AMA-APP-SENT
7/18/95

STATE MEDICAL BOARD OF OHIO

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

REQUEST FOR APPLICATION FORMS
(MEDICAL OR OSTEOPATHIC)

PLEASE TYPE OR PRINT CLEARLY

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

	LAST (Surname)	FIRST	MIDDLE	SUFFIX (Jr., II)
NAME:	MILLER	LAWRENCE	WHITFIELD	

	STREET & NUMBER
ADDRESS:	447 CARLETON CIRCLE

CITY	STATE	ZIP CODE	COUNTRY
SPARTANBURG	S.C.	29301	USA

TELEPHONE: BUSINESS: AREA CODE & NUMBER (803) 560-7006 HOME: AREA CODE & NUMBER (803) 574-3032

BIRTHDATE: MO/DAY/YR 4 1/5 1 42 BIRTHPLACE: CITY NEW YORK STATE N.Y. COUNTRY USA

MEDICAL OR OSTEOPATHIC EDUCATION

MEDICAL SCHOOL OF GRADUATION:

SCHOOL NAME
BOSTON UNIV. SCHOOL OF MEDICINE

STREET ADDRESS
80 EAST CONCORD ST.

CITY	STATE	COUNTRY
BOSTON	MA.	USA

DATES ATTENDED: FROM: MO/DAY/YR 9 1 1 63 TO: MO/DAY/YR 5 1/8 1 67

DEGREE RECEIVED: M.D. DATE RECEIVED: MO/DAY/YR 5 1/8 1 67

Revised 01/24/94

OVER ⇨

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

SCHOOL NAME
NONE

STREET ADDRESS

CITY | STATE | COUNTRY

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

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

SCHOOL NAME

STREET ADDRESS

CITY | STATE | COUNTRY

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

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

FIFTH PATHWAY

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

HOSPITAL OR INSTITUTION

AFFILIATED WITH:

NAME OF MEDICAL SCHOOL | CITY | STATE | ZIP CODE

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

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

CONTINUED ⇨

GRADUATE MEDICAL EDUCATION

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

A.	6 / 67 month/year TO 6 / 68 month/year	Hospital, University or Other: LOS ANGELES COUNTY - UNIV. OF SOUTHERN CALIFORNIA MED. CENTER Complete Street Address: 100 STATE ST. Street & Number LOS ANGELES CALIF City State/Country Zip	Position & Department: ROTATING INTERN	Level of Training (check one only): ☒ 1st year ☐ 2nd year ☐ 3rd year or above
B.	11 / 71 month/year TO 6 / 75 month/year	Hospital, University or Other: LOS ANGELES COUNTY - UNIV. OF SOUTHERN CALIFORNIA MED. CENTER Complete Street Address: WOMEN'S HOSPITAL 100 STATE ST. Street & Number LOS ANGELES CALIF City State/Country Zip	Position & Department: RESIDENT - OBSTETRICS & GYNECOLOGY	Level of Training (check one only): ☐ 1st year ☐ 2nd year ☒ 3rd year or above
C.	month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department:	Level of Training (check one only): ☐ 1st year ☐ 2nd year ☐ 3rd year or above
D.	month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department:	Level of Training (check one only): ☐ 1st year ☐ 2nd year ☐ 3rd year or above

OVER ⇨

WRITTEN EXAMINATIONS TAKEN

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

STATE	DATE TAKEN	TYPE OF EXAM	SECTIONS TAKEN	FINAL RESULTS
mA.	(MO/YR) 6/65	(✓ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☒ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✓ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☒ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✓ ONE ONLY) ☒ PASS ☐ FAIL
mA.	(MO/YR) 4/67	(✓ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☒ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✓ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☒ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✓ ONE ONLY) ☒ PASS ☐ FAIL
CA.	(MO/YR) 3/68	(✓ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☒ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✓ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☒ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✓ ONE ONLY) ☒ PASS ☐ FAIL
SC	(MO/YR) /91	(✓ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☒ STATE BOARD	(✓ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☒ FULL	(✓ ONE ONLY) ☒ PASS ☐ FAIL
	(MO/YR) /	(✓ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✓ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✓ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✓ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✓ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✓ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✓ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✓ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✓ ONE ONLY) ☐ PASS ☐ FAIL
	(MO/YR) /	(✓ ONE ONLY) ☐ FLEX (PRE-1985) ☐ FLEX (1985 - 1993) ☐ NATIONAL BOARDS ☐ USMLE ☐ STATE BOARD	(✓ ONE ONLY) ☐ PARTIAL ☐ FULL COMPONENT ☐ I ☐ II PART ☐ 1 ☐ 2 ☐ 3 STEP ☐ 1 ☐ 2 ☐ 3 ☐ PARTIAL ☐ FULL	(✓ ONE ONLY) ☐ PASS ☐ FAIL

CONTINUED ⇨

LICENSES IN THE UNITED STATES & CANADA

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

STATE/PROVINCE	ISSUE DATE	LICENSE #	BASIS OF LICENSE	LICENSE CURRENT
CA.	(MO/YR) 8/68	G15106	(✓ ONE ONLY) ☒ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER	(✓ ONE ONLY) ☒ YES ☐ NO Expiration date: 4/30/96
CT.	(MO/YR) 4/75	017163	(✓ ONE ONLY) ☒ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER	(✓ ONE ONLY) ☒ YES ☐ NO Expiration date: 4/30/96
NC	(MO/YR) 9/91	17443	(✓ ONE ONLY) ☒ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER	(✓ ONE ONLY) ☒ YES ☐ NO Expiration date: 12/31/95
SC	(MO/YR) 10/91	15742	(✓ ONE ONLY) ☐ NATIONAL BOARDS ☐ FLEX ☒ STATE BOARD EXAM ☐ USMLE ☐ OTHER	(✓ ONE ONLY) ☒ YES ☐ NO Expiration date: 12/31/96
	(MO/YR) /		(✓ ONE ONLY) ☐ NATIONAL BOARDS ☐ FLEX ☐ STATE BOARD EXAM ☐ USMLE ☐ OTHER	(✓ ONE ONLY) ☐ YES ☐ NO Expiration date:

AMERICAN MEDICAL ASSOCIATION NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE

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

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

For further information contact the AMA at the address below:

