Illinois Department of Professional Regulation

Nikki M. Zollar
Director

Jim Edgar
Governor

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

April 12, 1996

State Medical Board of Ohio
77 South High Street
17th Floor
Columbus, OH 43266-0315

I, Nikki M. Zollar, do hereby certify that I am the Director of the Department of Professional Regulation, a department of the government of the State of Illinois; that I am the keeper of the records of the Department of Professional Regulation and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	SHEELA M. BARHAN
WAS ISSUED LICENSE NO:	036-091135
ON:	07/03/95
TO PRACTICE AS A:	LICENSED PHYSICIAN AND SURGEON
LICENSED BY:	ACCEPTANCE OF EXAM
CURRENT LICENSURE STATUS IS:	ACTIVE
CURRENT LICENSE EXPIRES:	07/31/96

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED.

OTHER: Temporary Certificate Physician and Surgeon No. 125-028615, was issued June 5, 1992. No disciplinary action on file.

The information above is the only certification information provided by this Department. If other information is needed, it must be obtained from the above-named individual or the agency or institution which initially generated the information. To expedite the certification process, the above format is the standard format prepared for all professions regulated by this Department.

For detailed information regarding the type and length of discipline, if any, submit a written request to the Regulatory Unit at the Department's Chicago office.

Nikki M. Zollar
Director

S E A L

STATE MEDICAL BOARD OF OHIO
96 APR 18 PM 3:

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800
TDD 217/524-6735

James R. Thompson Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/814-4500

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 4 - VERIFICATION OF LICENSE

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

TO BE COMPLETED BY APPLICANT

Barhan, Sheela, Madhav	036-091135	07/01/95
Name in full (last, first, middle, suffix)	License number	Issue date (mo/day/yr)
1241 W. Cornelia Ave Chicago IL 60657	04-15-66	Tulane Medical School
Complete address (street, city, state & zip)	Date of birth	Medical school of graduation

I HEREBY AUTHORIZE THE LICENSING AGENCY OF THE STATE OR PROVINCE OF Illinois TO FURNISH THE INFORMATION BELOW TO THE STATE MEDICAL BOARD OF OHIO.

Sheela M. Barhan 3/2/96

Signature of applicant Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province

Name of Licensee

License Number

Issue Date

Is License current: ❑ Yes ❑ No If not, please explain:

STATE MEDICAL BOARD OF OHIO
96 APR 18 PM 3:36

OVER ⇨

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?

❑ YES ❑ NO ❑ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state?

❑ YES ❑ NO ❑ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?

❑ YES ❑ NO ❑ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

_____
Signature

_____
Title

_____
Date

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

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION

MAIL TO HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice in the State of Ohio. The State Medical Board of Ohio requires that my graduate medical education be certified. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

Barhan, Sheela, Madhav
Name in full (last, first, middle, suffix)

04-15-66
Date of birth (mo/day/yr)

1241 W. Cornelia Ave. Chicago IL 60657
Complete address (street, city, state & zip)

Tulane Medical School
Medical school of graduation

I hereby authorize University of Illinois
Hospital or training institution

to furnish the following information concerning my graduate medical education to the State Medical Board of Ohio.

Sheela M. Barhan
Signature of applicant

3/2/96
Date

TO BE COMPLETED BY HOSPITAL OR TRAINING INSTITUTION

I offer the following in support of his/her application for full licensure:

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

His/her relationship with patients is: Excellent

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

His/her command of the English language is: Excellent

Additional comments: _____

STATE MEDICAL BOARD OF OHIO
96 APR 17 PM 4:06

OVER ⇨

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION
MEDICINE OR OSTEOPATHIC MEDICINE

This certifies that Sheela Barham MD has successfully completed
(name of applicant)

not less than 48 months of graduate medical education through the:
- ☐ 1st year level
- ☐ 2nd year level
- ☒ 3rd year level or above

as a(n):
- ☐ intern
- ☒ resident
- ☐ clinical fellow

in obstet Gynecol (department)

at University of Illinois (name of hospital) 1740 W. Taylor St Chicago IL 60612 (complete street address of hospital)

from 7/1/92 (beginning mo/day/yr) to 6/30/96 (ending mo/day/yr).

