FLORIDA
DEPARTMENT OF HEALTH
BOARD OF MEDICINE
4052 Bald Cypress Way, Bin #C03
Tallahassee, Florida 32399-3253
(850) 245-4131

MAY 29. '01
AMOUNT

RECEIVED
JUN 4 2001
DEPARTMENT OF HEALTH
BOARD OF MEDICINE

Received Date : 6/1/01
Deposit Date : 6/1/01
Deposit # : 167029
Batch Number : 014478
Validation # : 900195915
Check Amount : $503.00 ✓
PRO_CDE : 1501

1501 MEDICAL DOCTOR
APPLICATION FOR LICENSURE

READ INSTRUCTIONS FOR IMPORTANT INFORMATION (Application is non-refundable)

1. APPLICATION CATEGORY/APPLICABLE FEES: CLIENT 1501
(TYPE OR PRINT LEGIBLY IN BLACK– CHECK APPROPRIATE LICENSURE AVENUE)
[ ] EXAMINATION (1024) (application fee $410, background check $43) Total $453.00
[ ] C-SPEX (1022) (application fee $410, background check $43) Total $453.00
[ ] STATE BOARD EXAM (Prior to 1974) (1022) (application fee $410, background check $43) Total $453.00
[X] ENDORSEMENT (1021) (application fee $460, background check $43) Total$503.00

2. SOCIAL SECURITY NUMBER: [redacted]

3. NAME: SEKHARAN, (Last) NARAYANSWAMI (First) CHANDRA (Middle)

a. Have you ever changed your name through marriage or through action of a court? [ ] YES [X] NO

If 'yes', list name(s) (Last, First, Middle) and Date(s) of changes

b. Have you ever been know by any other name (aliases)? [X] YES [ ] NO

SHEKHARAN, NARAYANSWAMI
If 'yes', list name(s) (Last, First, Middle, and Suffix)

4. MAILING ADDRESS (where you receive mail):

54 MAGNOLIA BLUFF RD. (Street and number or PO Box) | NATCHEZ (City) | MS (State/Province) | 39120 (Zip/Postal Code) | USA (Country)

a. PRIMARY PRACTICE/PHYSICAL ADDRESS (where you can be located):

54 Magnolia Bluff Rd. (Street and number) | NATCHEZ (City) | MS (State/Province) | 39120 (Zip/Postal Code) | USA (Country)

b. TELEPHONE: (601) 443-9012 Home: Area Code/Phone Number (601) 443-9012 Work: Area Code/Phone Number

c. E-MAIL ADDRESS: NSEKHARAN@aol.com

5. PERSONAL DATA:
HEIGHT: 5'6½" WEIGHT: 150 lbs.
EYE COLOR: Brown HAIR COLOR: Black
BIRTH DATE: 12/04/1937 (Month/Day/Year) BIRTH PLACE: Madras/INDIA (City)(State/Province)(Country)

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

6. Are you a citizen of the U.S.? [X] YES [ ] NO

a. If you are a Naturalized citizen please provide date and place of Naturalization:

5/02/1977 & BERRIEN COUNTY, BERRIEN SPRINGS, MICHIGAN
(Month/Day/Year) (City/State/Province/Country)

b. If you are not a U.S. citizen, please provide alien number: _____

7. Have you ever been in the United States Military and/or Public Health Service? [ ] YES [X] NO

_____
If 'yes' list branch of service, rank, dates of service (Enclose copy of discharge form)

a. Have charges, now or ever, been brought against you by any branch of the United States Military and/or Public Health Service? [ ] YES [X] NO
If 'yes' explain on a separate sheet, providing accurate details.

8. Do you hold or have you ever held a license to practice Medicine or any other profession in any US, or foreign country? [ ] YES [X] NO
If 'yes' list State or Country/Profession/License Number (use back of page or attachment)
Verification of each license must be received directly from the licensing authority, regardless of status of license.

_____
State or Country/Profession/License Number

_____
State or Country/Profession/License Number

a. List the year and state/province/country where you legally first began to practice medicine?

