APP-SENT 5/10/91

STATE MEDICAL BOARD OF OHIO
REQUEST FOR APPLICATION FORMS

PLEASE TYPE OR PRINT CLEARLY

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

NAME: SEKHARAN (LAST (Surname)) NARAYANSWAMI (FIRST) C. (MIDDLE) (SUFFIX (Jr.,II))

ADDRESS: 130- WEST (STREET & NUMBER) NAPIER (CITY) BENTON HARBOR (STATE) MICH (ZIP) 49022 (COUNTRY)

TELEPHONE: BUSINESS: (616) 929-4445 (AREA CODE & NUMBER) HOME: (616) 429-4906 (AREA CODE & NUMBER)

BIRTH DATE: 12/04/1931 (MO/DAY/YR) BIRTH PLACE: MADRAS (CITY) INDIA (STATE/COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: DARBHANGA MEDICAL COLLEGE (SCHOOL NAME) - BIHAR (STREET ADDRESS) - INDIA (CITY STATE COUNTRY)

8/23/57 (FROM: MO/DAY/YR) 4/30/62 (TO: MO/DAY/YR) MBBS (DEGREE RECEIVED) 02/01/63 (DATE RECEIVED: MO/DAY/YR)

OTHER MEDICAL SCHOOLS ATTENDED: (IF "NONE ENTER "NONE") NONE (SCHOOL NAME STREET ADDRESS CITY STATE COUNTRY)

8/23/57 (FROM: MO/DAY/YR) 4/30/62 (TO: MO/DAY/YR) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

(SCHOOL NAME STREET ADDRESS CITY STATE COUNTRY)

/ / (FROM: MO/DAY/YR) / / (TO: MO/DAY/YR) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

E.C.F.M.G. CERTIFICATE: YES X NO ____ NUMBER 40452 DATE ISSUED 2/19/66

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: (IF "NONE", ENTER "NONE") NONE (HOSPITAL OR INSTITUTION) AFFILIATED WITH: (NAME OF MEDICAL SCHOOL)

ADDRESS: (STREET & NUMBER CITY STATE ZIP) DATE: / / (FROM) / / (TO)

QUALIFYING EXAM TAKEN: DATE: / /

POSTGRADUATE TRAINING

LIST ALL POSTGRADUATE TRAINING (INTERNSHIP, RESIDENCY OR CLINICAL FELLOWSHIP), UNDERTAKEN IN THE U.S. OR CANADA. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

HOSPITAL: BERGEN PINES COUNTY HOSPITAL (NAME) PARAMUS (STREET ADDRESS) N.J. (CITY STATE)

POSITION: INTERNSHIP DEPARTMENT: ____ DATE: 12/20/1965 (FROM: MO/YR) 12/20/66 (TO: MO/YR)

HOSPITAL: WAYNE STATE UNIV. DEPT OF OBGYN. HUTZEL HOSP. (NAME) DETROIT (STREET ADDRESS) MICH (CITY STATE)

POSITION: RESIDENCY DEPARTMENT: OBGYN. DATE: 1/1/67 to 12/30/70 (FROM: MO/YR) (TO: MO/YR)

HOSPITAL: (NAME STREET ADDRESS CITY STATE)

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

HOSPITAL: (NAME STREET ADDRESS CITY STATE)

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

LICENSES IN OTHER COUNTRIES

LIST ALL FOREIGN COUNTRIES IN WHICH YOU HOLD OR HAVE HELD A FULL RIGHT TO PRACTICE MEDICINE AND SURGERY. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

COUNTRY:_____ ISSUE DATE: __/__/__ LICENSE #_____ CURRENT:YES__ NO__

COUNTRY _____ ISSUE DATE: __/__/__ LICENSE #_____ CURRENT:YES__ NO__

LICENSES IN THE UNITED STATES

LIST ALL STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY. INDICATE THE LICENSE NUMBER, DATE OF ISSUANCE, WHETHER OR NOT THE LICENSE IS CURRENT, AND THE BASIS OF LICENSURE (E.G., FLEX EXAM, ENDORSEMENT OF OTHER STATE LICENSE, ENDORSEMENT OF DIPLOMATE STATUS, ETC.) IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

STATE: MICHIGAN ISSUE DATE: 6/3/93 LICENSE #: 031864 CURRENT:YES X NO__

BASIS OF LICENSURE: FLEX

STATE: _____ ISSUE DATE: __/__/__ LICENSE #: _____ CURRENT:YES__ NO__

BASIS OF LICENSURE: _____

STATE: _____ ISSUE DATE: __/__/__ LICENSE #: _____ CURRENT:YES__ NO__

BASIS OF LICENSURE: _____

STATE BOARD OR FLEX EXAMINATIONS TAKEN

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

FLEX
~~STATE~~: _____ DATE TAKEN: 12/2 to 12/4/93 PASS: X FAIL: ____ FULL ( ) PARTIAL ( )