It is further certified that the above named:
- ☒ will be awarded a certificate on } 6/30/96 mo/day/yr
- ☐ was awarded a certificate on } _____ mo/day/yr
- ☐ was not awarded a certificate
  please explain: _____

and that the training:
- ☒ was accredited by ACGME/AOA, Royal College of Physicians and Surgeons, College of Family Physicians or National Joint Commission
- ☐ was not accredited by ACGME/AOA, Royal College of Physicians and Surgeons, College of Family Physicians or National Joint Commission

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

(SEAL OF HOSPITAL)*

There is no hospital seal pr

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

Mary G Menaker

OFFICIAL SEAL
MARY G MENAKER
NOTARY PUBLIC STATE OF ILLINOIS
MY COMMISSION EXPIRES 07/28/97

_____ MD
Signature of Medical Director or Program Director
(Original signature only, names stamps will not be accepted)

Bruce Rosenzweig MD
Name (please print or type)

3/18/96
Date

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

Revised 02/09/94

3-39

MEDICINE OR OSTEOPATHIC PRELIMINARY EDUCATION FORM

NAME: LAST (Surname): BARHAN | FIRST: SHEELA | MIDDLE: MADHAV | SUFFIX (Jr., II):

HIGH SCHOOL OR EQUIVALENT:
SCHOOL NAME: CRISFIELD HIGH | CITY: CRISFIELD, | STATE: MD | COUNTRY: USA
DATES ATTENDED: FROM (MO/DAY/YR): 09/01/79 TO (MO/DAY/YR): 05/31/84

UNDERGRADUATE COLLEGE OR EQUIVALENT:
SCHOOL NAME: LOYOLA College | CITY: BALTIMORE | STATE: MD | COUNTRY: USA
DATES ATTENDED: FROM (MO/DAY/YR): 08/01/84 TO (MO/DAY/YR): 06/01/88 | DEGREE RECEIVED: BS

RJBohn

SCHOOL NAME | CITY | STATE | COUNTRY
DATES ATTENDED: FROM (MO/DAY/YR): / / TO (MO/DAY/YR): / / | DEGREE RECEIVED:

STATE MEDICAL BOARD OHIO 96 JAN -5 PM 55

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:
SCHOOL NAME: TULANE | CITY: NEWORLEANS | STATE: LA | COUNTRY: USA
DATES ATTENDED: FROM (MO/DAY/YR): 08/01/88 TO (MO/DAY/YR): 06/05/92 | DEGREE RECEIVED: M.D.

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: 89391 DATE ISSUED: APR 05 1996

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

Ray L. Bumgarner
Entrance Examiner

Thomas E. Butler M.D.
Secretary

The Federation of State Medical Boards

of the United States, Inc.

400 FULLER WISER ROAD, SUITE 300
EULESS, TEXAS 76039-3855
(817) 868-4000
FAX (817) 868-4099

EXAMINEE: SHEELA MADHAV BARHAN

Ray Q. Bumgarner, JD
Executive Director
Ohio State Medical Board
77 S. High Street
17th Floor
Columbus, OH 43215

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

FIN: 660415004 Date of Certification: 03/12/96

DATE OF EXAM	STATE EXAM TAKEN FOR	STATE ID #	COMP 1	COMP 2
06/92	LOUISIANA	21663	78	79

COMPONENT 1 of FLEX is designed to evaluate measurable aspects of the knowledge and understanding of basic and clinical sciences, with specific emphasis on principles and mechanisms underlying disease and modes of therapy.

COMPONENT 2 of FLEX is designed to assess the additional cognitive abilities required of physicians who will ultimately assume independent reponsibilities for the general health care of patients.

* *

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

msb

Tulane University

School of Medicine

Whereas

Sheela Madhav Barhan

has duly fulfilled all the requirements prescribed, therefore the degree of

Doctor of Medicine

is this day conferred with all the rights, honors, privileges, and responsibilities pertaining thereto.

In evidence thereof, *there is impressed upon this Diploma the seal of the University and the signatures of the Chairman of the Board of Administrators, the President of the University, the Chancellor of the Medical Center, and the Dean of the School of Medicine.*

Given at New Orleans, in the State of Louisiana,
June sixth, Nineteen hundred and ninety-two.

