONS
614 H Street, N.W.
Washington, D.C. 20001

April 5, 1972

Hiroko T. Felton

Applicant.....Jeevan Ramkissoon Mathura

Address.....

1

TO WHOM IT MAY CONCERN:

The applicant whose name and address are given above has applied for a reciprocal license to practice the healing art in the District of Columbia. This voucher is being forwarded to you regarding his moral character and professional experience.

Your prompt return of this voucher, properly executed and signed by you, will greatly assist the Commission when considering his application for license. Your reply will be considered as confidential information by the Commission.

The Commission on Licensure to Practice the Healing Art will expect any person signing this voucher to understand that the Commission is required, by law, to obtain evidence of the good character of applicants for license as a Medical Doctor. Statements by responsible persons with actual knowledge of the applicant's character and experience will be considered by the Commission as evidence in this regard.

Practice in the medical profession involves relations with the public that necessitate a high degree of honor, integrity and professional ability. Therefore, the Commission desires the person subscribing to this voucher to understand fully that the purpose of the law requiring a license is to protect the public from the practice of medicine by persons whose character is questionable or who are not competent to engage in such practice.

PLEASE RETURN THIS VOUCHER TO:

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Economic Development

Office of Special Operations

614 H Street, N.W.

Washington, D.C. 20001

CITIZEN'S VOUCHER

April 12, 1972

TO THE COMMISSION ON LICENSURE, HEALING ARTS PRACTICE ACT, D.C. :

I hereby certify that since July 1 1968 (INSERT DATE), I have been so closely associated with Dr. Jeevan Ramkisson Mathura (APPLICANT'S NAME), residing in (CITY AND STATE), as to be able to intelligently express an opinion as to his character, mental condition, and habits, and that to the best of my knowledge and belief, he is of good moral character and free from mental defects and drug habits liable to interfere with the proper practice of the healing art.

I certify further that to my personal knowledge he has been actually engaged in the practice of Medicine for not less than one continuous year immediately preceding March 1972 (DATE OF APPLICATION).

Remarks: I recommend him highly without reservation.

clinical assistant professor
Columbia University
(PROFESSION OR BUSINESS)

HIROKO T. FELTON, M.D.
(NAME-PRINT OR TYPE)

Hiroko T. Felton M.D.
(SIGNATURE)

/(ADDRESS)

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF ECONOMIC DEVELOPMENT
OFFICE OF SPECIAL OPERATIONS
WASHINGTON, D. C.



ADDRESS REPLY TO:
614 H St., N.W.

April 5, 1972

Reference Alfred J. Williams Applicant Jeevan Ramkissoon Mathura
Address _____ Address _____

TO WHOM IT MAY CONCERN:

The applicant whose name and address are given above has applied for a reciprocal license to practice the healing art in the District of Columbia. This voucher is being forwarded to you regarding his moral character and professional experience.

Your prompt return of this voucher, properly executed and signed by you, will greatly assist the Commission when considering his application for license. Your reply will be considered as confidential information by the Commission.

The Commission on Licensure to Practice the Healing Art will expect any person signing this voucher to understand that the Commission is required, by law, to obtain evidence of the good character of applicants for license as a Medical Doctor. Statements by responsible persons with actual knowledge of the applicant's character and experience will be considered by the Commission as evidence in this regard.

Practice in the medical profession involves relations with the public that necessitate a high degree of honor, integrity, and professional ability. Therefore, the Commission desires the person subscribing to this voucher to understand fully that the purpose of the law requiring a license is to protect the public from the practice of medicine by persons whose character is questionable or who are not competent to engage in such practice.

PLEASE RETURN THIS VOUCHER TO:

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Economic Development
Office of Special Operations
614 H Street, N.W.
Washington, D.C. 20001

CITIZEN'S VOUCHER

4/15/72, 1972

TO THE COMMISSION ON LICENSURE, HEALING ARTS PRACTICE ACT, D. C.:

I hereby certify that since 1968, I have been
(Insert date)

so closely associated with Dr. Jeevan Mathura, residing
(Applicant's name)

in New York, New York as to be able to intelligently
(City and State)

express an opinion as to his character, mental condition, and

habits, and that to the best of my knowledge and belief, he is of
good moral character and free from mental defects and drug habits
liable to interfere with the proper practice of the healing art.

I certify further that to my personal knowledge he has been

actually engaged in the practice of Obs-Gyn

for not less than one continuous year out of the three years

immediately preceding 4/15/72.
(Date of Application)

Remarks: _____

Physician - Obs-Gyn
(Profession or Business)

Frederic J. Williams M.D.
(Name - Print or Type)

[Signature]
(Signature)

1st St. N.W.
(Address)

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF ECONOMIC DEVELOPMENT

OFFICE OF SPECIAL OPERATIONS
614 H Street, N.W.
Washington, D.C. 20001

SECOND REQUEST

May 4, 1972

Dr. Noel O. Mohammed

Applicant Jeevan R. MATHURA

Address..