STATE: _____ DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

STATE: _____ DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

ADDITIONAL ELIGIBILITY INFORMATION - ANSWER ALL QUESTIONS

DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS? PENDING ___ (YES) ✓ NO ___ DATE 12/93

DIPLOMATE OF THE NATL BOARD OF OSTEO MEDICAL EXAMINERS? PENDING ___ YES ___ NO ___ DATE __/__

ARE YOU APPLYING TO SIT FOR THE FLEX EXAM IN OHIO? YES ___ NO X

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

A U.S. CITIZEN? YES X NO ___ BASIS OF CITIZENSHIP NATURALIZED DATE: 5/2/1997

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

DEGREE OBTAINED (CHECK ONLY ONE): ACTA_____ TITULO_____ MEDICO CIRUJANO_____

HAVE YOU ACHIEVED A SCORE OF AT LEAST TWO HUNDRED THIRTY (230) ON THE TEST OF SPOKEN ENGLISH OF THE EDUCATIONAL TESTING SERVICE AS REQUIRED UNDER SECTION 4731.09, O.R.C.? (THE TOEFL, ECFMG EXAM, etc., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TSE) YES___ NO X

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

IF YES, GIVE FULL ADDRESS AT THAT TIME:

_____

STREET ADDRESS CITY STATE ZIP

CERTIFICATION

I, N.C. SEKHARAN, HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING REQUEST FOR APPLICATION FORM; THAT THE STATEMENTS THEREIN ARE STRICTLY TRUE IN EVERY RESPECT AND THAT I HAVE READ AND UNDERSTAND THIS CERTIFICATION.

N.C. Sekharan 3/22/91

SIGNATURE DATE

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

APPLICATION FOR MEDICAL & OSTEOPATHIC LICENSURE

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

ALL RESPONSES MUST BE TYPED

1. SOCIAL SECURITY NUMBER: Redacted

2. FULL NAME (Use no initials): SEKHARAN (LAST (Surname)) NARAYANSWAMI (FIRST) CHANDRA (MIDDLE) ____ (SUFFIX (Jr., II))

3. NAME (As you prefer it inscribed on your Ohio license): SEKHARAN (LAST (Surname)) N. (FIRST) C. (MIDDLE) ____ (SUFFIX (Jr., II))

4. ALTERNATE NAMES (IF "NONE" ENTER "NONE"): NONE (LAST (Surname)) ____ (FIRST) ____ (MIDDLE) ____ (SUFFIX (Jr., II))

5. CURRENT ADDRESS: 130. W. NAPIER (STREET NUMBER & NAME) BENTON HARBOR (CITY) MI (STATE) 49022 (ZIP CODE) ____ (COUNTRY)

6. PHYSICAL DESCRIPTION: 5ft 7" (HEIGHT) 148 lbs. (WEIGHT) BLACK (HAIR COLOR) BROWN (COLOR OF EYES) — (IDENTIFYING MARKS)

7. SEX: MALE [✓] FEMALE [ ] FOR STATISTICS ONLY (Optional)

8. CITY IN OHIO WHERE YOU PLAN TO PRACTICE: MILLERSBURG (CITY) ____ (OR) ____ (COUNTY)

PLANS OF PRACTICE: ____

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

NAME OF SPECIALTY BOARD	BOARD CERTIFIED YES	BOARD CERTIFIED NO	YEAR CERTIFIED	COUNTRY
ABOG	[✓]	[ ]	1973/1989	
	[ ]	[ ]		
	[ ]	[ ]		

FOR OFFICE USE ONLY 34 Md 35

1-5
38-6-100
5-12-91
185.00 fee 1720

91 MAY 17 AM 10:55 STATE MEDICAL BOARD

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

ADDITIONAL INFORMATION

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

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

13.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[✓]
14.	Have you ever been treated but not hospitalized, for emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[✓]
15.	Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, been requested to appear before or fined by the responsible agency?	[ ]	[✓]
16.	Have you ever been convicted or been found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	[ ]	[✓]
17.	Have you ever forfeited collateral, bail or bond for breach or violation of any law, police regulation, or ordinance other than for minor traffic violation, been summoned into court as a defendant, or had any lawsuit (other than malpractice suit) filed against you?	[ ]	[✓]
18.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf or paid such a claim yourself?	[✓]	[ ]
19.	Have you ever been denied, or relinquished, participation in any third party reimbursement program, whether governmental or private, or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	[ ]	[✓]
20.	Have you ever been denied licensure, application for licensure, or privilege of taking examination, or withdrawn any application, in any state, territory, province, or country for any reasons?	[ ]	[✓]

AD

FORM 1

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, ABRAHAM KOSHY, a licensed and practicing physician in the state of
Name of Recommending Physician
MICHIGAN affirm that N. C. SEKHARAN, has been known
Name of Applicant
to me personally and professionally for ≥ 20 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Very good
His/her command of the English language is: Excellent
I rate his/her ability to work well with peers and medical staff as: Good
His/her relationship with patients is: Good
Additional comments: _____

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

Signature of Recommending Physician

ABRAHAM KOSHY
Name of Recommending Physician
(Please print or type)

2620 NILES RD, ST-JOSEPH MICH 49085
Address of Recommending Physician
(Include City, State, Zip)

(616) 429-2242
Telephone Number
(Include Area Code)

ELSIE ADELE RANTZ
(SEAL) Notary Public, Berrien County, Michigan
My Commission Expires Sept. 24, 1994

MICHIGAN 0327 32
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 28 day of May, 19 91.

