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Form 4A

## ... Hospital/Clinic Affiliation Form JAN 10 1997

**To Applicant:** In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by the *Chief of Staff* or *physician in charge* if *no Chief of Staff*, in each hospital/clinic where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself, directly to:

Kentucky Board of Medical Licensure  
310 Whittington Parkway, Suite 1B  
Louisville, Kentucky 40222

Name: Walter T. Bowers, II M.D./D.O.  
(Please print)

(Signature)

Address: \_\_\_\_\_

**To Reference Source:** Please complete this form, sign and return to the Board (KBML) at the above stated address. Your response is confidential, pursuant to Kentucky law. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. *No Substitutions will be accepted in lieu of this form.*

\*\* Please Print or Type all Information \*\*

**Important:** The processing time for licensure directly depends on timely receipt of critical forms such as this.

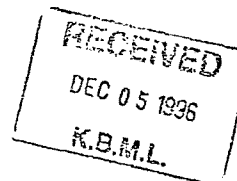
- What privileges were extended to the applicant? Active / OB-GYN
- Affiliation Dates: From 7-1-79 To Present
- Were any limitations imposed on such privileges? No If YES, please explain briefly and attach certified copies of any documentation pertaining to such action.
- Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? No If "Yes", please explain briefly and attach certified copies of any documentation pertaining to such action.

Derogatory Information, if any: None

Comments, if any: \_\_\_\_\_

Chief of Staff: \_\_\_\_\_

Hospital/Clinic: The Christ HospitalAddress: 2139 Auburn Ave. Cincinnati, OH 45219Date: 1-7-97Signature of Chief of Staff: [Signature](Seal of Hospital)  
(If none, so indicate)



November 25, 1996

Chairman, Credentials Committee

Kentucky Board of Medical Licensure

RE: Walter T. Bowers, M.D.  
STATUS: Current  
STAFF CATEGORY: Associate  
DEPARTMENT/DIVISION: Obstetrics and Gynecology  
ORIGINAL APPOINTMENT: 01/22/90  
CURRENT APPOINTMENT: 01/01/95 TO 12/31/96

Based on a review of the credentials file, the above-named professional is/was a member in good standing of the Medical and Dental Staff at Children's Hospital Medical Center. The file reveals no disciplinary action or involuntary restriction of clinical privileges.

Sincerely,

*Michelle B. Stultz R.N.*

Michelle B. Stultz, R.N.  
Manager  
Medical and Dental Staff Office

3333 Burnet Avenue  
Cincinnati, Ohio 45229-3039

An Equal Opportunity Employer

... Hospital/Clinic Affiliation Form

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DEC 05 1996  
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**To Applicant:** In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by the Chief of Staff or physician in charge if no Chief of Staff, in each hospital/clinic where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself, directly to:

Kentucky Board of Medical Licensure  
310 Whittington Parkway, Suite 1B  
Louisville, Kentucky 40222

Name: Walter T. Bowers, II M.D./D.O.  
(Please print)

[Signature]  
(Signature)

Address: [Redacted]

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•• Please Print or Type all Information ••

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1. What privileges were extended to the applicant? Associate, Surgery, Obstetrics, Gynecology
2. Affiliation Dates: From 1-22-90 To Present
3. Were any limitations imposed on such privileges? no If YES, please explain briefly and attach certified copies of any documentation pertaining to such action.
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? no If "Yes", please explain briefly and attach certified copies of any documentation pertaining to such action.

Derogatory Information, if any: none

Comments, if any: Please see letter

Chief of Staff: Michael Farrell, M.D. Hospital/Clinic: CHMC Medical Center

Address: 3333 Burnet Avenue Cincinnati, Ohio 45229

Date: 11/30/96

Signature of Chief of Staff: [Signature]

(Seal of Hospital)  
(If none, no indicate)



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K.B.M.L.

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Kentucky Board of Medical Licensure  
310 Whittington Parkway, Suite 1B  
Louisville, Kentucky 40222

Name: Walter T. Bowers, II M.D./D.O.

(Please print)

(Signature)

Address: [REDACTED]

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•• Please Print or Type all Information ••

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1. What privileges were extended to the applicant? OB/Gyn - Country
2. Affiliation Dates: From 5/84 To Present
3. Were any limitations imposed on such privileges? No If YES, please explain briefly and attach certified copies of any documentation pertaining to such action.
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? No If "Yes", please explain briefly and attach certified copies of any documentation pertaining to such action.

Derogatory Information, if any: \_\_\_\_\_

Comments, if any: \_\_\_\_\_

Chief of Staff: Andrew F. Robbing Hospital/Clinic: Dove Mountain Hospital

Address: 375 Drymuth Ave, Cate, OH 45220-2409

Date: 12/3/96

Signature of Chief of Staff: Andrew Robbing

(Seal of Hospital)  
(If none, so indicate)