_____
(Year) (State/Province/Country)

9. **EDUCATION:** UNDERGRADUATE/GRADUATE MEDICAL EDUCATION – Starting with undergraduate education, list all schools, colleges and universities attended, whether completed or not, in chronological order. Submit a separate sheet of paper if needed.

(College Name/Address)	(Domicile)	(Major/Minor Course of Study)	(From: MM/YY – To: MM/YY)	(Degree Received)
ST. XAVIERS COLLEGE, BOMBAY, INDIA	INDIAN	MICROBIOLOGY/ZOOLOGY	1953 - 1957	B.S.C.

(College Name/Address) (Domicile) (Major/Minor Course of Study) (From: MM/YY – To: M/YY) (Degree Received)

(College Name/Address) (Domicile) (Major/Minor Course of Study) (From: MM/YY – To: MM/YY) (Degree Received)

(College Name/Address) (Domicile) (Major/Minor Course of Study) (From: MM/YY – To: MM/YY) (Degree Received)

10. Doctor of Medicine Degree was obtained from:

DARBHANGA MEDICAL COLLEGE (Name of School/Institution), M.B.B.S. (Degree Title) on 1962 (Month, Day, Year)

11. Have you ever been dropped, suspended, placed on probation, expelled or requested to resign from any school, college or university? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

12. Was attendance in Medical school for a period other than the normal curriculum? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

a. Did you take a leave of absence during medical school? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

b. Were you required to repeat any of your medical education? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

13. **INTERNATIONAL MEDICAL GRADUATES PROVIDE THE FOLLOWING:** CLERKSHIP(S) Be specific: Account for each clerkship. List specific date(s), type of rotation, and name and location of hospital, institution or individual where clerkship was performed or supervised. List affiliate University/College.

(Medical School Rotation; Institution/Individual Address/City/State/Country)	(Affiliate Program)	(From: MM/YY – To: MM/YY)
DARBHANGA MEDICAL COLLEGE	OB/GYN	1962-1963

13a. ECFMG standard certificate or results letter number (list number and date of issuance) 40452 2/09/1966

14. Have you ever taken the National Board Medical Examination(FLEX) and/or USMLE? [X] YES [ ] NO

14a. If 'yes' to question #14, list dates and Examinations taken DEC. 1970

14b. If you are using a combination of National Boards, FLEX, and/or USMLE completed prior to the year 2000, please list which examinations and dates

15. **PROFESSIONAL/POSTGRADUATE EDUCATION:** List in chronological order from date of graduation from Medical school, to present, all professional/postgraduate training (Internship/Residency/Fellowship).

(Program Name and full mailing address required)	(Specialty Area)	(From: MM/YY – To: MM/YY)
WAYNE STATE UNIVERSITY, DETROIT, MICHGAN	OB/GYN	01/1967 – 12/1970

15a. *Have you ever been placed on probation, restrictions, suspension, revocation, modification, allowed to resign, requested to leave, temporarily or permanently or otherwise acted against by a Medical training program prior to completion of training?* [ ] YES [X] NO
(If 'yes', list below and see instructions for required documentation.)

16. PRACTICE/EMPLOYMENT: List in chronological order from date of graduation from medical school to present, all employment, non-employment and/or any unaccounted period of time. (if needed, continue on back of page or a separate page)

(Name and full mailing address of employment)	(Type of Employment)	From: MM/YY To: MM/YY
SEKHARAN & SEKHARAN M.D.P.C. 130 W. NAPIER, BENTON HARBOR, MI	SELF_EMPLOYED	01/1971 - 10/1991
CENTER FOR WOMEN"S HEALTH 49 SGT. S.PRENTISS DR. NATCHEZ, MS 39120	SELF_EMPLOYED	10/1991 - 08/1999
FULL TIME LOCUM TENENS WORK		09/1999 - Present

17a. Have you had responsibility for graduate medical education within the last 10 years? [ ] YES [X] NO

17b. Do you currently hold a faculty appointment at a Medical/health-related institution of higher learning? [ ] YES [X] NO
(If 'yes', complete section 17b)

17c. List any hospital/health institution/clinic or medical facility where you have faculty appointment: N/A.