Elsie Adele Rantz
Notary Public

9-24-94
Date Commission Expires

SPORT COLOR
RE

Signature of Applicant

March 1991
Date Photo Taken

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

STATE MEDICAL BOARD OF OHIO
91 JUN -3 AM 10:56

FORM 1

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, William Leshey, a licensed and practicing physician in the state of
Name of Recommending Physician
Michigan affirm that Narayanswami C. Sekharan, has been known
Name of Applicant
to me personally and professionally for 17 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: excellent
His/her command of the English language is: excellent
I rate his/her ability to work well with peers and medical staff as: excellent
His/her relationship with patients is: excellent
Additional comments: _____

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

William Leshey
Signature of Recommending Physician

2985 Bluffwood Ter
St. Joseph, Mi 49085
Address of Recommending Physician
(Include City, State, Zip)

William Leshey
Name of Recommending Physician
(Please print or type)

616 9838292
Telephone Number
(Include Area Code)

Michigan 033805
State of Licensure and License Number
of Recommending Physician

(SEAL) ELSIE ADELE RANTZ
Notary Public, Berrien County, Michigan
My Commission Expires Sept. 24, 1994

Subscribed and sworn to this 3 day of July, 19 91.

Elsie Adele Rantz
Notary Public

9-24-94
Date Commission Expires

N. C. Sekharan
Signature of Applicant

March 1991
Date Photo Taken

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

STATE MEDICAL BOARD OF OHIO
91 JUL -5 PM 2:32

AD

FORM 1

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, ABRAHAM KOSHY, a licensed and practicing physician in the state of
Name of Recommending Physician
MICHIGAN affirm that N. C. SEKHARAN, has been known
Name of Applicant
to me personally and professionally for _____ years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Very Good
His/her command of the English language is: Excellent
I rate his/her ability to work well with peers and medical staff as: Good
His/her relationship with patients is: Good
Additional comments: _____

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

A. KOSHY
Signature of Recommending Physician

ABRAHAM KOSHY MD
Name of Recommending Physician
(Please print or type)

2820 NILES RD, ST. JOSEPH MICHIGAN 49085
Address of Recommending Physician
(Include City, State, Zip)

(616) 429-7242
Telephone Number
(Include Area Code)

(SEAL) ELSIE ADELE RANTZ
Notary Public, Berrien County, Michigan
My Commission Expires Sept. 24, 1994

032732 MICHIGAN
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 28 day of May, 1991.

Elsie Adele Rantz
Notary Public

9-24-94
Date Commission Expires

RT COLOR

Signature of Applicant

March 1991
Date Photo Taken

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

91 MAY 31 PM 12:59
STATE MEDICAL BOARD OF OHIO

AD

FORM 2

CERTIFICATE OF POST-GRADUATE TRAINING

MAIL TO HOSPITAL OR INSTITUTION OF POSTGRADUATE TRAINING IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice medicine in the State of Ohio. The State Medical Board of Ohio requires that my postgraduate training be certified. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

This certifies that N. C. SEKHARAN (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[ ] intern
[✓] resident in OB-GYN (Department)
[ ] clinical fellow

at WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE AFFILIATED HOSPITALS (Name of Hospital) (Complete Address of Hospital)

from JAN 1 1967 (beginning (month/day/year)) to DEC 31 1970 (ending (month/day/year)). It is further certified that the above name

[✓] was awarded a certificate on DEC 31 1970 (month/day/year)
[ ] was not

and that the training

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

(SEAL OF HOSPITAL)

Signature of Medical Director or Program Director
(Original signatures only, name stamps will not be accepted)

David B. Cotton, M.D.
Name (Please print or type)

May 16, 1991
Date

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

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

AD

FORM 2

CERTIFICATE OF POST-GRADUATE TRAINING

MAIL TO HOSPITAL OR INSTITUTION OF POSTGRADUATE TRAINING IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice medicine in the State of Ohio. The State Medical Board of Ohio requires that my postgraduate training be certified. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