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

OVER ⇨

ADDITIONAL ELIGIBILITY INFORMATION

ANSWER ALL QUESTIONS	YES	NO
Are you a licentiate of the Medical Council of Canada?	☐	☒
Are you applying to take Step 3 of the USMLE in Ohio? ☐ June or ☐ December	☐	☒
Do you have a valid ECFMG Certificate? Number: _____ Date Issued: ___/___ MO/YR	☐	☒
Have you held a current and unrestricted license in the US for five years or more? (Refer to the TSE section in the Eligibility Packet for more information)	☒	☐
Have you been actively practicing medicine and surgery or osteopathic medicine and surgery (approved training included) in the US for five years or more? (Refer to the TSE section in the Eligibility Packet for more information)	☒	☐
Have you applied for or taken the Test of Spoken English (TSE)* of the Educational Testing Service (ETS)? Date Taken: ___/___ MO/YR Score: _____	☐	☒
Have you achieved a score of at least two hundred thirty (230) on TSE* of the ETS? Date Taken: ___/___ MO/YR Score: _____	☐	☒

*[THE TOEFL, ECFMG EXAM, ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH (TSE)]

CERTIFICATION

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

Lawrence W. Miller MD
Signature of Applicant

7 19 195
Date

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

1-13

9-22-10
8-1-95
365 pts
2466

STATE MEDICAL BOARD OF OHIO

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

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number: Redacted [redacted]

2. Full Name (Use no initials):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
MILLER	LAWRENCE	WHITFIELD	

3. Name (As you prefer it inscribed on your Ohio license):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
MILLER	LAWRENCE	W.	

4. Maiden Name Or Other Names Used (If none, enter "NONE"):

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
NONE			

5. Current Address:

STREET & NUMBER			
447 CARLETON CIRCLE			
CITY	**STATE**	**ZIP CODE**	**COUNTRY**
SPARTANBURG	S.C.	29301	USA

6. Physical Description:

HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	IDENTIFYING MARKS
5'11"	195 lbs	BLOND	BLUE	NONE

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

8. City In Ohio Where You Plan To Practice:

CITY	OR	COUNTY
CLEVELAND		

PLANS OF PRACTICE: OHIO PERMANENTE MEDICAL GROUP

95 JUL 3 PM 1:47

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

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
OBSTETRICS AND GYNECOLOGY	☒	☐	1977	USA
MEDICAL MANAGEMENT	☒	☐	1990	USA
	☐	☐		

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

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

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

HOSPITALS WHERE I HELD STAFF PRIVILEGES 6/81 - 1/92

	month/year	Hospital, University or Other: / Complete Street Address / Street & Number / City State/Country Zip	Position & Department	% Clinical / % Admin.
E.	5 82 — TO — 5 85	FRANKFURT ARMY REGIONAL MED. CNTR. 97th GENERAL HOSPITAL; FRANKFURT, GERMANY; APO NY AE 09242	DEPT. OB/GYN; 3RD ARMORED DIVISION SURGEON	33% / 67%
F.	6 86 — TO — 6 90	CUTLER ARMY HOSPITAL; FT. DEVENS, MA. 01433	HOSPITAL COMMANDER	0 / 100%
G.	12 90 — TO — 3 92	WOMACK ARMY HOSPITAL; FT. BRAGG, N.C 28307	CHIEF, DEPT. OF OB/GYN	90% / 10%
H.	TO			

LAWRENCE W. MILLER, M.D.

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

Miller

	Month/Year	Hospital, University or Other / Complete Street Address / Street & Number / City, State/Country, Zip	Position & Department	% Clinical / % Admin.
E.	8 76 TO 6 81	UNIV. OF CONNECTICUT HEALTH CENTER UNIVERSITY HOSPITAL FARMINGTON AVE. FARMINGTON CT.	ASST. PROF. DEPT. OF OB-GYN	80 / 20
F.	6 81 TO 1 92	U.S. ARMY - ACTIVE DUTY MEDICAL DEPT.	VARIOUS CLINICAL, ADMIN., AND SCHOOLS. HONORABLE DISCHARGE RANK: COLONEL	50 / 50
G.	1 92 TO PRESENT	SPARTANBURG REGIONAL MED. CNTR. 101 EAST WOOD ST. SPARTANBURG SC 29303	PRIVATE PRACTICE DEPT. OB-GYN	95 / 5
H.	1 92 TO PRESENT	MARY BLACK HOSPITAL 1700 SKYLYN DR. SPARTANBURG SC 29303	PRIVATE PRACTICE DEPT. OB-GYN	100 / 0

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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

Miller

		Hospital, University or Other:	Position & Department	% Clinical
A.	7 67 month/year TO 7 68 month/year	LOS ANGELES Co. - USC MED. CENTER	ROTATING INTERN	100 %
		Complete Street Address: 1200 N. STATE ST.		% Admin.
		Street & Number: LOS ANGELES CA (City, State/Country, Zip)		

		Hospital, University or Other:	Position & Department	% Clinical
B.	8 68 month/year TO 10 71 month/year	SQUADRON SURGEON	SQUADRON SURGEON	70
		Complete Street Address: 2/4 CAVALRY		% Admin. 30
		Street & Number: SCHWABACH GERMANY (City, State/Country, Zip)		

		Hospital, University or Other:	Position & Department	% Clinical
C.	10 71 month/year TO 6 75 month/year	LOS ANGELES Co. - USC MED CENTER WOMEN'S HOSPITAL	RESIDENT OB-GYN	100
		Complete Street Address: 1240 N. MISSION RD		% Admin.
		Street & Number: LOS ANGELES, CA. (City, State/Country, Zip)		

		Hospital, University or Other:	Position & Department	% Clinical
D.	7 75 month/year TO 7 76 month/year	HARTFORD HOSP.	PRIVATE PRACTICE - OB-GYN	95
		Complete Street Address: 80 E. JEFFERSON ST.		% Admin. 5
		Street & Number: HARTFORD CT. (City, State/Country, Zip)		

95 APR 31 PM 4:47 BOARD

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

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

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

STATE MEDICAL BOARD OF OHIO
95 JUL 31 PM 1:49

I, MARK T. HASH D.O., a licensed and practicing physician in the state of
(recommending physician)

South Carolina, affirm that LAWRENCE W. MILLER, M.D.
(state of residence) (applicant)

has been known to me personally for 1½ years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

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

*His/her relationship with patients is: Excellent

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

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

*Additional comments: I recommend Larry Miller MD to the state medical board of Ohio without any reservation. He will be an excellent addition to any medical practice in Ohio. His medical knowledge, interpersonal skills, and teaching abilities are without equal.

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

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

Signature of Recommending Physician
(name stamps not acceptable)

MARK T. HASH DO
Name of Recommending Physician
(please type or print clearly)

(803) 542-0116
Telephone Number
(include area code)

11 HIDDEN SPRINGS RD
SPARTANBURG SC 29302
Address of Recommending Physician
(include city, state and zip code)

SOUTH CAROLINA #0355
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 27th day of July, 1995.