(Name and full mailing address of Institution)	(Title of Appointment)

18a. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? (If 'yes' complete section 18b) [ ] YES [X] NO

b. List any hospital/health institution/clinic or medical facility where you hold staff privileges (Do Not List Training Privileges).

(Name/mailing address of Facility)	(Type of Privileges)	(Chief of Staff)	From: MM/YY To: MM/YY

b. (Continued)

(Name/mailing address of Facility)	(Type of Privileges)	(Chief of Staff)	From: MM/YY To: MM/YY
(Name/mailing address of Facility)	(Type of Privileges)	(Chief of Staff)	From: MM/YY To: MM/YY

c. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, placed on probation, asked to resign or asked to take a temporary leave of absence or otherwise acted against by any facility? [ ] YES [X] NO
(If 'yes', list below and see instructions for required documentation)

(Name of Institution)	(Date: MM/DD/YY)	(Violation)	(Final Action)	(Under Appeal? Y/N)
(Name of Institution)	(Date: MM/DD/YY)	(Violation)	(Final Action)	(Under Appeal? Y/N)

d. Have you ever been asked, or allowed to resign from any facility in lieu of disciplinary action or during any pending investigations into your practice? [ ] YES [X] NO
(If 'yes', list below and see instructions for required documentation)

(Name/Address of Facility)	(Date: MM/DD/YY)	(Violation/Investigation)	(Reason for Resignation)
(Name/Address of Facility)	(Date: MM/DD/YY)	(Violation/Investigation)	(Reason for Resignation)

e. Have you ever had any staff privileges restricted or not renewed by any facility in lieu of disciplinary action? [ ] YES [X] NO
(If 'yes', list below and see instructions for required documentation)

(Name/Address of Facility)	(Date: MM/DD/YY)	(Circumstances)	(Final Action)
(Name/Address of Facility)	(Date: MM/DD/YY)	(Circumstances)	(Final Action)

19a. CERTIFICATION: Are you certified by any Specialty Board recognized by the American Board of Medical Specialties, or specialty board approved by the Florida Board of Medicine? [X] YES [ ] NO
(If 'yes', list below and enclose a copy of each certification or letter of verification)

(Board Name)	(Certification/Specialty/SubSpecialty)	(Date of Certification)
AMERICAN BOARD OF OB/GYN	OB/GYN	11/16/1973
(Board Name)	(Certification/Specialty/SubSpecialty)	(Date of Certification)

19b. Have you ever applied for, taken an examination for, or failed to receive specialty board certification or recertification for any reason? [ ] YES [X] NO
(If 'yes', explain on a separate sheet, providing full details.)

Notes from
N. C. SEKHARAN, M.D.

ORIGINAL board certification
11/16/1973
Recertification by ACOG in
12/8/1989
1996 and
1999.

19c. Have you ever had any sanctions taken against you by a specialty board or other similar national organization? [ ] YES [X] NO
(If 'yes', list below and see instructions for required documentation.)

(Name of Specialty Board)	(Date: MM/DD/YY)	(Circumstances)	(Final Action)	(Under Appeal? Y/N)
(Name of Specialty Board)	(Date: MM/DD/YY)	(Circumstances)	(Final Action)	(Under Appeal? Y/N)
(Name of Specialty Board)	(Date: MM/DD/YY)	(Circumstances)	(Final Action)	(Under Appeal? Y/N)

ALL AFFIRMATIVE ANSWERS FOR QUESTIONS 20-36 MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

20. Have you had any application for professional license or any application to practice Medicine denied by any state board or other governmental agency of any state, territory, or country? [ ] YES [X] NO

21. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Medical practice act, unprofessional or unethical conduct? [ ] YES [X] NO

22. Have you ever had any professional license or license to practice Medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? [ ] YES [X] NO