This certifies that N. C. SEKHARAN (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[X] intern
[ ] resident in _____ (Department)
[ ] clinical fellow

at BERGEN PINES COUNTY HOSPITAL (Name of Hospital), PARAMUS - N. JERSEY (Complete Address of Hospital)

from ~~DEC~~ 1965 20th (beginning month/day/year) to DEC 1966 20th (ending month/day/year). It is further certified that the above name

[✓] was awarded a certificate on DEC 20 1966 (month/day/year)
[ ] was not

and that the training

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

X M Menacker MD
Signature of Medical Director or Program Director
(Original signatures only, name stamps will not be accepted)

(SEAL OF HOSPITAL)

MOREY Menacker D.O.
Name (Please print or type)

MAY 17 1991
Date

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

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

STATE MEDICAL BOARD
91 MAY 22 AM 11:18

STATE OF MICHIGAN

John Engler, Governor

DEPARTMENT OF LICENSING AND REGULATION
Kathleen M. Wilbur, Director

P.O. Box 30018
Lansing, Michigan 48909
Telephone: (517) 373-1870
Telecommunication Device for the Deaf (517) 335-4478

MICHIGAN BOARD OF MEDICINE
(517) 373-9102

MARCH 21, 1991

STATE OF OHIO MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

CERTIFICATION OF LICENSURE

I hereby certify that a standard search of the available records of the Michigan Department of Licensing and Regulation, Bureau of Health Services indicates the following:

NARAYANSWAMI C SEKHARAN, M.D.

WAS ISSUED LICENSE NO:	**031864**
ISSUED ON:	**6-7-73**
TO PRACTICE AS A:	**MEDICAL DOCTOR**
LICENSURE STATUS IS:	**CURRENT UNTIL 1-31-94**
ISSUED ON THE BASIS OF:	**FLEX**
REGULATORY INFORMATION:	

The above format is the standard format prepared for all the professions regulated by this Bureau. If other information is needed, please contact this office at (517) 373-0680.

Sincerely,

Grace Schlak

Grace Schlak
Administrative Support Staff

Fee Received: 3-11-91

STATE OF MICHIGAN

JOHN ENGLER, Governor
XXXXXXXXXXXXXXXXXXXXXXXXXXXX

DEPARTMENT OF LICENSING AND REGULATION
Kathleen M. Wilbur, Director
XXXXXXXXXXXXXXXXXXXXXXXXXXXX
P.O. Box 30018
Lansing, Michigan 48909
Telephone: (517) 373-1870
Telecommunication Device for the Deaf (517) 335-4478

March 27, 1991

Ohio Medical Board
77 S. High St., 17th Floor
Columbus, Ohio 43215

Dear Medical Board: RE: Narayanswami C Sekharan, M.D.

In response to your recent Freedom of Information Act request in the above matter, this is to inform you that:

XXXX based on the spelling provided, we have no record of any formal complaints or disciplinary action against the referenced individual(s).

____ your request for licensing information has been referred to the appropriate Licensing Board.

____ we have attached the following documents:

Many of our documents have been reduced to microfiche. As a result the attached documents may be in the form of microfiche rather than paper. We apologize for any inconvenience this may cause. If you do not have a microfiche viewer readily available, it is our understanding that many libraries have viewers available for public use.

If you have any questions regarding the attached information, please do not hesitate to contact me.

Sincerely,

Mary Ann Fillis

MaryAnn Fillis, Staff Assistant
Health Investigation Division
Bureau of Health Services
(517) 335-1765

STATE OF MICHIGAN

Telephone: (517) 373-1870
Telecommunication Device for the Deaf:
(517) 335-4478

JOHN ENGLER, Governor

DEPARTMENT OF LICENSING AND REGULATION

P.O. BOX 30018, LANSING, MICHIGAN 48909
KATHLEEN M. WILBUR, Director

MICHIGAN BOARD OF MEDICINE
(517) 373-9102

MAY 21, 1991

OHIO STATE MEDICAL BOARD
RAY Q. BUMGARNER, EXECUTIVE DIRECTOR
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43215

CERTIFICATION OF LICENSURE

I hereby certify that a standard search of the available records of the Michigan Department of Licensing and Regulation, Bureau of Health Services indicates the following:

NARAYANSWAMI C. SEKHARAN, M.D.

WAS ISSUED LICENSE NO:	031864
ISSUED ON:	6-7-73
TO PRACTICE AS A:	*MEDICAL DOCTOR*
LICENSURE STATUS IS:	*EXPIRES:* 1-31-94
ISSUED ON THE BASIS OF:	FLEX
REGULATORY INFORMATION:	NONE

The above format is the standard format prepared for all the professions regulated by this Bureau. If other information is needed, please contact this office at (517) 373-0680.

Sincerely,

Grace Schlak

Grace Schlak
Administrative Support Staff

Fee Received: 5-15-91

FORM 3

CERTIFICATE OF STATE BOARD

TO ALL STATE BOARDS-DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED

This form must be completed for applicants who are applying for endorsement of another state license.