Notary Public Signature

8 DEC 2003
Date Commission Expires

Signature of Applicant

Date Photo Taken: 7 / 95
Mo./Yr

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

Revised 02/09/94

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

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

STATE MEDICAL BOARD OF OHIO
APR 31 PM 1:48

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Robert G. Reiheld MD, a licensed and practicing physician in the state of
(recommending physician)

South Carolina, affirm that LAWRENCE W. MILLER, M.D.
(state of residence) (applicant)

has been known to me personally for 1 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

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

*His/her relationship with patients is: Excellent

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

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

*Additional comments: _____

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

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION
MEDICINE OR OSTEOPATHIC MEDICINE

Signature of Recommending Physician
(name stamps not acceptable)

Robert G. Reiheld MD
Name of Recommending Physician
(please type or print clearly)

(803) 560-7100
Telephone Number
(include area code)

210 Catawba St.
Spartanburg SC, 29303
Address of Recommending Physician
(include city, state and zip code)

SC 17563 - Ohio 35-03-1882
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 27th day of July, 1995.

Notary Public Signature

8 DEC 2003
Date Commission Expires

Lawrence W. Miller MD
Signature of Applicant

Date Photo Taken: 7 195
Mo./Yr

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

Revised 02/09/94

AUG - 1 1995

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION

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

Dear Sir:

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

TO BE COMPLETED BY APPLICANT

MILLER, LAWRENCE W.
Name in full (last, first, middle, suffix)

4/15/42
Date of birth (mo/day/yr)

447 CARLETON CIRCLE
SPARTANBURG S.C. 29301
Complete address (street, city, state & zip)

BOSTON UNIVERSITY
Medical school of graduation

I hereby authorize LOS ANGELES CO. GENERAL / U.S.C. MEDICAL CENTER WOMEN'S HOSPITAL
Hospital or training institution

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

Lawrence W. Miller MD
Signature of applicant

7/26/95
Date

TO BE COMPLETED BY HOSPITAL OR TRAINING INSTITUTION

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

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

His/her relationship with patients is: Very good.

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

His/her command of the English language is: Very good.

Additional comments:

OVER ⇨

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

This certifies that Lawrence W. Miller has successfully completed
(name of applicant)

not less than 12 months of graduate medical education through the:
- [x] 1st year level
- [ ] 2nd year level
- [ ] 3rd year level or above

as a(n):
- [x] intern
- [ ] resident
- [ ] clinical fellow

in Rotating
(department)

at LAC+USC Medical Center
(name of hospital)

1200 North State Street, Los Angeles, CA 90033
(complete street address of hospital)

from June 24, 1967 to June 24, 1968.
beginning (mo/day/yr) ending (mo/day/yr)

It is further certified that the above named:
- [ ] will be awarded a certificate on} _____ mo/day/yr
- [x] was awarded a certificate on} 6/24/68 mo/day/yr
- [ ] was not awarded a certificate
  please explain: _____

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

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

(SEAL OF HOSPITAL)*

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

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

Ralph C. Jung, M.D.
Name (please print or type)

August 4, 1995
Date

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

Revised 02/09/94

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

AUGUST 1, 1995

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

TO WHOM IT MAY CONCERN:

Please be advised that Connecticut General Statutes Section 20-13e, effective July 1, 1984, mandates that certain matters involving the investigation and rehabilitation of physicians remain confidential. Therefore, in response to your inquiry regarding the status of the physician identified below, at this time we are providing only publicly disclosable information. In order for this office to confirm or deny whether there is any confidential information relevant to your inquiry, a release from such physician must be provided.

IF YOU WISH TO ESTABLISH WHETHER CONFIDENTIAL INFORMATION EXISTS CONCERNING THIS PHYSICIAN, PLEASE HAVE HIM/HER SIGN THE REVERSE SIDE OF THIS FORM, WHICH CONSTITUTES A RELEASE FOR SUCH INFORMATION, AND RETURN IT TO THIS OFFICE.

This is to certify that the public records of the Connecticut Department of Public Health indicate that:

LAWRENCE W MILLER MD
447 CARLETON CIRCLE
SPARTANBURG SC 29301

Was issued Connecticut: PHYSICIAN/SURGEON license

Date of Issue: 04/04/75 License Number: 017163 Expiration: 04/30/96

Status of license: CURRENT Validation number : 95-629827

Disciplinary History
Public Documents attached:
There are no Public Documents: LDS

STATE MEDICAL BOARD OF OHIO
95 AUG -7 PM 4:48

Sincerely,
D Tomassone
Debra J. Tomassone
Chief
Licensure and Registration

DJT:LDS
9987Q

(Seal)

Phone: (203) 566-2879 FAX: 203-566-1279
150 Washington Street — Hartford, CT 06106
An Equal Opportunity Employer

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES
BUREAU OF HEALTH SYSTEM REGULATION
DIVISION OF MEDICAL QUALITY ASSURANCE

CONSENT FOR RELEASE OF CONFIDENTIAL DISCIPLINARY RECORDS

This is to certify that I hereby give my consent and authorize the Department of Public Health and Addiction Services, Division of Medical Quality Assurance, to confirm the existence of any pending complaints and to release any records of disciplinary action maintained by that Division (with the exception of any documents identified below) to:

Send verification to: _____
FACILITY: _____
ADDRESS: _____
_____
_____

I understand that these records are confidential pursuant to the provisions of Connecticut General Statutes §20-13e and may not be disclosed without my permission. This information will only be disclosed when this release is executed by me. I also understand that if I am a participant in a rehabilitation program sponsored by a County Medical Association or by the Connecticut State Medical Society that I have the right to contact the Association or Society prior to signing this release. Please honor a mechanically reproduced copy of this release.