(Name of Agency)	(Date: MM/DD/YY)	(Circumstances)	(Final Action)	(Under Appeal? Y/N)
(Name of Agency)	(Date: MM/DD/YY)	(Circumstances)	(Final Action)	(Under Appeal? Y/N)
(Name of Agency)	(Date: MM/DD/YY)	(Circumstances)	(Final Action)	(Under Appeal? Y/N)

23. Have you ever been convicted or found guilty, regardless of adjudication, resolution, or expungement, or pled guilty or Nolo Contendere to a criminal misdemeanor or felony in any jurisdiction? [ ] YES [X] NO
(If 'yes', list below and see instructions for required documentation)

(Offense)	(Date: MM/DD/YY)	(Jurisdiction)	(Final Action)	(Under Appeal? Y/N)
(Offense)	(Date: MM/DD/YY)	(Jurisdiction)	(Final Action)	(Under Appeal? Y/N)
(Offense)	(Date: MM/DD/YY)	(Jurisdiction)	(Final Action)	(Under Appeal? Y/N)

resolution or expungement? [ ] YES [X] NO
(If 'yes', list below and see instructions for required documentation)

(Offense)	(Date: MM/DD/YY)	(Jurisdiction)	(Final Action)	(Under Appeal? Y/N)
(Offense)	(Date: MM/DD/YY)	(Jurisdiction)	(Final Action)	(Under Appeal? Y/N)

25. Have you ever been criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances? [ ] YES [X] NO

26. Have you ever had employment terminated for cause? [ ] YES [X] NO

27. Have you ever been warned or called before the United States Drug Enforcement Agency (DEA)? [ ] YES [X] NO

28. Have you ever been made an offer to compromise or entered into any other arrangement or other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? [ ] YES [X] NO

29. Have you ever been denied, or surrendered a DEA Registration? [ ] YES [X] NO

30. Are you now or have you within the in the last two years enrolled been in, required to enter into or participated in any drug, alcohol or impaired practitioner or recovery program?

31. During the course of your Medical education and training or practice experience, have you undergone counseling, therapy, or treatment for any condition that impacted your ability to function in any educational or practice setting?

32. In the last two years, have you been admitted to or confined within a hospital or institution for the purpose of obtaining treatment or therapy for any condition of any kind during the course of your medical education, training, or practice experience?

33. In the last two years, have you declined to follow the recommendation or request of a physician, counselor, employer, supervisor, training program director or representative that you enter therapy or treatment for any condition?

34. Do you have any condition that might affect your ability to practice your profession or that might affect your ability to safely perform any procedures or tasks that are within the scope of your practice?

35. In the last two years, have you voluntarily or otherwise been a patient in an institution for treatment of any condition, including drug addiction/abuse, or excessive use of alcohol?

37. LIABILITY CLAIMS:

Within the previous ten years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? [X] YES [ ] NO
(If "yes", complete and attach Exhibit I for each occurrence)

38. Have any actions in bankruptcy court or any civil judgements ever been entered against you arising from your professional activity? [ ] YES [X] NO
(If 'yes', list below and see instructions for required documentation)

(Date of Occurance)	(Location)	(Claimant)	(Amount)	(Date of Final Disposition)
(Date of Occurance)	(Location)	(Claimant)	(Amount)	(Date of Final Disposition)
(Date of Occurance)	(Location)	(Claimant)	(Amount)	(Date of Final Disposition)

39. Have you ever been the subject of a lawsuit or insurance claim, settled or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, or employee? [X] YES [ ] NO
(If 'yes', list below and see instructions for required documentation)

*** SEE ATTACHED EXPLANATIONS

(Date of Occurance)	(Location)	(Claimant)	(Amount)	(Date of Final Disposition)
(Date of Occurance)	(Location)	(Claimant)	(Amount)	(Date of Final Disposition)
(Date of Occurance)	(Location)	(Claimant)	(Amount)	(Date of Final Disposition)

40a. List all Medical/Professional Society or Association Memberships:

(Name of Society/Association)	(Mailing Address)	(Dates of Affiliation: From/To)
ACOG	P. O. BOX 96920 WASHINGTON DC 20090-6920	1973 to current
(Name of Society/Association)	(Mailing Address)	(Dates of Affiliation: From/To)
(Name of Society/Association)	(Mailing Address)	(Dates of Affiliation: From/To)
(Name of Society/Association)	(Mailing Address)	(Dates of Affiliation: From/To)

b. Have you ever had an application for membership denied by a Medical Society or Association? [ ] YES [X] NO
(If 'yes', complete section 40e and see instructions for required documentation)

c. Have you ever had a Medical Society or Association membership suspended? [ ] YES [X] NO
(If 'yes', complete section 40e and see instructions for required documentation)

d. Have you ever been notified to appear before a Medical Society or Association regarding charges/complaints filed against you? [ ] YES [X] NO
(If 'yes', complete section 40e and see instructions for required documentation)

41. OPTIONAL INFORMATION:

a. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature within the previous ten years.

(Title)	(Publication)	(Date)
(Title)	(Publication)	(Date)
(Title)	(Publication)	(Date)
(Title)	(Publication)	(Date)

b. DO YOU PARTICIPATE IN THE MEDICAID PROGRAM? N/A [ ] YES [ ] NO
If yes list:

(Type of Provider)	(state)
(Type of Provider)	(state)

c. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES, HONORS OR AWARDS:

(Activity/Honor/Award)	(Organization)
(Activity/Honor/Award)	(Organization)
(Activity/Honor/Award)	(Organization)
(Activity/Honor/Award)	(Organization)

d. LANGUAGES OTHER THAN ENGLISH: Indicate languages other than English used by you to communicate with patients and any translation service available for patients at your primary place of practice.

e. COMMENTS/ADDITIONAL INFORMATION: Any comments/information you want the board to be aware of.

42. AFFIDAVIT OF APPLICANT:

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.083 and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Medicine in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

APRIL 2002

Date of Expiration

N-C-Sethuram 4-27-01

(Signature of Applicant/required) **(Date Signed/required)**

N.C. SEKHARAN, M.D.
54 Magnolia Bluff Road
Natchez, MS 39120
TEL 601-443-9012
FAX 601-442-5318
E-mail nsekharan@aol.com

April 25, 2001

To:
Florida Board of Medicine
4052 Bald Cypress Way Bin#CO3
Tallahassee, FL,32399-3253

Here are my medical school diploma and transcripts that I have. I apologize for the quality of the print but that is all I have.

Sincerely,

N. C. Sekharan

My tracking # is 80451

Bihar University

I, the Vice-Chancellor of the University of Bihar, do hereby make known that Narayan Swami Chandra Shekharam of the Darbhanga Medical College, has this day been admitted to the degrees of Bachelor of Medicine and Bachelor of Surgery, having been first certified by duly appointed Examiners to be qualified to receive the same. I do hereby declare that he is competent and authorised to practise Medicine, Surgery and Midwifery.

The original diploma was granted in Hindi under the signature of the Vice-Chancellor. The English version of the original is [illegible] under proviso to reg. 18 of Chapter II of the Regulations.

Controller of Examinations

Registrar

SUBJECTS OF EXAMINATION

1. Human Anatomy
2. Human Physiology
3. Pharmacology & Materia Medica
4. Forensic Medicine including Toxicology
5. Hygiene & Public Health
6. Pathology & Bacteriology
7. Medicine
8. Surgery
9. Obsetrics, Gynaecology, Diseases of the New-born & Infant Hygiene
10. Ophthalmology & Diseases of the Ear, Nose & Throat

BIHAR UNIVERSITY

The 1st February, 1963

sd/ P. L. Shrivastava.
Vice-Chancellor

State of Mississippi
County of Adams

Lucinda Boswell Okare

Notary Public State of Mississippi At Large
My Commission Expires: January 13, 2002
Bonded Thru Heiden, Brooks & Garland, Inc.

Dr. S. M. Nawab
FRCS, FICS, MRCOG.
Retired Principal,
Darbhanga Medical College.

Phone : 3043
P. O. D. M. C.
DARBHANGA (Bihar)

Dated 9 C 1987

TO WHOM IT MAY CONCERN

This is to certify that I had known Dr.N.C.Sekharan for 5 years although his period of study at Darbhanga Medical College. Further, I can certify that Dr.Narayan Swami Chandra Sekharan, Dr.Narayan Swami Chandra Shekharan and Dr.N.C.Sekharan (or Shekharan) are all one and the same person.

(S. M. Nawab)
Retd. Principal,
Darbhanga Medical College

Countersigned
9/1/91
Principal
Darbhanga Medical College
LAHERIASARAI

30187

THE DEPARTMENT OF HEALTH
FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FLORIDA 32399-3253

APPLICANT COMPLETES #'S 1 THROUGH 4

1. TO: DARBHANGA MEDICAL COLLEGE.
NAME OF MEDICAL SCHOOL

PRINCIPAL DARBHANGA MEDICAL COLLEGE, P.O. D.M.C.
ADDRESS OF MEDICAL SCHOOL

LAHERIASARAI. DIST. DARBHANGA. BIHAR. INDIA.
CITY - STATE - ZIP - COUNTRY

FROM: MEDICAL GRADUATE

MEDICAL SCHOOL: PLEASE COMPLETE NUMBERS 5 AND 6, AND AUTHENTICATE BY SIGNATURE AND SEAL (SCHOOL OR NOTARY). RETURN THIS FORM TO THE FLORIDA BOARD OF MEDICINE. THANK YOU!

2. NAME: NARAYANSWAMI C. SELVARAN S.S.# [redacted]

3. PROFESSION: MEDICAL DOCTOR

4. DATE OF BIRTH: Dec. 4th 1939

5. TYPE OF DEGREE: M.D. DATE DEGREE GRANTED: M.B.B.S.

6. COMMENTS: MBBS IS BACHELOR OF MEDICINE & BACHELOR OF SURGERY AND IS THE GRADUATE DEGREE.

MEDICINE BOARD
2001 MAY 30 AM 11:37

VERIFIED BY S. N. Sinha
SIGNATURE

SEAL
PRINCIPAL
Darbhanga Medical College
LAHERIASARAI

DR. S.N.SINHA.
NAME

PRINCIPAL DARBHANGA MEDICAL COLLEGE
LAHERIASARAI. BIHAR. INDIA. TITLE

Form Number DH MQA1000-1/01

THE DEPARTMENT OF HEALTH
FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FLORIDA 32399-3253

APPLICANT COMPLETES #'S 1 THROUGH 4

1. TO: DARBHANGA MEDICAL COLLEGE
NAME OF MEDICAL SCHOOL

PRINCIPAL DARBHANGA MEDICAL COLLEGE, P.O. D.M.C.,
ADDRESS OF MEDICAL SCHOOL

LAHERIASARAI. DIST. DARBHANGA. BIHAR. INDIA.
CITY - STATE - ZIP - COUNTRY

FROM: MEDICAL GRADUATE

MEDICAL SCHOOL: PLEASE COMPLETE NUMBERS 5 AND 6, AND AUTHENTICATE BY SIGNATURE AND SEAL (SCHOOL OR NOTARY). RETURN THIS FORM TO THE FLORIDA BOARD OF MEDICINE. THANK YOU!

2. NAME: NARAYANSWAMI C. SEKHARAN S.S.# [redacted]

3. PROFESSION: MEDICAL DOCTOR

4. DATE OF BIRTH: Dec. 4th. 1937

5. TYPE OF DEGREE: M.D. DATE DEGREE GRANTED: M.B.B.S.

6. COMMENTS: MBBS IS BACHELOR OF MEDICINE & BACHELOR OF SURGERY AND IS THE GRADUATE DEGREE.

VERIFIED BY S. N. Sinha
SIGNATURE

SEAL PRINCIPAL Darbhanga Medical College LAHERIASARAI

DR. S.N.SINHA
NAME

PRINCIPAL DARBHANGA MEDICAL COLLEGE
LAHERIASARAI. BIHAR. INDIA. TITLE

Form Number DH MQA1000-1/01