FIECEIVEL Form 4A

••• Hospital/Clinic Affiliation Form JAN 1 0 1837

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky Hersitady Board of Medical Licensure requires this form to be reemplated by the Chief of Staff or physician in charge V and Chief of Staff, in each hoppital/clinic where you have practiced medicine during the five (5) years preceding your application. My signature below is your subscript to release any and all information in your files, feverable or otherwise regarding myself, directly to:

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

(Fleam print)

Address:

To Reference Source: Please complete this form, sign and return to the Board (KBML) at the above stated ackiness. 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 Frint or Type all Information . ·

	Whenever a contract of the con
estant: Theproc	easing time for licensure directly depends on simply receipt of critical forms such as this.
What privileges w	tre extended to the applicant
Affiliation Dates:	From 7-1-79 To Present
Were any limitation attach certified co	one imposed on such privileges? // U If YES, please explain briefly and pies of any documentation pertaining to such action.
otherwise discipli	ver revoked, suspended, restricted, limited, reprinsended, placed on probation or need NO If "Yes", please explain briefly and attach certified copies of any resining to such settlon
Deregatory Inform	nation, if any. NOL
Comments, if any	G
Chief of Staff_	Harpity VC Linie The Christ Abypital
Address 215	39 Autres ave Cicinati OH 45219'
Dele: 1-7-	97 Signature of Chief of State That That
	(5 of -2) (-3) (-3)

(L'exert en indexes)





November 25, 1996

Chairman, Credentials Committee

Kentucky Board of Medical Licensure

RE: Walter T. Bowers, M.D.

STATUS: Current
STAFF CATEGORY: Associate
DEPARTMENT/DIVISION: Obstatrics and Gynsoology
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 chingal privileges. clinical privileges.

Sincerely,

Michelle B Stultz RN

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

3333 Burnet Avenue Cincinnati, Ohio 45229-3039

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	• • • Hospital/Clinic Affiliation Form • DEC 0 5 1896 Form 4A
Me hos	Applicant: In applying for a license to practice medicine in the Commonwealth of Keather Milliannicky Board of chief licensure requires this form to be completed by the Chief of Staff or physician in charge if no Chief of Staff, in each pricial where you have practiced medicine during the five (5) years preceding your application. My signature below is your hority 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, Kenticky 40222
Na	me: Welter T. Bowers, II MD.D.O.
	(Please print) (Signature)
Ad	dress:
(Z24)	
LC:3	Reference Source: Please complete this form, sign and return to the Board (KBML) at the above stated address. Your prize is confidential, pursuant to Kentucky law. All applicants have signed a general release, which relieves anyone of liability information furnished in good faith. No Substitutions will be accepted in the of this form.
	· · Please Print or Type all Information · ·
Im	portant: The processing time for licensure directly depends on timely receipt of critical forms such as this.
1.	What privileges were extended to the applicant? ASSOCIATE, SUITALTY - UBS+ENICE & Gynecolog
2,	What privileges were extended to the applicant? ASSOCIATE Surgery · Obstetrics & Gynecolog  AMillation Dates: From 1-22-90 To Present
3.	Were any limitations imposed on such privileges? 71 O 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? \( \frac{1}{2} \)
	Derogatory Information, if any:
	none
	Comments, If any. Please, See letter
	ChicfofState Micchael Farrell, M.D. Hospital/ClinicCHMC Medical Center
	Address: 3333 Burnet Avenue Cincinnati, Ohio 45229

Date 11/35/96 Signature of Chief of Staff 11 Charl faully Signature (Staff of Hompital)
(Staff of Hompital)

RECEIVED

## ••• Hospital/Clinic Affiliation Form •• DEC 0 4 193Form 4A

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kontucky, 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

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

(Piesse print)

Value: (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 forms.

• Please Print or Type all Information • •

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

1. What privileges were extended to the applicant? TB/Dyn - Courtes.

2. Affiliation Dates: From 5/84 To Occount

3. Were any limitations imposed on such privileges? 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? 71-1 If "Yer", please explain briefly and attach certified copies of any documentation pertaining to such setion.

Derogatory Information, If any:

Comments, if any:

Chief of State A Continuant Robbing Hospital/Clinic Doop Horroreton Viscotel

Address: 375 Div meth ane: Center, OR 45220 2407

Dete: 1/3/41 Signature of Chief of Staff: (Seed of Hospital)

(Seed of Hospital)