Robert H. Bork
Chairman of the Board of Administrators

Neal A. Vanselow
Chancellor of the Medical Center

Eamon M. Kelly
President of the University

Dean of the School of Medicine

AMA-APP-SENT
1/12/96

STATE MEDICAL BOARD OF OHIO

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

REQUEST FOR APPLICATION FORMS
(MEDICAL OR OSTEOPATHIC)

PLEASE TYPE OR PRINT CLEARLY

I hereby submit the following information in order to receive an application:

STATE MEDICAL BOARD OF OHIO
96 JAN -9 PM 1:55

	LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
NAME:	BARHAN	SHEELA	MADHAV	

	STREET & NUMBER
ADDRESS:	1241 West Cornelia Ave

CITY	STATE	ZIP CODE	COUNTRY
Chicago	IL	60657	USA

	AREA CODE & NUMBER		AREA CODE & NUMBER
TELEPHONE: BUSINESS:	(312) 996-7430	HOME:	(312) 248-5031

	MO/DAY/YR		CITY	STATE	COUNTRY
BIRTHDATE:	04/15/66	BIRTHPLACE:	Canton	Ohio	USA

Should I Barhan, S

MEDICAL OR OSTEOPATHIC EDUCATION

MEDICAL SCHOOL OF GRADUATION:

SCHOOL NAME		
Tulane Medical School		
STREET ADDRESS		
1430 Tulane Ave		
CITY	**STATE**	**COUNTRY**
New Orleans	La	USA

		MO/DAY/YR		MO/DAY/YR
DATES ATTENDED:	FROM:	08/01/88	TO:	06/05/92

DEGREE RECEIVED:	M.D.	DATE RECEIVED:	MO/DAY/YR 06/06/92

Revised 01/24/94

OVER ⇨

OTHER MEDICAL SCHOOLS ATTENDED: (IF NONE, ENTER "NONE")

SCHOOL NAME

STREET ADDRESS

CITY | STATE | COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

SCHOOL NAME

STREET ADDRESS

CITY | STATE | COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM: (IF NONE, ENTER "NONE")

HOSPITAL OR INSTITUTION: None

AFFILIATED WITH:

NAME OF MEDICAL SCHOOL | CITY | STATE | ZIP CODE

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

QUALIFYING EXAM TAKEN: DATE TAKEN: MO/DAY/YR / /

CONTINUED ⇨

GRADUATE MEDICAL EDUCATION

List ALL graduate medical education (internship, residency, or clinical fellowship), undertaken in the U.S. or Canada. If additional space is needed, please attach an extra sheet. (If none, enter "NONE")

	month/year	TO month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	Level of Training (check one only)
A.	07 92	01 96	University of Illinois 1740 W. Taylor St. Chicago IL / USA 60612	OB-GYN Resident	☐ 1st year ☐ 2nd year ☑ 3rd year or above
B.					☐ 1st year ☐ 2nd year ☐ 3rd year or above
C.					☐ 1st year ☐ 2nd year ☐ 3rd year or above
D.					☐ 1st year ☐ 2nd year ☐ 3rd year or above

OVER ⇨

WRITTEN EXAMINATIONS TAKEN

List each and every written (FLEX, National Boards, USMLE or State Board) exam taken whether in Ohio or any other state, territory or province. Use one section for each exam portion taken. If additional space is needed, please attach an extra sheet.

STATE	DATE TAKEN	TYPE OF EXAM	SECTIONS TAKEN	FINAL RESULTS
Louisiana	(MO/YR) 06 / 92	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☒ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☑ I ☑ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☑ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✔ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✔ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✔ ONE ONLY) ☐ PASS ☐ FAIL

CONTINUED ⇨

LICENSES IN THE UNITED STATES & CANADA

List ALL states/provinces **whether the license is current or not** in which you are or have been licensed (except temporary, educational permits, etc.) to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number, date of issuance, and the basis of licensure (e.g., FLEX, endorsement of diplomate status, USMLE, endorsement of another state license, state board exam, etc.) If additional space is needed, please attach an extra sheet. (If none, enter "NONE")