Documents the Department is Not Authorized to Release:

_____ Signature

_____ Date

_____ Name - Printed or Typed

_____ Conn.medical license number

_____ Address

_____ Date of Birth

_____ Address

_____ Expiration Date of license

(203) 566-5296
DBB:
FAX 566-6606
consent/3
0842
(u)

150 Washington Street, Hartford, CT 06106

STATE MEDICAL BOARD OF OHIO

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

1995 JUL 31 PM 2:41

DEPT. OF HEALTH SERVICES
LICENSES REGISTRATION

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 4 - VERIFICATION OF LICENSE

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

TO BE COMPLETED BY APPLICANT

#017163

MILLER, LAWRENCE W.
Name in full (last, first, middle, suffix)

17163
License number

4/4/75
Issue date (mo/day/yr)

447 CARLETON CIRCLE
SPARTANBURG, S.C. 29301
Complete address (street, city, state & zip)

4/15/42
Date of birth

BOSTON UNIVERSITY
Medical school of graduation

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

STATE OF CONNECTICUT
DEPT. OF PUBLIC HEALTH &
ADDICTION SERVICES (L & R-MD)
150 WASHINGTON STREET
HARTFORD, CT 06106

SEE ATTACHED

Lawrence W. Miller MD
Signature of applicant

7/26/95
Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province

Name of Licensee

License Number

Issue Date

STATE MEDICAL BOARD OF OHIO
95 AUG -7 PM 4:48

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

OVER ⇨

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

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

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

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

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

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

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

_____
Signature

_____
Title

_____
Date

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

LLR

SOUTH CAROLINA DEPARTMENT OF LABOR, LICENSING & REGULATION

David M. Beasley
Governor
Lewis F. Gossett
Director

BOARD OF MEDICAL EXAMINERS
101 Executive Center Drive
Saluda Building, Suite 120
Post Office Box 212269
Columbia, SC 29221-2269
(803) 731-1650
TT: (803) 734-4190
FAX: (803) 731-1660

August 3, 1995

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

TO WHOM IT MAY CONCERN:

This is to certify that the records of the South Carolina Board of Medical Examiners indicate the following information:

Physician: Lawrence W. Miller, M.D.

Date of Birth: April 15, 1942

License number: 15742

Issue date: October 28, 1991

Expiration date: December 31, 1996

Basis of Licensure: National Boards.

Status: Active and in good standing.

According to our records, this licensee has not been disciplined.

This written request was received in the Board office on July 28, 1995.

Very truly yours,

Donna G. Howard

Donna G. Howard
Administrative Assistant

SEAL

95 AUG -7 PM 4:44
STATE MEDICAL BOARD OF OHIO

RECEIVED
95 JUL 28 AM 10:05
MEDICAL EXAMINERS

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 4 - VERIFICATION OF LICENSE

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

TO BE COMPLETED BY APPLICANT

MILLER, LAWRENCE W.
Name in full (last, first, middle, suffix)

15742
License number

10/28/91
Issue date (mo/day/yr)

447 CARLETON CIRCLE
SPARTANBURG, S.C. 29301
Complete address (street, city, state & zip)

4/15/42
Date of birth

BOSTON UNIVERSITY
Medical school of graduation

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

Lawrence W. Miller MD
Signature of applicant

7/26/95
Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province

Name of Licensee

License Number

Issue Date

STATE MEDICAL BOARD OF OHIO
95 AUG -7 PM 4:44

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

OVER ⇨

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

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

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

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

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

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

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

_____
Signature

_____
Title

_____
Date

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

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 4 - VERIFICATION OF LICENSE

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

TO BE COMPLETED BY APPLICANT

MILLER, LAWRENCE Whitfield
Name in full (last, first, middle, suffix)

34685
License number

9/21/91
Issue date (mo/day/yr)

447 CARLETON CIRCLE
SPARTANBURG, S.C. 29301
Complete address (street, city, state & zip)

4/15/42
Date of birth

BOSTON UNIVERSITY
Medical school of graduation

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

Lawrence W. Miller MD
Signature of applicant

7/26/95
Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

NC
State/Province

Lawrence Whitfield Miller
Name of Licensee

34685
License Number

9/21/91
Issue Date

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

OVER ⇨

FORM 4 - VERIFICATION OF LICENSE - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

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

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

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

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

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

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

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

Signature

Title

8/15/95
Date

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

Revised 05/26/92

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, *Governor*

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CA 95825-3236
(916) 263-2653

August 24, 1995

Ohio State Medical Board
77 S. High Street, 17th Fl.
Columbus, OH 43266-0315

TO WHOM IT MAY CONCERN:

This is to verify that Dr. Lawrence W. Miller, born on 4/15/42, was issued California physician and surgeon's certificate #G 15106, on 8/1/68, based on National Board Credentials. The license is current and renewal fees are paid through 4/30/96. There is no current record of accusation and/or disciplinary activity.

Patti Mahan
Licensing Program

To expedite the verification process, the above is the standard format used by the Medical Board of California.

SEAL

STATE MEDICAL BOARD OF OHIO
95 AUG 29 PM 1:41

AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

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

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor transferable.

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

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for licensure and that any fee I submitted is not refundable nor transferable.

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

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

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

(NOTARY SEAL)

Lawrence W. Miller MD
Signature of Applicant

Subscribed and sworn to before me this 27th day of July 1995.

Notary Public Signature

8 Dec 2003
Date Commission Expires

STATE MEDICAL BOARD OF OHIO
JUL 31 PM 1:47

Revised 05/26/92

Mary Black

STATE MEDICAL BOARD OF OHIO

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

DATE: 8/8/95

Dear Doctor:

Dr. Lawrence Miller MD who is/was Staff, OB/GYN, 1/92-present 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 applicant 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 him/her? approx 5 yrs

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

(3) At what hospital? Mary Black Memorial Hospital

(4) How would you rate his/her medical knowledge and techniques? not able to assess 2° to very limited exposure to this physician

(5) In your opinion, is he/she a person of good moral and ethical character? " " " " " " " " " "

(6) Does he/she work well with peers and medical staff? yes

(7) Does he/she relate well to patients? Do not know

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

(9) Would you recommend him/her for licensure? can not assess

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,

Cathy Hacker
Licensure Assistant

Signature of Physician

Dean Davis
Name of Physician (please type or print clearly)

Dept Chairman
Position

SC 13757
State of Licensure & Licensure Number

Telephone No. 803 583 4556 (Include Area Code)

8/19/95
447 CARLETON CIR.
SPARTANBURG, S.C.
29301

Dear Ms. Hacker,

I have enclosed additional material requested in support of my application for licensure in the State of Ohio. Specifically, I have enclosed the translation of my medical school diploma with a notarized signature on the school's letterhead. I have listed the Army hospitals where I had privileges from 6/81 - 1/92. The hospitals in Frankfurt and Ft. Stevens have subsequently been decommissioned. Other active duty time was spent in various non-medical practice duties as airborne and air assault school and post-graduate study at the U.S. Army Command and General Staff College. I have also been deployed on combat operations.

Your letter to me dated 8/8/95 listed the portions of my application that had not been completed. As of today, with the additional material enclosed, I think that all of the incomplete portions should now be complete. Do your records show anything else missing ?? I don't know what independent background information you are seeking for the Board - can I be of some help getting this ? I am scheduled to begin work on 20 October 95, do you think my license will be approved by then ?