Acting on behalf of the _____
Name of State Board

I do hereby certify that Dr. N. C. SEKHARAN
Name of Licensee

was on the _____ day of _____ 19____, granted a license to practice _____ in the State of _____ based upon written examination of:

[ ] FLEX Examination administered in this state

[ ] Examination administered in _____, but accepted as if taken in this state

[ ] Written examination prepared by this state

[ ] Other (Please specify)_____

***License current? Yes____ No____ If not, please explain_____

I further certify that the aforesaid physician in his/her written examination before this Board on _____, obtained a general average of _____or a FLEX Weighted Average of _____ in the following subjects:

SUBJECT	PERCENTAGE	SUBJECT	PERCENTAGE

or a Component I score of_____on _____ and Component II score of _____on _____
month/year month/year

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 details. Include information as to whether licensee is aware of investigation.

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 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 details.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

_____
Signature of Secretary, President or Executive Secretary, Original signatures only, name stamps will not be accepted.

Upon completion, return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

_____
Date

AFFIDAVIT AND RELEASE

AFFIDAVIT AND
RELEASE OF
APPLICANT

The affidavit and release below must be completed by ALL applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being returned to you.

ss STATE OF MICHIGAN

COUNTY OF BERRIEN

I, N. C. SEKHARAN hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and the Routes to Licensure and I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable or transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that failure to complete this application as requested by the Board within six months can be considered as abandonment of any request for licensure and that any fee I submitted is not refundable or transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives, and any person furnishing information, any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization, or similar institution; or to any professional association.

I further understand that a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained therein or to be furnished, which if false, can subject me to permanent denial of said certificate.

N. C. Sekharan
Signature of Applicant

Subscribed and sworn to before me this 13th day of May 19 91.

Elsie Adele Rantz
Notary Public Signature

ELSIE ADELE RANTZ
Notary Public, Berrien County, Michigan
My Commission Expires Sept. 24, 1994
(NOTARY SEAL)

September 24, 1994
Date Commission Expires

PRELIMINARY EDUCATION FORM

38-6

My name IN FULL is SEKHARAN (LAST) NARAYANSWAMI (FIRST) C. (MIDDLE)

High School or Equivalent: ST. STANISLAUS HIGH SCHOOL (SCHOOL NAME) BOMBAY (CITY) INDIA (STATE) (COUNTRY)

7, 1942 (FROM: MO/YR) 6/1953 (TO: MO/YR) (DEGREE)

Undergraduate College or Equivalent: ST. XAVIER'S COLLEGE (SCHOOL NAME) BOMBAY (CITY) INDIA (STATE) (COUNTRY)

1953 (FROM: MO/YR) 1957 (TO: MO/YR) BACHELOR OF SCIENCE (DEGREE)

(SCHOOL NAME) (CITY) (STATE) (COUNTRY)

/ (FROM: MO/YR) / (TO: MO/YR) (DEGREE)

Medical School of Graduation: Bihar Univ. DARBHANGA MEDICAL COLLEGE (SCHOOL NAME) BIHAR (CITY) INDIA (STATE) (COUNTRY)

8, 57 (FROM: MO/YR) 4, 62 (TO: MO/YR) MD (DEGREE)

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 78759

DATE ISSUED: 6-18-91

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

Kay L. Bumgarner
Entrance Examiner

Henry G. Cramblett M.D.
Secretary

The Federation of State Medical Boards

of the United States

INCORPORATED

6000 WESTERN PLACE, SUITE 707
FORT WORTH, TEXAS 76107-4618
(817) 735-8445

To: Ohio State Medical Board.

Subject: Examination and Board Action History Report 2nd Copy

NARAYANSWAMI CHANDRA SEKHARAN
130 WEST NAPIER
BENTON HARBOR, MI
49022

Alternate name(s)
SEKHARAN,N C
SEKHARAN,NARAYANSWAMI

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

FIN: 371204501 Date of Certification: 05/21/91

EXAMINATION DATE: 12/70
STATE TAKEN FOR: 123

BASIC SCIENCE

Anatomy:	70.00
Physiology:	66.00
Biochemistry:	66.00
Pathology:	77.00
Microbiolgy:	73.00
Pharmacology:	68.00
Behavioral Science:	.00
BASIC SCIENCE AVE.:	70.00

CLINICAL SCIENCE

Medicine:	76.00
Surgery:	78.00
Obstetrics:	92.00
Public Health:	71.00
Pediatrics:	71.00
Psychiatry:	63.00
CLINICAL SCIENCE AVG.:	75.20
CLINICAL COMPETENCE AVG.:	78.50
FLEX WEIGHTED AVG.:	76.00

Furthermore: *
A search of the Federation's Board Action D
Bank reveals no reported disciplinary infr
on the above named physician.

