



**APPLICATION FOR LICENSE TO PRACTICE MEDICINE /
OSTEOPATHIC MEDICINE IN INDIANA**

State Form 29495 (R9 / 7-96)
Approved by State Board of Accounts, 1994

Health Professions Bureau
402 W. Washington St., Room 041
Indianapolis, IN 46204
Telephone number: (317) 232-2960

980079999

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

Application fee	\$50-
Date fee paid (month, day, year)	7-24-98
Receipt number	3771-286-110-01/03
Application number	
License number	01049641
License issuance date (month, day, year)	10/14/98

Permit fee	
Date fee paid (month, day, year)	
Receipt number	
Permit number	3828
Permit issuance date (month, day, year)	7-21-98



DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (last, first, middle, maiden)	MELTZER, LEIGH REGENSTRIEF	Check one: <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO	Social Security number *	[REDACTED]
Address (number and street or Rural Route)	6451 SOUTH WIND CIRCLE			
City, state, ZIP code	COLUMBIA MD 21044			
Telephone number (daytime)	[REDACTED]	Birthdate (mo., day, yr.)	6-10-65 Newport News, Virginia	

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit?
 Yes No

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of School	Indiana University School of Medicine	Location	Indianapolis	Date of Graduation (Month, Day, Year)	April 30 1991
----------------	---------------------------------------	----------	--------------	---------------------------------------	---------------

EXAMINATION

Check appropriate box(es) indicating which examination or combination of examinations you have taken.
(Please review instruction sheet for address and telephone numbers on how scores may be obtained.)

<input type="checkbox"/> FLEX EXAMINATION	<input type="checkbox"/> STATE BOARD EXAMINATION
<input type="checkbox"/> Component I <input type="checkbox"/> Component II <input type="checkbox"/> Other	Examination taken in which state?
<input checked="" type="checkbox"/> NATIONAL BOARD OF MEDICAL EXAMINERS	<input type="checkbox"/> LMCC EXAMINATION
<input checked="" type="checkbox"/> Part I <input checked="" type="checkbox"/> Part II <input checked="" type="checkbox"/> Part III	
<input type="checkbox"/> USMLE EXAMINATION	<input type="checkbox"/> NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS
<input type="checkbox"/> Step I <input type="checkbox"/> Step II <input type="checkbox"/> Step III	<input type="checkbox"/> Part I <input type="checkbox"/> Part II <input type="checkbox"/> Part III

RECEIVED

JUL 21 1998

Health Professions Bureau

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED
Indiana University	Bloomington, IN	8-83 through 5-87

MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED
Indiana University School of Medicine	Indianapolis, IN	8-87 through 5-91

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA
(Include ALL internships, residencies and / or fellowships)

NAME OF PROGRAM	LOCATION	FROM (month, year)	TO (month, year)
University of Maryland Medical Systems	Baltimore, MD	7-1-91	6-30-95

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL

GENERAL LOCATION	DATE
Baltimore, Maryland	7-91 through 6-95
Columbia, Maryland	6-95 through present

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE
University of Maryland Medical Systems Baltimore MD	Resident Physician OB-GYN	7-91 through 6-95
Drs. Esposito, Mayer, Hogan + Assoc. 11085 Little Patuxent Parkway Columbia, MD 21044	OB-GYN	8-95 through present

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION

STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
MD	Medical Doctor - authorized physician + surgeon	D47222	April, 1995	Active

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

- | | |
|--|---|
| 1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (including Indiana) or country? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 3. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 4. Have you ever been charged with drug addiction? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 5. Have you ever been convicted of, plead guilty or <i>nolo contendere</i> to:
A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?
B. Any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines.) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 8. Have you ever had a malpractice judgment against you or settled any malpractice action? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant

Wign R. Meltzer MD

Date signed (month, day, year)

7-13-98

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for medical licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Date signed (month, day, year)

7-13-98

Signature of applicant

Wign R. Meltzer MD

RECEIVED
JUL 21 1998
Health Professions Bureau



**UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE**

405 West Redwood Street, 3rd Floor
Baltimore, Maryland 21201-1703
410 328-5959
FAX: 410 328-8389

**DEPARTMENT OF OBSTETRICS, GYNECOLOGY
& REPRODUCTIVE SCIENCES**
Office of the Program Director

June 26, 1998

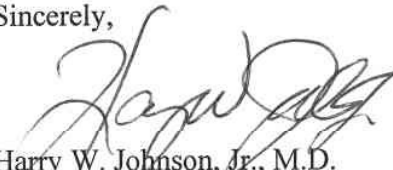
TO WHOM IT MAY CONCERN:

RE: Leigh Meltzer, MD

This is to certify that Leigh Meltzer was a resident in Obstetrics and Gynecology at the University of Maryland Medical System in Baltimore, Maryland. She began the program on 7/1/91 and completed her training in good standing on 6/30/95.

If further information is required, please contact us.