Thank you,

Lawrence W. Miller MD

Boston University
School of Medicine

Office of The Registrar
80 East Concord Street
Boston, Massachusetts
02118
617 638-4160

Rachel H. Paquette
Registrar

BOSTON UNIVERSITY
IN THE COMMONWEALTH OF MASSACHUSETTS

THE SENATE AND TRUSTEES EXTEND GREETINGS
TO ALL THOSE TO WHOM THIS DOCUMENT MAY BECOME KNOWN.

SINCE Lawrence Whitfield Miller BEING POSSESSED OF A PROPER DISPOSITION AND ENDOWED WITH AN UPRIGHT CHARACTER, HAS DEVOTED HIMSELF TO THE REQUIRED STUDIES IN THE MEDICAL SCHOOL OF THIS UNIVERSITY AND, AFTER A RIGID EXAMINATION SET BY INDIVIDUAL PROFESSORS, HAS PROVEN HIMSELF TO THOSE CONCERNED WITH HIM TO BE WELL VERSED IN THE ART AND SCIENCE OF MEDICINE.

THEREFORE, IT HAS PLEASED US, THE PROFESSORS OF THE ABOVE-NAMED SCHOOL, BY UNANIMOUS RESOLVE, TO AWARD TO HIM THE DEGREE OF

DOCTOR OF MEDICINE

AND TO CONFER ON HIM ALL THE BENEFITS, RIGHTS, HONORS AND PRIVILEGES ACCORDED THAT DEGREE HERE OR IN ANY PLACE WHERE THIS IS DISPLAYED.

IN TESTIMONY OF WHICH, BY VIRTUE OF THE AUTHORITY VESTED IN US WE HAVE SUBSCRIBED OUR NAMES TO THIS DOCUMENT, SECURED BY THE SEAL OF THE UNIVERSITY on this 28th day of May, 1967 IN THE 191st YEAR OF THE FOUNDING OF OUR COMMONWEALTH.

(Franklin G. Ebaugh, Jr.)
DEAN

(Harod C.Case)
PRESIDENT

(Leonard D. Osler)
SECRETARY
OF THE FACULTY

(Vincent P. Clarke)
SECRETARY
OF THE BOARD OF TRUSTEES

Boston University
School of Medicine

Office of
Student Affairs
80 East Concord Street
Boston, Massachusetts
02118-2394
TEL: (617) 638-4166 or 4194
FAX: (617) 638-4491

Arthur J. Culbert, Jr., Ph.D.
Associate Dean
for Student Affairs
Director
Early Medical School
Selection Program

COUNTY OF NORFOLK
COMMONWEALTH OF MASSACHUSETTS

I, Arthur J. Culbert, do solemnly swear that the attached translation is to the best of my knowledge and belief a full, true and correct version of the original, with nothing added and nothing deleted.

Arthur J. Culbert, Ph.D.
Associate Dean for Student Affairs

August 15, 1995
Date

Sworn to and subscribed before me on this 15th day of August in the year 1995.

Rachel H. Paquette
Notary Public

08/15/95
Date

My commission expires May 20, 1999

The State of South Carolina
Military Department

L9090
9/8/95

STANHOPE S. SPEARS
MAJOR GENERAL
THE ADJUTANT GENERAL

OFFICE OF THE ADJUTANT GENERAL
1 NATIONAL GUARD ROAD
COLUMBIA, S.C. 29201-4766

TAG-MP-RR

1 September 1995

MEMORANDUM FOR RECORD

SUBJECT: Professional Privileges and Malpractice Verification

1. On 14 January 1994 the undersigned contacted Carey Cotton, The Credentials Coordinator at, Fort Bragg, NC, (919) 432-5263, and verified that Dr. Lawrence W. Miller had professional privileges at this installation from June 1990 to 31 December 1992. These privileges had not been restricted, revoked, limited, suspended, denied, nor had any disciplinary measures been directed or considered. He served as chief of OB/GYN at Womack Army Hospital, Fort Bragg, NC, from JAN 91 - DEC 91.

2. Carey Cotton also stated that Dr. Miller was covered for medical malpractice through Title 10, USC Section 1089, The Gonzoles Act, while on active duty. No suits or claims were filed during his tour at Fort Bragg, NC, from June 1990 to 31 December 1992.

HOLLY L. WHALEN
SFC, SCARNG
AMEDD Staffing Technician

STATE MEDICAL BOARD
OF OHIO
95 SEP -8 AM 11:46

The State of South Carolina
Military Department

OFFICE OF THE ADJUTANT GENERAL
1 NATIONAL GUARD ROAD
COLUMBIA, S.C. 29201-4766

STANHOPE S. SPEARS
MAJOR GENERAL
THE ADJUTANT GENERAL

TAG-MP-RR

1 September 1995

MEMORANDUM FOR RECORD

SUBJECT: Professional Privileges and Malpractice Verification

1. On 14 January 1994 the undersigned contacted Carey Cotton, The Credentials Coordinator at, Fort Bragg, NC, (919) 432-5263, and verified that Dr. Lawrence W. Miller had professional privileges at this installation from June 1990 to 31 December 1992. These privileges had not been restricted, revoked, limited, suspended, denied, nor had any disciplinary measures been directed or considered. He served as chief of OB/GYN at Womack Army Hospital, Fort Bragg, NC, from JAN 91 - DEC 91.

2. Carey Cotton also stated that Dr. Miller was covered for medical malpractice through Title 10, USC Section 1089, The Gonzoles Act, while on active duty. No suits or claims were filed during his tour at Fort Bragg, NC, from June 1990 to 31 December 1992.

HOLLY L. WHALEN
SFC, SCARNG
AMEDD Staffing Technician

Post-it™ brand fax transmittal memo 7671	# of pages ▸
To Cathy Hacker	From Holly Whalen
Co. State Medical Board	Co. SCARNG
Dept.	Phone # (803) 748-4428
Fax # (614) 466-4670	Fax # (803) 748-4447

Larry K. Totten, MD
Medical Executive Committee

John E. Keith, Jr., MD
Chief of Staff

Richard E. Moretz, MD
Vice Chief of Staff
Utilization Review Committee

Sami B. Elhassani, MD
Secretary
Medical Audit/Record Committee

T. Keith Wood, MD
Anesthesia Services
Division of the Department of Surgery

R. Steve Stewart, MD
Department of Emergency Medicine

Ralph A. Tesseneer, MD
Department of Family Practice

Jack M. Cole, MD
Department of Medicine

Dean E. Davis, MD
Department of Obstetrics & Gynecology

W. Mac Davis, MD
Department of Pathology

George C. Glenn, III, MD
Department of Pediatrics

Penelope Galbraith, MD
Department of Radiology

Thomas A. McLeod, MD
Department of Surgery

James D. Bearden, III, MD
Cancer Care Committee

Wilson P. Smith, MD
Critical Care Committee

Scott W. Younkin, MD
Infection Control Committee

James E. Bradof, MD
Institutional Review Board

Sami B. Elhassani, MD
Perinatal Morbidity/Mortality & Neonatal Special Care Unit Committee & Continuing Medical Education Committee