STATE MED
91 MAY 28 AM 10:0

msb

ddi

The Federation of State Medical Boards

of the United States

INCORPORATED

6000 WESTERN PLACE, SUITE 707
FORT WORTH, TEXAS 76107-4618
(817) 735-8445

To: Ohio State Medical Board.

Subject: Examination and Board Action History Report

NARAYANSWAMI SEKHARAN

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

FIN: 371204501 Date of Certification: 03/14/91

EXAMINATION DATE: 12/70
STATE TAKEN FOR: 123

BASIC SCIENCE

Anatomy:	70.00
Physiology:	66.00
Biochemistry:	66.00
Pathology:	77.00
Microbiolgy:	73.00
Pharmacology:	68.00
Behavioral Science:	.00
BASIC SCIENCE AVE.:	70.00

CLINICAL SCIENCE

Medicine:	76.00
Surgery:	78.00
Obstetrics:	92.00
Public Health:	71.00
Pediatrics:	71.00
Psychiatry:	63.00
CLINICAL SCIENCE AVG.:	75.20
CLINICAL COMPETENCE AVG.:	78.50
FLEX WEIGHTED AVG.:	76.00

* *

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

Mercy

STATE MEDICAL BOARD OF OHIO

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

DATE June 17, 1991

Dear Doctor:

Dr. Narayanswami C. Sekharan, MD who is/was Active Staff Physician-OB/GYN-1-71 to 5-91 is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. This form must be completed and returned to our office within two (2) weeks to ensure processing of the doctor's application. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 17 yrs

(2) What is/was your supervisory capacity? none

(3) At what hospital? Mercy Memorial Medical Center Inc.

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

(5) In your opinion, is this doctor a person of good moral and ethical character? yes

(6) Does this doctor work well with peers and medical staff? fairly well

(7) Does he/she relate well to patients? OK

(8) How is his/her command of the English language? (if applicable) good

(9) Would you recommend this doctor for licensure? yes

Additional comments, please: (if needed, an extra sheet of paper may be used)

Please return this form to the Ohio State Medical Board at the above address,
Sincerely,

April R. Woody
April Woody
Licensure Assistant

STATE MEDICAL BOARD
91 AUG 15 AM 8:35

R Brown
Signature of Doctor, please type or print name legibly beneath

Robert Brown MD
Vice Chairman,
Department of OB/GYN
Position

Telephone No. _____ (Include Area Code)

BIHAR UNIVERSITY

DARBHANGA MEDICAL COLLEGE LAHERIASARAI (BIHAR INDIA)

*******.

1. Name.	Shri N.C. Shekharan.	
2. Date of joining the College. ...	23rd August, 1957.	
3. Date of passing Intermediate M.B.B.S. Examination.	March, 1959.	
4. Date of passing Final M.B.B.S. Part I, Examination.	March, 1961.	
5. Date of passing Final M.B.B.S. Part II, Examination.	April, 1962.	
6. Prize Medal Certificate of Honours...	1. Awarded College Gold Medal for the best actor in Drama in the year 1961.	
	2. Got University Honours in Anatomy in the Intermediate M.B.B.S. Examination, 1959.	
	3. Got University Honours in Pharmacology & Forensic Medicine in the Final M.B.B.S Part I Examination, 1961.	
	4. Got Class Honours in Pharmacology durin the year 1960-61.	
7. Scholarship & Other Distinctions...	1. Got first Merit Scholarship during the year 1960-61. & 1961-62.	
	2. Stood first in the University First M.B.B.S. Examination held in the month of March, 1959.	
	3. Stood First in the University Final M.B.B.S. Part I Examination held in the month of March, 1961.	
	4. Stood Second in the University Final M.B.B.S. Part II Examination held in the month of April, 1962.	
8. Extra-Curricular Activities. ...	1. Represented Bihar University in 1952 in the Inter University Youth Festival.	
	2. Represented Darbhanga Medical College in all India Dramatic Competition held under the Angpices of the Himanchal Theatre Simla and received prize for the best makeup and supporting actor.	
	3. Represented Bihar University in the Inter College Youth Festival in the year 1961 in English Debate .	
9. General Remarks.	He bears a good moral character.	

This Copy is a true copy of original document
Elsie Adele Rantz - 7-1-91
ELSIE ADELE RANTZ
Notary Public, Berrien County, Michigan
My Commission Expires Sept. 24, 1994

DARBHANGA MEDICAL COLLEGE
No. 2536
Date 2.5.63
LAHERIASARAI

LAHERIASARAI
Dated, the .....1963.
5. 2. 63

(T.P. Gupta)
D.T.C., D.C.M.S. (Lond)
Principal & Dean,
Faculty of Medicine
Darbhanga Medical College .

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATE

3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A. ☐ PHONE: 215 386-5900 ☐ CABLE: EDCOUNCIL, PHILADELPHIA

REQUEST FOR VERIFICATION FROM THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG)

Please complete items 1, 2 and 3 and send this form with a self-addressed envelope to ECFMG. ECFMG will complete items 4, 5 and 6 and return the form to you.