STATE/PROVINCE	ISSUE DATE	LICENSE #	BASIS OF LICENSE	LICENSE CURRENT
Louisiana	(MO/YR) 07/93	021663	(✔ ONE ONLY) ☐ NATIONAL BOARDS ☒ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER ____	(✔ ONE ONLY) ☒ YES ☐ NO Expiration date: ____
Illinois	(MO/YR) 07/95	036-091135	(✔ ONE ONLY) ☐ NATIONAL BOARDS ☒ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER ____	(✔ ONE ONLY) ☒ YES ☐ NO Expiration date: ____
	(MO/YR) /		(✔ ONE ONLY) ☐ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER ____	(✔ ONE ONLY) ☐ YES ☐ NO Expiration date: ____
	(MO/YR) /		(✔ ONE ONLY) ☐ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER ____	(✔ ONE ONLY) ☐ YES ☐ NO Expiration date: ____
	(MO/YR) /		(✔ ONE ONLY) ☐ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER ____	(✔ ONE ONLY) ☐ YES ☐ NO Expiration date: ____

AMERICAN MEDICAL ASSOCIATION
NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE

The American Medical Association (AMA) has implemented a National Physician Credentials Verification Service (NPCVS), which for a fee will verify a physician's possessive credentials.

Are you currently a member of the AMA's NPCVS? ☐ YES ☒ NO

For further information contact the AMA at the address below:

AMERICAN MEDICAL ASSOCIATION
NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE
515 N. STATE STREET, 4TH FLOOR
CHICAGO, IL 60610
(312)464-5000

STATE MEDICAL BOARD OF OHIO
96 JAN -9 PM 1:55

OVER ⇨

ADDITIONAL ELIGIBILITY INFORMATION

ANSWER ALL QUESTIONS	YES	NO
Are you a licentiate of the Medical Council of Canada?	☐	☑
Are you applying to take Step 3 of the USMLE in Ohio? ☐ June or ☐ December	☐	☑
Do you have a valid ECFMG Certificate? Number: _____ Date Issued: ___/___ MO/YR	☐	☑
Have you held a current and unrestricted license in the US for five years or more? (Refer to the TSE section in the Eligibility Packet for more information)	☐	☑
Have you been actively practicing medicine and surgery or osteopathic medicine and surgery (approved training included) in the US for five years or more? (Refer to the TSE section in the Eligibility Packet for more information)	☐	☑
Have you applied for or taken the Test of Spoken English (TSE)* of the Educational Testing Service (ETS)? Date Taken: ___/___ MO/YR Score: _____	☐	☑
Have you achieved a score of at least two hundred thirty (230) on TSE* of the ETS? Date Taken: ___/___ MO/YR Score: _____	☐	☑
***[THE TOEFL, ECFMG EXAM, ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH (TSE)]**		

CERTIFICATION

I hereby certify that I am the person referred to in the foregoing Request for Application forms and that the statements herein are strictly true in every respect.

Shirley M. Graham
Signature of Applicant

01/03/96
Date

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

Revised 01/24/94

3-39 # 610 $ 335.00 3-28-96

STATE MEDICAL BOARD OF OHIO

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

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number: [redacted]

2. Full Name (Use no initials): LAST (Surname): BARHAN | FIRST: SHEELA | MIDDLE: MADHAV | SUFFIX(Jr., II):

3. Name (As you prefer it inscribed on your Ohio license): LAST (Surname): BARHAN | FIRST: SHEELA | MIDDLE: MADHAV | SUFFIX(Jr., II):

4. Maiden Name Or Other Names Used (If none, enter "NONE"): LAST (Surname): NONE | FIRST: | MIDDLE: | SUFFIX(Jr., II):

5. Current Address: STREET & NUMBER: 1241 W. CORNELIA AVE
   CITY: CHICAGO | STATE: IL | ZIP CODE: 60657 | COUNTRY: USA

6. Physical Description:

HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	IDENTIFYING MARKS
5'6"	140	BLACK	BROWN	

7. Sex: ☐ MALE ☒ FEMALE For statistics only (optional)

8. City In Ohio Where You Plan To Practice: CITY: DAYTON OR COUNTY: MONTGOMERY
   PLANS OF PRACTICE: UNIVERSITY OB-GYN FACULTY

9. Specialty Boards (U.S.A., Canada and foreign countries):

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
OB-GYN	☐	☒	Anticipate	written Board-96 Oral Board-98
	☐	☐		
	☐	☐		

FOR OFFICE USE ONLY ☐ 34 ☒ 35 ☐ Examination ☐ Endorsement

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

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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 "looking for residency program" or "vacation", as well as your permanent address for this period. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did locum tenens, you must list all hospitals where you worked and include complete dates and addresses. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. **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.

BARHAN

A.

month/year	Hospital, University or Other: / Complete Street Address / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
06 92	Vacation / Waiting to Start of Residency		
TO			
07 92			

B.

month/year	Hospital, University or Other: / Complete Street Address / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
07 92	University Illinois Affiliated Hospitals	OB-GYN. Resident	100%
TO	840 S. Wood St.		
06 96	Chicago IL / USA 60612		

C.

month/year	Hospital, University or Other: / Complete Street Address / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
TO			

D.

month/year	Hospital, University or Other: / Complete Street Address / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
TO			

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

E.

month/year TO month/year	Hospital, University or Other: Complete Street Address Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

F.

month/year TO month/year	Hospital, University or Other: Complete Street Address Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

G.

month/year TO month/year	Hospital, University or Other: Complete Street Address Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

H.

month/year TO month/year	Hospital, University or Other: Complete Street Address Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

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 physician 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 A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Janet Perkins-Howland, MD, a licensed and practicing physician in the state of
(recommending physician)

Illinois, affirm that Sheela Barhan
(state of residence) (applicant)

has been known to me personally for 4 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: excellent

*His/her relationship with patients is: excellent

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

*His/her command of the English language is: excellent

*Additional comments: recommendation without reservation

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

Signature of Recommending Physician
(name stamps not acceptable)

J. Perkins - Howland, MD
Name of Recommending Physician
(please type or print clearly)

(708) 848 9179
Telephone Number
(include area code)

322 Washington, Oak Park IL 60302
Address of Recommending Physician
(include city, state and zip code)

IL, 036-092278
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

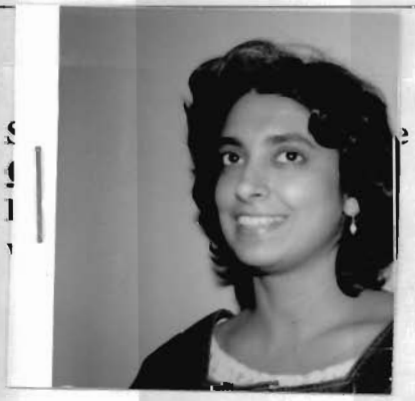
(NOTARY SEAL)

Subscribed and sworn to before me this 6th day of March, 1996.

Harriet Ann Johnson
Notary Public Signature

OFFICIAL SEAL
HARRIET ANN JOHNSON
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES FEB. 2, 1999

Date Commission Expires



Signature of Applicant

Date Photo Taken: 03/96
Mo./Yr

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

Revised 02/09/94

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

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 physician 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 A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Azita Ardakani, a licensed and practicing physician in the state of
(recommending physician)

Illinois, affirm that Sheela Barhan
(state of residence) (applicant)

has been known to me personally for 4 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: Excellent

*His/her relationship with patients is: Excellent

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

*His/her command of the English language is: Excellent

*Additional comments: I Recommend without Reservation

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

A. Ardakani
Signature of Recommending Physician
(name stamps not acceptable)

Azita Ardakani
Name of Recommending Physician
(please type or print clearly)

(708) 383-9233
Telephone Number
(include area code)

100 Forest Ave #801 Oak Park IL 60301
Address of Recommending Physician
(include city, state and zip code)

Illinois 036-089177
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 6th day of March, 1996.

Harriet A Johnson
Notary Public Signature

OFFICIAL SEAL
HARRIET ANN JOHNSON
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES FEB. 2, 1999

Date Commission Expires

Sharla M. Barbour
Signature of Applicant

Date Photo Taken: 03/96
Mo./Yr

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

Revised 02/09/94

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 4 - VERIFICATION OF LICENSE

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

TO BE COMPLETED BY APPLICANT

Barhan, Sheela, Madhav	021663	07/01/93
Name in full (last, first, middle, suffix)	License number	Issue date (mo/day/yr)
1241 W. Cornelia Ave Chicago IL 60657	04-15-66	Tulane Medical School
Complete address (street, city, state & zip)	Date of birth	Medical school of graduation

I HEREBY AUTHORIZE THE LICENSING AGENCY OF THE STATE OR PROVINCE OF Louisiana TO FURNISH THE INFORMATION BELOW TO THE STATE MEDICAL BOARD OF OHIO.

Sheela M. Barhan 3/2/96

Signature of applicant Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

Louisiana	Sheela Madhav Barhan
State/Province	Name of Licensee
021663	7-1-93
License Number	Issue Date

STATE MEDICAL BOARD OHIO 96 MAR 1 PM 3:15

Is License current: ☑ Yes ☐ No If not, please explain: _____

OVER ⇨

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?

☐ YES ☑ NO ☐ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state?

☐ YES ☑ NO ☐ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?

☐ YES ☑ NO ☐ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

Yvette M. Banks
Signature

Secretary
Title

3/7/96
Date

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

STATE MED... OF OH...
96 MAR 11 PM 3:...

Revised 05/26/92

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

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.

(Please place a ✔ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
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 or resign privileges at 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 reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or 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 graduate medical education?	☐	☑
5.	Have you ever transferred from one graduate medical education to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑

OVER ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

		YES	NO
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by, or have you ever been notified of, any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Are you now or have you ever been, addicted to or excessively used alcohol, drugs, or other substances which may cause physical or psychological dependence, or impairment of the ability to practice?	☐	☑
14.	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 an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑
15.	Have you ever been treated but not hospitalized for emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑
16.	Have you ever been denied, or surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑

CONTINUED ⇨

ADDITIONAL INFORMATION-MEDICINE OR OSTEOPATHIC MEDICINE
PAGE THREE

	YES	NO
17. Have you ever been convicted or found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	☐	☑
18. Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☑
19. 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? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
20. Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
21. Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, include Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
22. Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

STATE MEDICAL BOARD OF OHIO
96 MAR 2 PM 4:04

Revised 1/12/95

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 considered as incomplete.

ss STATE OF Illinois

COUNTY OF Cook

I, Sheela Barhan, 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 that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor 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 or osteopathic 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 my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for licensure and that any fee I submitted is not refundable nor 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, of 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 issuance of a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

(NOTARY SEAL)
"OFFICIAL SEAL"
PATSY MASON
Notary Public Cook County, Illinois
My Commission Expires Nov. 30, 1996

Sheela M. Barhan
Signature of Applicant

Subscribed and sworn to before me this 16th day of March 1996.

Patsy Mason
Notary Public Signature

11/30/96
Date Commission Expires

Revised 05/26/92

FOR BOARD USE ONLY

NAME: Barkan, Sheila M

CERTIFICATE NO.: 70345

DATE ISSUED: May 8, 1996

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE OR OSTEOPATHIC MEDICINE

FILED: January 12, 1996

FEE: _____

DETERMINATION:

BOARD ACTION:

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 _____ 4-24-98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-07-0345-B	$371.00	05/01/98

SHEELA MADHAV BARHAN,M.D.
3901 MAPLE GROVE LANE
BEAVERCREEK OH 45440-3481

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

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

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935070345 " "0000037100"

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

Street
Street
City State Zip Code
County

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

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

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

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

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

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

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

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

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

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

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2001 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Sheela Barhan 3/10/01
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-07-0345-B	$305.00	04/01/2001

SHEELA MADHAV BARHAN,M.D.
279 TIMBERLEAF DR
BEAVERCREEK OH 45430

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY

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

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

279 TIMBERLEAF DR
STREET
STREET
BEAVERCREEK OH 45430
CITY STATE ZIP CODE
GREENE
COUNTY

:96969696 2: 0935070345 II 00000305001

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

128 E APPLE ST
Street
STE 3800
Street
DAYTON OH 45409
City State Zip Code
Montgomery
County

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

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

YES ☐ NO ☒ 2.) *Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?* ***You may answer "NO" to this question if*** *you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.*

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

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

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

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

REQUIRED:
[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 2001 - 2003 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** *AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.*

X Sheela Barhan 2/6/03
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-07-0345-B	$305.00	04/01/03	07/01/03

SHEELA MADHAV BARHAN,M.D.
279 TIMBERLEAF DR
BEAVERCREEK OH 45430

0935070345 30500

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY

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

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

279 TIMBERLEAF DR
STREET
STREET
BEAVERCREEK OH 45430
CITY STATE ZIP CODE
GREENE
COUNTY

APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

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

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

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

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

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

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

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

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

4120 BERRY WOMENS HEALTH
Street
MIAMI VALLEY HOSPITAL
Street
DAYTON OH 45409
City State Zip Code
MONTGOMERY
County

REQUIRED:
SOCIAL SECURITY NUMBER
[redacted]

Date Posted: 3/2/2005 8:56:09 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	35.070345
License Name	SHEELA BARHAN
Email Address	

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   ..... OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME

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

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   ..... NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   ..... NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints

against you?

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 2/24/2007 2:00:46 PM

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

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

Address Information

BUSINESS ADDRESS	MIAMI VALLEY HOSPITAL 4130 BERRY WOMENS HEALTH DAYTON, OH 45409 Montgomery County United States of America 937-208-2850
CREDENTIAL MAIL ADDRESS	279 TIMBERLEAF DR BEAVERCREEK, OH 45430 Greene County United States of America 937-208-2850
MAIN	279 TIMBERLEAF DR BEAVERCREEK, OH 45430 Greene County United States of America 937-208-2850

License Information

License Number	35.070345
License Name	SHEELA BARHAN
Email Address	rbuena@sbcglobal.net

Fees

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

Specialty Codes

1. Please select one specialty from the field below
   ..... OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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

Date Posted: 3/15/2009 10:59:12 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	35.070345
License Name	SHEELA BARHAN

Fees

Relicensure Fee	$305.00
	========
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Date Posted: 4/3/2011 10:18:06 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.

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License Information

License Number	35.070345
License Name	SHEELA BARHAN

Fees

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

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

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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?

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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?

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Social Security Number

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. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 25-29

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.)

. 5-9

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

. 25-29

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

. 0

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).

. 15-19

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

. 10-14

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

. 5-9

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

. 0

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

. 10-14

Workforce Counties

1. Enter the first zip code:

. 45409

2. Enter the first county:

. . . . . Montgomery

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 5-10

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)

. . . . . YES

Workforce Language Question

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

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Spanish

2. Select a language from the drop down list.

. . . . . Italian

3. Select a language from the drop down list.

. . . . . *{not Answered}*

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

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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: 6/13/2013 11:25:40 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

Wright State University School of Medicine
Dept. of OB/Gyn
128 E. Apple St., Suite 3800 CHE
DAYTON, OH 45409
Montgomery County
United States of America
937-208-2850
smbarhan@mvh.org

License Information

License Number 35.070345
License Name SHEELA BARHAN

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 40-44

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

. 5-9

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

. 5-9

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

. 5-9

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

. 0

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)".

. 25-29

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

. 1-4

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:

. 45409

2. Enter the first county:

. . . . . Montgomery

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

. . . . . N/A

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)

. . . . . YES

Workforce Language Question

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

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1093771453

DEA number

1. Please enter your DEA number

. . . . . BB4901078

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: 6/7/2015 10:18:27 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	35.070345
License Name	SHEELA BARHAN

Fees

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

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

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

. . . . . *{not Answered}*

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

. . . . . *{not Answered}*

CME-Physicians

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

. . . . . YES

Discipline

1. **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?

. . . . . NO

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

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 25-29

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

. 10-14

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.)

. 40-44

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

. 25-29

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

. 0

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).

. 40-44

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

. 35-39

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

. 1-4

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:

. 45409

2. Enter the first county:

. . . . . Montgomery

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

. 5-10

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?

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1. Are you certified by an ABMS Board?

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ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1093771453

DEA number

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

. . . . . BB4901078

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

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: 1/16/2017 2:05:10 PM

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Address Information

BUSINESS ADDRESS	Wright State University School of Medicine Dept. of OB/Gyn 128 E. Apple St., Suite 3800 CHE DAYTON, OH 45409 Montgomery County United States 937-208-2850 sheela.barhan@wright.edu
CREDENTIAL MAIL ADDRESS	279 TIMBERLEAF DR BEAVERCREEK, OH 45430 Greene County United States 937-429-4803 sheela.barhan@wright.edu
MAIN	279 TIMBERLEAF DR BEAVERCREEK, OH 45430 Greene County United States 937-429-4803 sheela.barhan@wright.edu

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License Name	SHEELA BARHAN

Fees

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Total Fees	**$305.00**

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1. **Did you provide a Credential email address? Please note this information is a public record.**

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1. Please select one specialty from the field below

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

. . . . . *{not Answered}*

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

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. . . . . Misty Uhl, CNP, Mary Gorniak CNP, Kitty Lowry CNM, Donna Gau-Jata CNM, Anne Erikson CNM,

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 10-14

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. 1-4

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. 25-29

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

. 25-29

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

. 0

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).

. 15-19

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

. 50-54

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

. 5-9

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

. 0

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

. 15-19

Workforce Counties

1. Enter the first zip code:

. 45409

2. Enter the first county:

. . . . . Montgomery

3. Enter the second zip code:

. . . . . *{not Answered}*

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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

. 5-10

3. Multi-specialty Group

. 2-5

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

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1. Are you certified by an ABMS Board?

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1. Please enter your current NPI number

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. . . . . YES

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.

Submission Date and Time: 4/2/2019 10:59 AM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

Title
Dr.
First Name
SHEELA
Middle Name
MADHAV
Last Name
BARHAN
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
4/15/1966
Email Address
sheela.barhan@wright.edu
Phone Number
9374294803
Other Phone Number
9372082850
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
Asian Indian
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if not applicable leave blank
1093771453
Enter home US zip-code. Enter NA if unavailable
45430

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
No Response
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
Ohio
In which city were you born?
CANTON

Employment Status

Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

279 TIMBERLEAF DR
BEAVERCREEK
OH
45430
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

279 TIMBERLEAF DR
BEAVERCREEK
OH

45430
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No Response
Has your spouse served in the military?
Yes
If you answered "Yes", are they currently serving in the military?
No
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:
smbarhan@premierhealth.com

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Medical Speciality Certification - American Board of Medical Specialties (ABMS)
Medical Speciality - Obstetrics and Gynecology (ABMS)
Medical SubSpeciality - null

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position

that requires this license (e.g. student or recent graduate) employment location information is optional. Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - wright state physicians
Practice Settings - Office/Clinic - Multi Specialty Group
Street Address - 400 Sugar Camp Circle
City - dayton
State - OH
Zip Code - 45409
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 12

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 90
Teaching/Academic - 10
Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - Yes
Current Employment Arrangement - Salaried
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - Yes

Name of Practice Site - wright state physicians
Practice Settings - Hospital - Inpatient
Street Address - 1 Wyoming St
City - dayton
State - OH
Zip Code - 45409
Major Area of Focus or Specialty - Obstetrics and Gynecology (ABMS)
Total Hours Worked at this practice site, per Week - 40

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 15
Teaching/Academic - 50
Research - 5
Professional Services - 0
Administrative Activities - 30
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - Yes
Current Employment Arrangement - Salaried
Other Employment Arrangement - null

Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - Yes

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue.

Question - 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?
Answer - No

Question - At any time since submission of your last application for renewal 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.
Answer - No

Question - 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?
Answer - No

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

Question - Primary DEA Number
Answer - BB4901078

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - Yes

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - Yes

Question - 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?
Answer - No

Question - 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?
Answer - No

Question - 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?
Answer - No

Question - Do you currently supervise one or more Physician Assistants?
Answer - No

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

Attestation
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.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 4/2/2019 10:59 AM
Type your First Name and Last Name as they appear on the application to sign electronically.
SHEELA BARHAN
Submit your Application -After clicking the 'Submit' button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.