Jan L. Porter, MD
Pharmacy & Therapeutics Committee

M. Dubose Medlock, Jr., MD
Surgical Case Review Committee

John W. Nelson, MD
Transfusion Review Committee

Mary Black
MEMORIAL HOSPITAL

September 1, 1995

Ohio State Medical Board
Attn: Cathy Hacker
77 South High Street
17th Floor
Columbus, OH 43266-0315

Dear Ms. Hacker:

Lawrence W. Miller, MD, was a member of the Active Medical Staff at Mary Black Memorial Hospital in the Department of Obstetrics & Gynecology from January 6, 1992 until August 31, 1995. He was member in good standing at the time of his resignation.

If Mary Black Memorial Hospital can be of further assistance, please contact the Medical Staff Office at (803) 573-3843.

Sincerely,

S. Mims

Sherri S. Mims
Credentialing Secretary

STATE MEDICAL BOARD
OF OHIO
95 SEP -5 AM 11:57

1700 Skylyn Drive • Post Office Box 3217 • Spartanburg, South Carolina 29304 • (803)573-3843

Larry K. Totten, MD
Medical Executive Committee

John E. Keith, Jr., MD
Chief of Staff

Richard E. Moretz, MD
Vice Chief of Staff
Utilization Review Committee

Sami B. Elhassani, MD
Secretary
Medical Audit/Record Committee

T. Keith Wood, MD
Anesthesia Services
Division of the Department of Surgery

R. Steve Stewart, MD
Department of Emergency Medicine

Ralph A. Tesseneer, MD
Department of Family Practice

Jack M. Cole, MD
Department of Medicine

Dean E. Davis, MD
Department of Obstetrics & Gynecology

W. Mac Davis, MD
Department of Pathology

George C. Glenn, III, MD
Department of Pediatrics

Penelope Galbraith, MD
Department of Radiology

Thomas A. McLeod, MD
Department of Surgery

James D. Bearden, III, MD
Cancer Care Committee

Wilson P. Smith, MD
Critical Care Committee

Scott W. Younkin, MD
Infection Control Committee

James E. Bradof, MD
Institutional Review Board

Sami B. Elhassani, MD
Perinatal Morbidity/Mortality & Neonatal Special Care Unit Committee & Continuing Medical Education Committee

Jan L. Porter, MD
Pharmacy & Therapeutics Committee

M. Dubose Medlock, Jr., MD
Surgical Case Review Committee

John W. Nelson, MD
Transfusion Review Committee

Mary Black
MEMORIAL HOSPITAL

September 1, 1995

Ohio State Medical Board
Attn: Cathy Hacker
77 South High Street
17th Floor
Columbus, OH 43266-0315

Dear Ms. Hacker:

Lawrence W. Miller, MD, was a member of the Active Medical Staff at Mary Black Memorial Hospital in the Department of Obstetrics & Gynecology from January 6, 1992 until August 31, 1995. He was member in good standing at the time of his resignation.

If Mary Black Memorial Hospital can be of further assistance, please contact the Medical Staff Office at (803) 573-3843.

Sincerely,

S. Mims

Sherri S. Mims
Credentialing Secretary

1700 Skylyn Drive • Post Office Box 3217 • Spartanburg, South Carolina 29304 • (803)573-3843

Mary Black 69090 9/8/95

STATE MEDICAL BOARD OF OHIO

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

DATE: 8/22/95

Dear Doctor,

Dr. Laurence Miller MD who is/was Staff, OB/GYN, 1/92 - present 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 applicant 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 him/her? 2 years

(2) What is/was your supervisory capacity? Chief of Staff

(3) At what hospital? Mary Black Hosp.

(4) How would you rate his/her medical knowledge and techniques? adequate

(5) In your opinion, is he/she a person of good moral and ethical character? yes

(6) Does he/she work well with peers and medical staff? yes

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

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

(9) Would you recommend him/her 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,

Cathy Hacker
Licensure Assistant

STATE MEDICAL BOARD OF OHIO 95 SEP 11 PM 1:54

John E. Keith Jr MD
Signature of Physician

John E. Keith, Jr MD
Name of Physician (please type or print clearly)

Chief of Staff
Position

SC 12526
State of Licensure & Licensure Number

Telephone No. 803 582-6396 (Include Area Code)

Womack

69090

STATE MEDICAL BOARD OF OHIO

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

DATE: 8/28/95

Dear Doctor:

Dr. Lawrence Miller MD who is/was Chief Staff, OB/GYN 12/90-3/92 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 applicant 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 him/her? N/A

(2) What is/was your supervisory capacity? N/A

(3) At what hospital? Womack Army Medical Center, Fort Bragg, NC

(4) How would you rate his/her medical knowledge and techniques? Good

(5) In your opinion, is he/she a person of good moral and ethical character? Good/yes

(6) Does he/she work well with peers and medical staff? Good/yes

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

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

(9) Would you recommend him/her for licensure? _____

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

This information is based on a review of copies of the credentials record and performance assessment.

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

Sincerely,

Cathy Hacker

Cathy Hacker
Licensure Assistant

_____
Signature of Physician

_____
Name of Physician (please type or print clearly)

_____
Position

_____
State of Licensure & Licensure Number

Telephone No. _____ (Include Area Code)

Vice & Fig
Credentials Coordinator

AFFIDAVIT AND RELEASE OF APPLICANT

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

ss STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG

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

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor transferable.

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

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for licensure and that any fee I submitted is not refundable nor transferable.

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

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

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

(NOTARY SEAL)

Lawrence W. Miller MD
Signature of Applicant

Subscribed and sworn to before me this 27th day of July 1995.

Notary Public Signature

8 Dec 2003
Date Commission Expires

95 JUL 31 PM 1:47
STATE MEDICAL BOARD OF OHIO

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

Diplomate Name: Lawrence W. Miller, MD

Date of Birth: 04/15/1942

Certification Date: 06/24/1968

Certificate #: 093210

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME PART I	Jun 1965	82.8	75	PASS	84	86	82	86	78	81	

					Med	Surg	Ob/Gyn	PM/PH	Ped	Psych
NBME PART II	Apr 1967	86	75	PASS	86	88	87	85	82	82
NBME PART III	Mar 1968	86.3	75	PASS						

STATE MEDICAL BOARD OF OHIO
95 AUG 10 AM 10: 11

DATE: 08/07/1995

SEE OTHER SIDE FOR SCORE INFORMATION

OH1144

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper.

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

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

95 JUL 31 PM 1:47
STATE MEDICAL BOARD OF OHIO

OVER ⇨

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

CONTINUED ⇨

ADDITIONAL INFORMATION-MEDICINE OR OSTEOPATHIC MEDICINE
PAGE THREE

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

STATE MEDICAL BOARD
OF OHIO
95 JUL 31 PM 1:47

Revised 1/12/95

LEE P. JEDZINIAK
Board Chairman

South Carolina Medical Malpractice
Liability Insurance
Joint Underwriting Association
P.O. Box 210768, Suite 110
121 Executive Center Drive
Columbia, S.C. 29221-0768
Tel. (803) 750-2382

August 3, 1995

STATE MEDICAL BOARD
OF OHIO
95 AUG -7 PM 1:16

State Board Medical Licensure
77 So. High St - 17th Floor
Columbus, Ohio 43266-0315

Re: Lawrence W. Miller, M.D.
POL # SB014828-

To whom it may Concern:

We have been requested By Dr Miller To provide a Claims history for him, while insured With the South Carolina Medical Malpractice JUA.

Our records show that he has had only one Claim which is Listed Below.

DIO 1-94 - D/R 12-94 - Open. pending. Alleged that There was failure to properly manage Labor and delivery that resulted in still Born Child.

We trust this is the information you Need.

Yours Truly,
C.L. Stewartson
SC JUA Manager

CC: Lawrence Miller, M.D.

7/27/95

Continuation Sheet. Additional Information
State Medical Board of Ohio

#3 - I have worked for a number of different medical practice organizations, both public and private over many years. In each case I have chosen to change a practice style, to move to a new location, experience new ideas and challenges as my interests and family's needs have changed. I have tried to summarize each, starting from completion of my internship; some dates are approximate.

1. Drafted into U.S. Army 8/68 and assigned as Squadron Surgeon in Schwabach, Germany. I resigned from active duty after completion of my required obligation in 10/71 to start my residency in OB-Gyn.

2. I completed my OB-Gyn Residency and terminated that medical practice organization because I had completed my training and graduated. I graduated in June 1975.

3. I entered private practice with Dr. Richard Jones in Hartford, Ct. I worked with him for 1 year. The University of Connecticut Medical Center in Farmington, Ct. began doing OB-Gyn sometime during the year I worked with Dr. Jones. I decided to join the University of Connecticut as full-time faculty in their Dept. of OB-Gyn under Dr. Jack Blechner.

4. I worked as an Assistant Clinical Professor of OB-Gyn from approximately 8/76 to 6/81. In 1981 my children were older, night call was heavy, rapid modernization of military forces intrigued me, and I wanted to travel overseas again. I joined the U.S. Army again.

5. I served in the Army in roles such as practicing physician, as hospital commander, and as combat operations planner. I rose to the rank of Colonel during what I thought was an interesting and challenging career. Following my deployment to the Persian Gulf War my wife and I decided that we should resume our civilian lifestyle. I resigned my active duty commission and moved to Spartanburg S.C. in January, 1992.

6. In Spartanburg I practiced until March 1993 with the physician by whom I was recruited. I had professional differences with him and began to look for an alternative situation in Spartanburg. Subsequently this physician resigned his medical license and his practice.

7. In March 1993 I joined my current practice associates. We have had a private practice and had had a contract with Spartanburg

7/27/95

Continuation Sheet 2 · Additional Information

#3 - Continued -

Regional Medical Center to provide professional staff teaching in OB-Gyn to their Family Medicine residents and to provide back-up patient care. Additionally I was appointed Assistant Clinical Professor in OB-Gyn by the Medical University of South Carolina (MUSC). I provided instruction to, guidance to, and assisted in professional care with the 3rd year MUSC resident assigned as "Chief Resident" in OB-Gyn at Spartanburg Regional. This Spring, Spartanburg Regional did not renew the contract it had had for many years with Dr. Hip, my employer. Spartanburg Regional has begun to establish a Physician-Hospital Organization (PHO). I decided that I did not want to join. I began looking for a position with a large, well-established HMO in a large, "healthy" city in a moderate climate. I have found such a situation and expect to begin practice in Cleveland as soon as my license is approved.

#19 - I have been a defendant in 2 legal actions involving professional liability over the past 10 years. In each of these cases I was listed in the medical record as the admitting Physician. Each of these cases was a hospital resident "staff" case that required a hospital faculty member to be listed as the admitting physician. My name was assigned in rotation.

The attorney, Mr. G. Dewey Oxner, Jr., assigned to me by my malpractice insurance carrier, has advised me that I should be dismissed from each case. He says that there was no physician/patient relationship since I never saw, knew about, or advised any treatment for either one. Their care was rendered by others on the hospital staff despite the fact that I was listed as the admitting physician by the admitting office. Each case is recent and currently pending. The attorney has petitioned the court with a Motion for Summary Jeedgement to dismiss me. I have enclosed a copy of his most recent letter to me. The deposition mentioned is scheduled for 7/28/95.

One case is Ronica Andrews et al versus Spartanburg Regional Medical Center, Lawrence W. Mills MD, and OB-Gyn Educational Associates, P.A. by the 7th Judical Court, Spartanburg S.C., case # 94-CP-42-2373. This

STATE MEDICAL BOARD OF OHIO
95 JUL 31 PM 1:48

7/27/95

Continuation Sheet 3 - Additional Information

#19 - continued

case involved a pregnant mother admitted in labor and whose infant died in-utero while in the hospital. No settlement or judgement has been reached.

The second case is Sherry Jarrett versus Ronald J. Long, Spartanburg Regional Medical Center, et al from the Court of Common Pleas, Myrtle Beach, S.C., 6 July 1995, case # 95-CP-42-1188. This case involved a pregnant mother admitted in labor, whose infant was born severely asphyxiated and has subsequently had developmental delays and cerebral palsy. No settlement or judgement has been reached.

I have contacted my insurance carrier - Joint Underwriters Association - P.O. Box 210768, Columbia S.C. 29221-0768, telephone # 803-750-5515. The individual contacted said he will forward a complete claims history report on me.

There is not a 10 year claim report available from J.U.A. since I was previously on active duty with the U.S. army. I had no claims filed against me during my entire military career. Since there was no private insurance carrier I can not send reports for the entire 10 years. I telephoned the State Medical Board of Ohio on 7/27/95 requesting advice about how to respond to this portion of item #19. I was told to write this enclosed explanation regarding my military status.

Lawrence W. Miller, MD

STATE MEDICAL BOARD OF OHIO
95 JUL 31 PM 1:48

HAYNSWORTH, MARION, McKAY & GUÉRARD, L.L.P.
ATTORNEYS AT LAW

1201 Main Street
AT&T Building—Suite 2400
Post Office Drawer 7157
Columbia, South Carolina 29202
(803) 765-1818
Facsimile (803) 765-2399

75 Beattie Place
Two Insignia Financial Plaza — Eleventh Floor
Post Office Box 2048
Greenville, South Carolina 29602
(803) 240-3200
Facsimile (803) 240-3300

134 Meeting Street
Fourth Floor
Post Office Box 1119
Charleston, South Carolina 29402
(803) 722-7606
Facsimile (803) 724-8016

May 20, 1995

Reply to Greenville Office
Direct Dial: 240-3208

Personal and Confidential

Lawrence W. Miller, M.D.
100 East Wood Street
Suite 400
Spartanburg, South Carolina 29303

Re: Ronica Z. and Matthew W. Andrews v.
Lawrence W. Miller, M.D., et al.
JUA File Nos.: CB004951 and 4952

Dear Larry:

Mike Spears is now involved in the case, so our Motion for Summary Judgment is being held in abeyance. Plaintiff's attorneys want to set your deposition and we will do so at a time convenient to you. The deposition will be held in your office, unless you want it held elsewhere.

I will be in touch.

Sincerely,

G. Dewey Oxner, Jr.

GDOjr/mm

95 JUL 3 PM 1:48
MEDICAL BOARD

"True and correct copy of the original document"
Lawrence W. Miller MD

MEDICINE OR OSTEOPATHIC PRELIMINARY EDUCATION FORM

9-22

NAME:

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
MILLER	LAWRENCE	WHITFIELD	

HIGH SCHOOL OR EQUIVALENT:

SCHOOL NAME	CITY	STATE	COUNTRY
KINGSWOOD SCHOOL	WEST HARTFORD	CT.	USA

DATES ATTENDED: FROM: MO/DAY/YR 91 156 TO: MO/DAY/YR 61 159

UNDERGRADUATE COLLEGE OR EQUIVALENT:

SCHOOL NAME	CITY	STATE	COUNTRY
BOWDOIN COLLEGE	BRUNSWICK	MAINE	USA

DATES ATTENDED: FROM: MO/DAY/YR 91 159 TO: MO/DAY/YR 7/17/63 DEGREE RECEIVED: B.A.

R J Baker

SCHOOL NAME	CITY	STATE	COUNTRY

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

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:

SCHOOL NAME	CITY	STATE	COUNTRY
BOSTON UNIV. SCHOOL OF MEDICINE	BOSTON	MA.	USA

DATES ATTENDED: FROM: MO/DAY/YR 91 163 TO: MO/DAY/YR 5/18/67 DEGREE RECEIVED: M.D.

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: 87515 DATE ISSUED: AUG 07 1995

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

Ray L. Bumgarner
Entrance Examiner

Thomas E. Butler M.D.
Secretary

STATE MEDICAL BOARD
OF OHIO
95 JUL 31 PM 1:48

UNIVERSITATIS BOSTONIENSIS

IN REPUBLICA MASSACHUSETTENSI

SENATUS ET CURATORES

OMNIBUS, AD QUOS HÆC LITERÆ PERVENERINT, SALUTEM.

Cum **Lawrence Whitfield Miller, A.B.**

ingenio bene preditum moribusque probis ornatum se studiis in Schola hujus Universitatis Medica requisitis addidisset, et, interrogationibus rigidis a professoribus singulis propositis, se in arte medicina et in scientiis ei inservientibus bene eruditum esse probuisset, idcirco nobis placuit professoribus scholæ antedictæ consentientibus eum gradu

MEDICINÆ DOCTORIS

adornare, et ei omnia insignia, jura, honores et privilegia ad eum gradum hic aut uspiam spectantia concedere.

In cujus rei testimonium literis hisce Universitatis sigillo munitis die XXVIII *mensis Maii anno salutis nostræ* MCMLXVII *Reipublicæ* CLXXXXI

Nos pro auctoritate nobis commissa nomina subscripsimus.

Decanus. — *Præses.*

Scriba Facultatis. — *Scriba Curatorum.*

UNIVERSITAS BOSTONIENSIS 1839 1869

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 Lawrence W. Miller MD.
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-9090	$250.00	05/01/96

LAWRENCE W MILLER,M.D.
8565 AMHERST DR
SUITE 2212
SAGAMORE HILLS OH 44067

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

8184 THACKERAY COURT
STREET
STREET
BROADVIEW HGTS OH 44147
CITY STATE ZIP CODE
CUYAHOGA
COUNTY

:969696962: 0935069090 :0000025000:

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

7331 SNOW RD
Street

Street

PARMA OH
City State Zip Code

CUYAHOGA
County

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

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

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

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

YES NO [ ] [X] 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] 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 Lawrence W Miller, MD 3/15/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-9090-M	$243.00	05/01/98

LAWRENCE W MILLER,M.D.
8184 THACKERAY COURT
BROADVIEW HTS OH 44147

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 2⑆ 0935069090⑈ ⑈0000024300⑈

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

12301 SNOW RD.
Street

Street

PARMA — OH — 44130
City — State — Zip Code

CUYAHOGA
County

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

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

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

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

YES [ ] NO [X] 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 [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 1998-2000 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 Lawrence W Miller MD 1/9/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-9090-M	$305.00	04/01/2000

LAWRENCE W MILLER,M.D.
8184 THACKERAY COURT
BROADVIEW HTS OH 44147

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

:969696962: 0935069090 :0000030500:

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

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, 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?*

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 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2000 - 2002 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 Lawrence W Miller 1/17/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-9090-M	$305.00	04/04/02	07/01/02

LAWRENCE W MILLER,M.D.
8184 THACKERAY COURT
BROADVIEW HTS OH 44147

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.

8184 THACKERAY COURT
STREET
STREET
BROADVIEW HEIGH OH 44147
CITY STATE ZIP CODE
CUYAHOGA
COUNTY

0935069090 30500

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, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.*

YES NO

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

YES NO

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

YES NO

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

YES NO

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

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

REQUIRED:

[redacted]

SOCIAL SECURITY NUMBER