TO WHOM IT MAY CONCERN:

The applicant whose name and address are given above has applied for a reciprocal license to practice the healing art in the District of Columbia. This voucher is being forwarded to you regarding his moral character and professional experience.

Your prompt return of this voucher, properly executed and signed by you, will greatly assist the Commission when considering his application for license. Your reply will be considered as confidential information by the Commission.

The Commission on Licensure to Practice the Healing Art will expect any person signing this voucher to understand that the Commission is required, by law, to obtain evidence of the good character of applicants for license as a Medical Doctor. Statements by responsible persons with actual knowledge of the applicant's character and experience will be considered by the Commission as evidence in this regard.

Practice in the medical profession involves relations with the public that necessitate a high degree of honor, integrity and professional ability. Therefore, the Commission desires the person subscribing to this voucher to understand fully that the purpose of the law requiring a license is to protect the public from the practice of medicine by persons whose character is questionable or who are not competent to engage in such practice.

PLEASE RETURN THIS VOUCHER TO:

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Economic Development

Office of Special Operations

614 H Street, N.W.

Washington, D.C. 20001

CITIZEN'S VOUCHER

11th MAY, 1972

TO THE COMMISSION ON LICENSURE, HEALING ARTS PRACTICE ACT, D.C. :

I hereby certify that since JULY 1968 (INSERT DATE), I have been so closely associated with Dr. JEEVAN MATHURA (APPLICANT'S NAME), residing in NEW YORK, NEW YORK (CITY AND STATE), as to be able to intelligently express an opinion as to his character, mental condition, and habits, and that to the best of my knowledge and belief, he is of good moral character and free from mental defects and drug habits liable to interfere with the proper practice of the healing art.

I certify further that to my personal knowledge he has been actually engaged in the practice of OBSTETRICS + GYNAECOLOGY for not less than one continuous year immediately preceding APRIL 72 (DATE OF APPLICATION).

Remarks: Since meeting Dr. Mathura I have always been impressed by his dedication to his profession and his ability to gain the confidence of his patients and respect of his colleagues.

OBSTETRICALIAN/GYNAECOLOGIST
(PROFESSION OR BUSINESS)

NOEL O. MOHAMMED M.D. F.A.C.O.G.,
(NAME-PRINT OR TYPE) F.I.C.S., M.R.C.O.G.

Noel Mohammed
(SIGNATURE)

1200 1st St. N.W.
(ADDRESS)

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF ECONOMIC DEVELOPMENT

OFFICE OF SPECIAL OPERATIONS

614 H Street, N.W.

Washington, D.C. 20001

Rec'd 4/18/72

Date: April 15, 1972

Harlem Hospital
Director of Medicine - Personnel
136th and Lenox Avenue
New York, New York

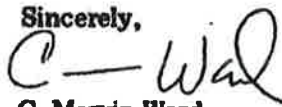
Re: Dr. Jeevan Ramkissoon Mathura

Dear Sir(s),

The physician whose name appears above has applied to the D.C. Commission on Licensure to Practice the Healing Art, for a license to practice the healing art in the District of Columbia.

In order to aid us in evaluating this application, we would greatly appreciate your providing the following information.

Sincerely,



C. Marvin Ward
Administrator


Investigator.....Les.....
CMW/pcq

Name.....Jeevan Ramkissoon Mathura.....Date of Birth.....
Period of Association: From.....7-1-68.....To.....present.....
Title of Position.....4th Yr. Resident (Chief).....
Method of Healing Practiced.....Medical Doctor.....

Rating of Applicant's Performance: We consider his services very satisfactory.

Remarks: He has good medical and diagnostic aptitude and is thorough and conscientious at all times. He has a pleasing personality and is well liked by his colleagues. We do not hesitate to recommend him for favorable consideration.

Sincerely yours,


Herbert G. Cave, M.D.

President, Medical Board, Harlem Hospital Center

(Agency, Institution, or Address of Private Practice)

(Name of Official)

(Title of Position)

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF ECONOMIC DEVELOPMENT

OFFICE OF SPECIAL OPERATIONS
614 H Street, N.W.
Washington, D.C. 20001

RECEIVED

APR 13 1972

FREEDMEN'S HOSPITAL
CHIEF OF MEDICAL DIRECTOR

Date: April 5, 1972

Freedmen's Hospital
Director of Medicine - Personnel
6th and Bryants Streets Northwest
Washington, D.C.

Jeevan Ramkissoon Mathura

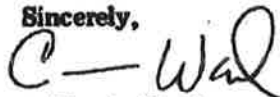
Re: Dr.....

Dear Sir(s),

The physician whose name appears above has applied to the D.C. Commission on Licensure to Practice the Healing Art, for a license to practice the healing art in the District of Columbia.

In order to aid us in evaluating this application, we would greatly appreciate your providing the following information.

Sincerely,



C. Marvin Ward
Administrator

Investigator..... Lee

CMW/pcq

Name..... Jeevan Ramkissoon Mathura Date of Birth.....