To be Completed by Official Requesting Verification:

FROM: (1) April R. Woody
Name
Asst. to Chief of Licensure
Title

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

TO: CORRESPONDENCE DEPARTMENT
EDUCATIONAL COMMISSION FOR
FOREIGN MEDICAL GRADUATES
(ECFMG)
3624 MARKET STREET, 4TH FLOOR
PHILADELPHIA, PA 19104-2685

(2) APPLICANT'S NAME: Narayanswami C. Sekharan, MD

(3) ECFMG NUMBER: 40452 corrigan

To be Completed by ECFMG:

(4) EXAMINATION RESULTS: ECFMG (77)

(5) ECFMG CERTIFICATE ISSUED: 4/8/66

(6) CERTIFICATE VALID THROUGH: indefinitely

VERIFIED BY: Maureen Tuen
Correspondence Department

DATE: 7/2/91

Corr. Form 236
June 1987

THE EDUCATIONAL COUNCIL
FOR
FOREIGN MEDICAL GRADUATES

SPONSORED BY

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
AMERICAN HOSPITAL ASSOCIATION
AMERICAN MEDICAL ASSOCIATION
FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES

CERTIFIES THAT

N. C. SEKHARAN

HAS SATISFIED ALL THE REQUIREMENTS OF THE COUNCIL
HAS SUCCESSFULLY PASSED ITS EXAMINATION
AND HAS BEEN AWARDED

CERTIFICATE NO. 40452

James C. McGuinness — PRESIDENT
G. Halsey Hunt — EXECUTIVE DIRECTOR

EVANSTON, ILLINOIS, U.S.A., FEBRUARY 9, 1966

I HEREBY CERTIFY THIS
IS A TRUE AND CORRECT COPY
OF THE ORIGINAL.
Roberta Burden
NOTARY PUBLIC

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

K. L. Verma
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

s/d P. L. Shrivastava.
Vice-Chancellor

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
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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

RESUME

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time you must state on the resume exactly what your activities were, such as "vacation" or "looking for residency program", as well as your permanent address for this period. For any time in which you worked for an "emergency medical group" or did locum tenens you must list all hospitals where you worked. If in private practice, indicate the hospitals where you hold or have held privileges and include complete addresses. Failure to include complete addresses will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

Sekharan

DATES IN CHRONOLOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
a. JAN 66 (month year) TO DEC 66 (month year)	BERGEN PINES COUNTY HOSPITAL Hospital/University/Other PARAMUS – N. JERSEY Street Address City/State Zip	MIXED INTERNSHIP	100%	
b. JAN 67 (month year) TO DEC 70 (month year)	WAYNE STATE UNIVERSITY Hospital/University/Other DETROIT, MICH Street Address City/State Zip	OB-GYN RESIDENT.	100%	
c. JAN 71 (month year) TO MAY 91 (month year)	MERCY MEMORIAL MEDICAL CENTRE Hospital/University/Other ST. JOSEPH – MICH Street Address City/State Zip	ACTIVE STAFF PHYSICIAN OB-GYN DEPT. CONSULTANT		
d. (month year) TO (month year)	Hospital/University/Other Street Address City/State Zip			
e. (month year) TO (month year)	Hospital/University/Other Street Address City/State Zip			

Test of Spoken English
OFFICIAL SCORE REPORT

NOTE: If you have any reason to believe that someone has tampered with this score report, please call toll free, 800-257-9547 to have the scores verified. Officials from Alaska, Hawaii, Pennsylvania, or Canada should call collect 215-750-8050. Remember, scores more than two years old cannot be verified. Photostat copies should not be accepted.

SCORES			
3.0	3.0	3.0	300
PRONUNCIATION	GRAMMAR	FLUENCY	OVERALL COMPREHENSIBILITY

EXAMINEE'S ADDRESS:

SEKHARAN NARAYANSWAM 4025459
130 WEST NAPIER AVE

BENTON HARBOR MI
49022

REGISTRATION NUMBER	NAME (Family or Surname, Given, Middle)
4025459	SEKHARAN NARAYANSWAM

TEST DATE (Month / Year)	CENTER NUMBER
JUL 91	X823

DATE OF BIRTH (Month/Day/Year)	SEX
12/04/37	M

INSTITUTION CODE
9636

NATIVE COUNTRY
INDIA

DEPARTMENT CODE: 99

DEPARTMENT NAME:
NOT LISTED

NATIVE LANGUAGE
TAMIL

SEE OTHER SIDE FOR EXPLANATION OF SCORES

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

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

X N. C. Sekharan 6/17/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2434	$160.00	07/01/92

NARAYANSWAMI C SEKHARAN,M.D.
130 W NAPIER
BENTON HARBOR MI 49022

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

PROCESSED 06/30/92

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

49 SGT S PRENTISS DR
STREET
STREET
NATCHEZ MS 39120
CITY STATE ZIP CODE
ADAMS
COUNTY

:96969696 2: 093506 2434 " "00000 16000"

PRINCIPAL
FROM THE

49 56
Street

Street
NATCH
City
ADAMS
County

HAVE YOU
PLED GU

YES NO
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☐ ☒

AT ANY TI
LAST APP
YOUR CE

YES NO
☐ ☒

YES NO
☐ ☑

YES NO
☐ ☒

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X N. C. Sekharan 3/29/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2434	$250.00	05/01/94

NARAYANSWAMI C SEKHARAN,M.D.
49 SGT. SOUTH PRENTISS DRIVE
NATCHEZ MS 39120

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: 093506 2434 " "00000 25000"

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

Street

Street

City *State* *Zip Code*

County

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

YES *NO*

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

YES *NO*

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

YES *NO*

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

YES *NO*

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES *NO*

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES *NO*

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

YES *NO*

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

YES *NO*

8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X N-C-Sekharan
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2434	$250.00	05/01/96

NARAYANSWAMI C SEKHARAN,M.D.
49 SGT. SOUTH PRENTISS DRIVE
NATCHEZ MS 39120

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

PROCESSED BY ARBYSCAN

☒ SPECIALTY CODE(S) CORRECT AS LISTED

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

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 093506 2434" "00000 25000"

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

Street

Street

City State Zip Code

County

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

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

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

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

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

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

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

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

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

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 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 N-C-Sekharan
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2434-S	$179.00	05/01/98

NARAYANSWAMI C SEKHARAN,M.D.
49 SGT. SOUTH PRENTISS DRIVE
NATCHEZ MS 39120

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
P O BOX 17880
STREET
NATCHEZ MS 39122
CITY STATE ZIP CODE
ADAMS
COUNTY

:969696962: 093506 2434 :00000 17900:

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

Street

Street

City State Zip Code

County

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

YES NO

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

YES NO

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

YES NO

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

YES NO

☐ ☒ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO

☐ ☒ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO

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

YES NO

☐ ☒ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO

☐ ☒ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

[redacted]

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-1999 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 N-C, Sekharan 2/18/99
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2434-S	$305.00	10/01/99

NARAYANSWAMI C SEKHARAN,M.D.
PO BOX 17880
NATCHEZ MS 39122

35-06-2434-S $305.00 8-5-99

P $45

:96969696 21:

093506 2434 " "0000030500"

I wish to apply for Emeritus status: ☐

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

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

Street: 10 SGT S PRENTISS DRIVE

Street:

City: NATCHEZ State: MS Zip Code: 39120

County: ADAMS

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

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

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

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

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

YES ☐ NO ☒ 5.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?

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

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

[redacted]

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43216 - 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 1999-2001 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 N-C. Sekharan
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-2434-S	$305.00	10/01/01

NARAYANSWAMI C SEKHARAN M.D.
54 MAGNOLIA BLUFF RD
NATCHEZ MS 39120

OHIO STATE MEDICAL BOARD
AUG 02 2001

40-5-6
#450
$305
8-27-01

:96969696 21: 093506 2434 " "0000030500"

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.

54 MAGNOLIA BLUFF RD
STREET
STREET
NATCHEZ MS 39120
CITY STATE ZIP CODE
ADAMS
COUNTY

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

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

Street

Street

City State Zip Code

County

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, 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?**

REQUIRED [redacted] Redacted

SOCIAL SECURITY NUMBER

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

Date: 8/29/01

Narayanswami Sekharan MD
54 Magnolia Bluff Rd.
Natchez, MS 39120

OHIO STATE MEDICAL BOARD
SEP 14 2001

Dear Doctor:

Please be advised that in reviewing your renewal application card for your Ohio license, we find that you failed to answer the following question(s). To continue processing your renewal, answer each checked question below:

	AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE: (only those questions marked with a ✓ apply to you)	YES	NO
☐	1.) *Have you been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a or misdemeanor or felony?*	☐	☐
☐	2.) *Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question if** you have successfully completed treatment at 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.*	☐	☐
☐	3.) *Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?*	☐	☐
☐	4.) *Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints filed against you?*	☐	☐
☐	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.*	☐	☐
☒	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?***	☐	☒
☐	**YOU DID NOT ANSWER ANY OF THE QUESTIONS. ANSWER EACH QUESTION (1 - 7) ABOVE.**		

OVER ⇨

I certify, that the information provided is true and correct.

N-C Sethara
Signature of Applicant

9-10-91
Date

Upon completion of this form, return directly to the Board. If your response is not received in this office by your date of expiration, your Ohio license will lapse by action of law.

Should you have any questions concerning this information, please contact me at the address indicated on the other side.

Sincerely,

Debra L. Jones

Debra L. Jones, Chief
C.M.E., Records and Renewal

DLJ:jdc