Sincerely,



Harry W. Johnson, Jr., M.D.
Assistant Professor, Dept. OB-GYN
Program Director

HWJ,jr/mke
(h\Meltzer.Lei\res-conf.let)

RECEIVED

JUL 21 1998

Health Professions Bureau

MARYLAND BOARD OF PHYSICIAN QUALITY ASSURANCE

P.O. Box 2571
4201 Patterson Avenue
Baltimore, MD 21215-0095
(410) 764-4777
Fax (410) 358-2252
e-mail: bpqa@erols.com

July 14, 1998

Requested by: INDIANA STATE BOARD OF MEDICINE

The following is available under the Maryland Public Information Act, State Government Article, Section 10-617(h), regarding the following practitioner:

MELTZER, LEIGH REGENSTRIEF
6451 SOUTH WIND CIRCLE
COLUMBIA, MD 21044

License Number: D0047222
Date Issued: April 25, 1995
Current Status: Active
Expiration Date: September 30, 1999
Medical School: IN UNIV SCH OF MED
Licensed By: National Boards
Specialty:
Charges: 0
Disciplinary Actions: NONE

No Maryland Health Claims Arbitration Office malpractice claims filed since July 1, 1986

Yvette McCluskey

Verification Clerk

07/14/1998

Date

This is a computer generated form which is acceptable by other states.

Licensing examination scores should be requested directly from the examining authority.

RECEIVED

JUL 23 1998

Health Professions Bureau



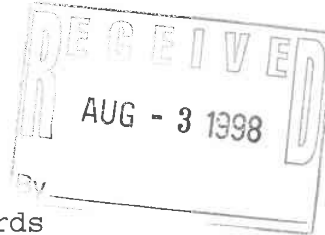
STATE OF INDIANA

FRANK O'BANNON, Governor

HEALTH PROFESSIONS BUREAU

402 West Washington Street Room 041
Indianapolis, Indiana 46204
Telephone: (317) 232-2960
Fax: (317) 233-4236
http://www.ai.org/hpb
Equal Opportunity Employer

7/29/98



DISCIPLINARY INQUIRIES
Federation of State Medical Boards
400 Fuller Wiser Road Suite 300
Eules, TX 76039

The "Medical Licensing Board of Indiana" requests a disciplinary search concerning the following individual:

NAME AND ADDRESS: LEIGH REGENSTRIEF MELTZER
6451 SOUTH WIND CIRCLE
COLUMBIA MD 21044
DATE OF BIRTH: 06/10/65
SOCIAL SECURITY NO.: [REDACTED]
MEDICAL SCHOOL OF GRADUATION: INDIANA UNIVERSITY
YEAR OF GRADUATION: 91

Please mail the response to the following address:

Health Professions Bureau
Medical Licensing Board of Indiana
402 W. Washington Street
Room 041
Indianapolis, IN 46204

Attention: Annette Smith
Endorsement Coordinator

Annette R. Smith
Signature



AUG 11 1998

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

AUG - 5 1998

James R. Winn, M.D.
JAMES R WINN M.D.
EXECUTIVE VICE-PRESIDENT

Health Professions Bureau

- Boards of: Athletic Trainers • Chiropractic Examiners • Dental Examiners • Dietitians • Environmental Health Specialists • Health Facility Administrators • Medical Licensing • Nursing • Optometry • Pharmacy • Podiatry • Psychology • Social Workers, Marriage & Family Therapists & Mental Health Counselors • Speech-Language Pathology & Audiology • Veterinary Medical • Controlled Substances Advisory Committee • Hearing Aid Dealer Advisory Committee • Hypnotist Committee • Occupational Therapy Committee • Optometric Legend Drug Prescription Advisory Committee • Physical Therapy Committee • Physician Assistant Committee • Respiratory Care Committee

CERTIFIED MARRIAGE RECORD

MARRIAGE RECORD NUMBER 9302437

GROOM JEFFREY TODD MELTZER

BRIDE LEIGH D REGENSTRIEF

APPLICATION DATE 05/13/93

DATE LICENSE PICKED UP 05/13/93

MARRIAGE OFFICIAL DENNIS C SASSO

OFFICIAL TITLE RABBI

DATE OF MARRIAGE 05/13/93

CLERK OF THE MARION CIRCUIT COURT FAYE I. MOWERY

THE CLERK OF THE MARION CIRCUIT COURT HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS AN EXACT COPY OF THE OFFICIAL MARRIAGE RECORD OF THE PARTIES LISTED.



SARAH M. TAYLOR

CLERK OF THE MARION CIRCUIT COURT

RECEIVED


JUL 21 1998

Health Professions Bureau

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
LICENSE, REGISTRATION OR CERTIFICATION RENEWAL
THE MARYLAND BOARD OF PHYSICIAN QUALITY ASSURANCE
CERTIFIES THAT

LEIGH REGENSTRIEF MELTZER
IS AN AUTHORIZED
PHYSICIAN AND SURGEON

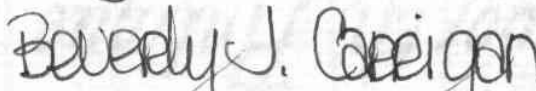
In accordance with H.O.A. Title 8 of the Annotated Code of Maryland

LIC. REG. CERT. NO. D47222	EXPIRATION DATE 09/30/99	
-------------------------------	-----------------------------	---

Martin P. Wasserman, M.D., J.D.
Secretary of Health and Mental Hygiene


SIGNATURE OF BEARER

This is a certified copy of the
original document.



BEVERLY J. CARRIGAN
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires September 6, 1999



RECEIVED

JUL 21 1998

Health Professions Bureau