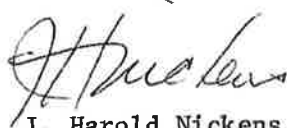
Period of Association: From..... 7-1-67 To..... 6-30-68

Title of Position..... Intern

Method of Healing Practiced..... Medicine and Surgery

Rating of Applicant's Performance: Satisfactory

Remarks:



J. Harold Nickens, M.D.
(Name of Official)

Acting Medical Director

(Title of Position)

Freedmen's Hospital, Washington, D.C. 20001
(Agency, Institution, or Address of Private Practice)

Licensee

Applicant
Licensee
Edit
Renewals
Generate Renewals
Renew
Lockbox
Lockbox Exceptions
Remove Renewals
Generate Log
Transactions
Accounting
Quick Lookup
Reminders
CE
Reports
Enforcement
User Security
Time Tracking
Export Utility
Bulk
Batch Control
Assignments
License Edit (Jasper powered)

- Generate Renewals
- Renew
- Lockbox
- Lockbox Exceptions
- Remove Renewals
- Generate Log
- Transactions
- Accounting
- Quick Lookup
- Reminders
- CE
- Reports
- Enforcement
- User Security
- Time Tracking
- Export Utility
- Bulk
- Batch Control
- Assignments
- License Edit (Jasper powered)

Person

Facility

Search

Clear

Search Results						
Name / License Type	Address	Subtype	License Number	Hold/Alert	Issue Date	Expiration Date
MATHURA, JEEVAN R.						
MEDICINE AND SURGERY			MD25651		06/07/1972	12/31/2018
MATHURA, JEEVAN R., JR						
MEDICINE AND SURGERY	1160 Varium Street, NE Washington DC 20017		MD036329		09/06/2006	12/31/2018
MEDICINE AND SURGERY			MD22189		12/10/1996	12/31/1998

All Licenses held by - MATHURA, JEEVAN R.						
License Type	Address	Sub Type	License Number	Hold/Alert	Status	
MEDICINE AND SURGERY			MD25651		Active	
CONTROLLED SUBSTANCE	1344 MARYLAND AVENUE, NE WASHINGTON DC 20002	Practitioner - Physician	CS8801833	Alert	Expired	

License Bond		Details	
No Data			

Employment		Details	
No Data			

Education				Details	
School Name	School Type	Date Graduated	Degree Certificate		
No Data					

CE Credits By Cycle				Details	
Current cycle	0.00	Not checked			
Last cycle	0.00	Not checked			
Other old cycles	0.00	Not checked			

Schedules		Details	
No Data			

CBC Override		Details	
Date to Override:	Comments:		
No Data			

Initial/Renewal Question Answers		Details	
Group Name	Group Response		
No Data			

Criminal Background Check				Details	
FBI Result	FBI Result Date	State Result	State Result Date		
Negative	11/26/2012	Negative	11/27/2012		

Specialties				Details	
Authority Code Label	Is Primary	Issue Date	Expiration Date		
Obstetrics & Gynecology-Board Cert					

Requirements			Details	
Name	Status	Date		
No Data				

Prerequisites				Details	
Name	License Type	License Number	Status		
No Data					

Inspection		Details	
No Data			

Exam				Details	
Exam Date	Exam State	Exam Type Label	Exam Score		
No Data					

Person Photo ID		Details	
			

Person Or Facility Document				Details	
Date Uploaded	Description	Category	Amendments		
01/30/2015		Person	N		

Person

Details

First Name: JEEVAN
Middle Name: R
Last Name: MATHURA
Suffix
Date of Birth:
Place Of Birth:
Gender: M
SSN:
Address Line 1: 1
Address Line 2:
Address Line 3:
Address Line 4:
Date Deceased:
Registration Code: 27710453

License

Details

License Number: MD25651
License Type: MEDICINE AND SURGERY
Renewal Id:
Profession: MEDICINE
Sub Type:
Date This Status: 01/01/2003
Status: Active
Effective Date: 01/01/2017
Reason Changed:
Expiration Date: 12/31/2018
Issue Date: 06/07/1972
from County:
State/Prov: NA
Application Recd Date:
Obtained By: Other
Reinstatement App Recd
Date:
Date Last Renewal: 12/29/2016
Disciplinary Limit Flag: N
Last Reprint Date: 12/22/2006

Facility

Details

Full Name: JEEVAN R. MATHURA
PersonId: 94965
Owner/Manager:
Address Line1:
Address Line2:
Address Line3:
Address Line4:

Practice Information

Details

In Active Practice Now?: Yes
Practice In DC: Yes
Active Practice in DC:
Hours per week?:

Alias

Details

Last Name	Date Changed	Alias Type Label
MATHURA		Merged
MATHURA		Merged
MATHURA		Merged

Employers for License

Details

No Data

Specialties

Details

Authority Code Label	Is Primary	Issue Date	Expiration Date
Obstetrics & Gynecology-Board Cert			

License Bond

Details

No Data

Employment

Details

No Data

Education

Details

Cederal Name:
Cederal Title:
Date Graduated:
Degree:

Requirements

Details

Name:
Status:
Date: