C.N. 107155 ✓

Initial Medical Licensure
PERSONAL INFORMATION
10/2009 INT

STOP! Completed application and ~~check~~ must be mailed to:
MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-1298 Toll Free: 800-492-6836

FOR BANK USE ONLY
Date
Check Number 16887 ✓
Amt Paid 170
Name Code
AppID 17

APPLICATION FOR INITIAL MEDICAL LICENSURE

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

✓1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.): CARHART JR

First name and middle name: LEROY HARRISON

(If applicable, please check a box and complete below) ☐ Complete Maiden Name OR ☐ Complete Former Name

Stop! **If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.**

✓2. **Public Address:** Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.

Street Address: **If you change your address prior to being licensed, immediately notify the Board in writing.**

BELLEVUE HEALTH & EMERGENCY

1002 WEST MISSION AVENUE

City: BELLEVUE State: NE Zip Code: 68005-3947

✓3. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

Street Address: **(Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.**

[redacted]

City [redacted] State [redacted] Zip Code [redacted]

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✓4. **Telephone (s):** Home [redacted] Office: 402-292-4164

Cell/Pager: - -

E-mail address: admin@drcarhart.com

✓5. **Date of Birth:** Month [redacted] Day [redacted] Year [redacted] ✓

6. **Gender:** [X] Male [ ] Female

✓7. **Race:** Multiracial applicants may select all applicable categories [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American [ ] Native Hawaiian or other Pacific Islander [X] White

Ethnicity: [ ] Hispanic or Latino [X] Not Hispanic or Latino

✓8. **Social Security Number:** [redacted]

For Board Use Only

License Number: D71127
Date Issued: 07/07/10
BPQA School Code: 041009 ✓
Federation School Code: 039010 ✓
Licensed By: [signature] Licensing Exam: FLEX

Initial Medical Licensure CHRONOLOGY 10/2009 INT

Print Your Name: LeRoy Harrison Carhart, MD Date: 6/10/10

9. Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

Date Medical School was Completed: month 06 year 73

Activities after completing medical school: Please type or print.

month	year	TO	month	year	Activity / Address
06	73	TO	07	74	Activity: Rotating Type 4 Medical Internship Address: Malcom Grow Hospital - Andrews Afb, MD
07	74	TO	12	75	Activity: General Surgery Residency Address: Hahnemann Medical College / Hosp. Philadelphia, PA
01	76	TO	06	77	Activity: General Surgery Resident Address: Atlantic City Med. Center - New Jersey
07	77	TO	06	78	Activity: Chief Resident, General Surgery Address: Atlantic City Med. Center - New Jersey
07	74	TO	06	78	Activity: Emergency Physician Address: Emergency Medical Assoc - Chester, PA
09	78	TO	02	85	Activity: General Surgeon, Chief of General Surgery, Chief of Emergency Med, Chairman Dept of Surg. Address: Ehrling Bergquist USAF Hosp. Offutt AFB, NE
07	78	TO	06	86	Activity: Assistant Professor, Dept. of Surgery Address: Creighton Univ. School of Medicine, Omaha, NE
06	82	TO	09	97	Activity: Assistant Professor, Dept of Surgery Address: UNMC - Omaha, NE

CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

month	year	TO	month	year	Activity:
08	78		09	83	ER STAFF PHYSICIAN

Address: ST. JOSEPH'S HOSPITAL OMAHA, NEBRASKA

month	year	TO	month	year	Activity:
01	82		02	85	ER PHYSICIAN AND GENERAL SURGEON

Address: JENNIE EDMUNDSON HOSPITAL - C. B. - IOWA

month	year	TO	month	year	Activity:
01	85		08	86	ER STAFF PHYSICIAN AND GENERAL SURGEON

Address: LUTHERAN MEDICAL CENTER - OMAHA, NE.

month	year	TO	month	year	Activity:
09	86		06	87	ER STAFF PHYSICIAN (FISHERMANGOLD CORPORATION)

Address: MERCY HOSPITAL, DAVENPORT, IOWA

month	year	TO	month	year	Activity:
02	85		PRESENT		MEDICAL DIRECTOR, STAFF PHYSICIAN

Address: BELLEVUE HEALTH/EMERGENCY CLINIC, INC. BELLEVUE NE

month	year	TO	month	year	Activity:
10	97		PRESENT		ADJUNCT ASS'T. PROFESSOR (CLINICIAN) DEPT. OF MICRO/PATH

Address: UNMC - OMAHA, NEBRASKA

month	year	TO	month	year	Activity:

Address:

month	year	TO	month	year	Activity:

Address:

month	year	TO	month	year	Activity:

Address:

month	year	TO	month	year	Activity:

Address:

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Print Your Name: LeRoy HARRISON GRUHART Date: 3/16/10

10. **MEDICAL EDUCATION: List all medical schools you have attended**

	From: MM/YY	To MM/YY
HAHNEMANN MEDICAL COLLEGE & HOSPITAL	08/69	06/73

Medical School From Which You Received Your Medical Degree: SAME AS ABOVE

Name of University Affiliation (if applicable): * HAHNEMANN UNIVERSITY HOSPITAL

Street Address: 230 N. BROAD STREET

City: PHILADELPHIA **State/Province:** PA **Country of citizenship during medical education:** USA

Language(s) of Instruction: ENGLISH

Type of Degree: ☑ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ Other:_____ (specify)

Date Degree The date you officially received your degree after all prerequisite obligations, required training, government service, etc.

Was Conferred: was satisfied.

Month 06 Day 03 Year 73

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada)
Attach the following documents to this application:

1) **A copy of your valid ECFMG certificate or Fifth Pathway Certificate;**

2) **A copy of your medical school diploma and a certified translation;**

3) **If you listed an affiliation above (see * in 10 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate. The certificate must include your name, name of the medical school, name of the university, and a certified translation.**

If your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change; Passport, INS card, birth certificate, court document, marriage license, court decree.

11. **How have you satisfied Maryland's *written and oral* English language competency requirements?**
(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

a. ☑ I graduated from a medical school **or**, after at least three years of attendance, a high school (includes GED), undergraduate college, or university **where English was the *only* language of instruction throughout** (you must provide documentation); **or**

b. ☐ I passed either ☐ the TOEFL **or** ☐ the ECFMG English test after December 31, 1973 **AND** I passed the ☐ TSE or ☐ OPI. If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board;

c. ☐ I passed the USMLE Step 2 Clinical Skills Exam.

Are you claiming speech impairment? ☐ NO ☐ YES If "YES," please write or call the Board for additional information.

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Initial Medical Licensure POSTGRADUATE TRAINING 10/2009 INT	Print Your Name: LeRoy Harrison Carhart Date: 6/10/10	Page 5 of 11

12. POSTGRADUATE TRAINING (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order ALL postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider **full time teaching in an LCME accredited medical school in the United States** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this application.

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education *after* successfully completing a Board approved Fifth Pathway program. If you have not met these two criteria, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete another year of ACGME/AOA accredited clinical postgraduate training in addition to the year(s) usually required by Maryland. All of the additional year must have begun after the date of the last fail. Teaching will not be accepted as an alternative to a year required following three or more fails. If you have not met this requirement, DO NOT submit this application. If you failed any part, step, or component of a medical exam four times, DO NOT SUBMIT THIS APPLICATION; you are not eligible for medical licensure in Maryland.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

PG Year #s 1	Place of Training: Malcom Grow USAF Hospital		month 07 year 73 TO month 06 year 74	✓	
	Address: Andrews AFB MD	Specialty: General Surg.	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐		
PG Year #s 2.5	Place of Training: Hahnemann Medical College & Hospital		month 07 year 74 TO month 12 year 76	✓	✓
	Address: 230 N Broad St Philadelphia PA	Specialty: Gen. Surgery	Accredited by: ACGME ☒ AOA ☐ RCPSC ☐		
PG Year #s 1.5	Place of Training: Atlantic City Medical Center		month 01 year 76 TO month 06 year 78	✓	✓
	Address: 1925 Pacific Ave Atlantic City, NJ	Specialty: Gen. Surgery	Accredited by: ACGME ☒ AOA ☐ RCPSC ☐		
PG Year #s	Place of Training:		month year TO month year		
	Address:	Specialty:	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐		
PG Year #s	Place of Training:		month year TO month year		
	Address:	Specialty:	Accredited by: ACGME ☐ AOA ☐ RCPSC ☐		

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

Print Your Name: LEROY HARRISON CARHART Date: 3-16-10

13. **Hospital Privileges After Postgraduate Training:** Please list all hospitals where you have had privileges or have provided services **after the completion of your postgraduate training** for the five year period preceding the filing of this application. Copy this page if more space is needed and enclose each signed and dated addition.

Hospital: NONE	month year TO month year	
Complete Address:	Department	
Hospital:	month year TO month year	
Complete Address:	Department	
Hospital:	month year TO month year	
Complete Address:	Department	

BELLEVUE HEALTH CENTER
1002 WEST MISSION AVENUE
SUITE 201
BELLEVUE, NE 68005
Tel: 402-292-4164 Fax: 402-291-4643

[redacted]

10887

3/2/2010

PAY TO THE ORDER OF Maryland Board of Physicians $**790.00

Seven Hundred Ninety and 00/100********** DOLLARS

Maryland Board of Physicians
PO Box 37217
Baltimore, MD 21297

MEMO credentialing

Linda Ehmeier
AUTHORIZED SIGNATURE

Security features. Details on back.

[redacted]

Lockbox: 37217
Date: 03/29/2010
Batch: 22
Item: ~~19~~ 22
Amount: $790.00
With "For Office Use Only" box

3/30/10

SUNTRUST

	TO	
Complete Address:	Department	
Hospital:	month year TO month year	
Complete Address:	Department	

14. **Medical Licensing Examinations** (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations.**

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send the complete medical licensing examination history and scores directly to this Board. In each examination category below, you will find information to help you contact the administering authority.

a. Have you ever failed any medical licensing examination (or part, step, or component thereof)? NO [redacted] YES [redacted]

b. Have you failed any medical licensing examination (or part, step, or component thereof) three or more times? N[redacted] YES [redacted]

If you answered "Yes" to a. **and** b., you must have successfully completed another year of ACGME-accredited clinical postgraduate training, in addition to the year(s) of training usually required for licensure in Maryland. No part of the additional year may have been taken before the date of the last fail. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.

IF YOU HAVE FAILED ANY PART, STEP, COMPONENT OR APPROVED EXAMINATION COMBINATION MORETHAN 3 TIMES, You may not be eligible for medical licensure in Maryland. For a complete explanation see COMAR 10.32.01.03 Licensure—Qualifications for Initial Licensure

a. **State Board Examination** List state(s): N/A

STATE BOARD DOES NOT INCLUDE STEP 3 OF USMLE, ORAL EXAMS, OR INTERVIEWS. State Board Examinations were licensing exams given by individual states. State Board Examinations taken after December 31, 1984 are not accepted for licensure in Maryland.

Send a copy of MBP IML7, *State Board Licensure and Examination Certification,* form to the state(s) which administered your licensing exam and ask the state(s) to send your exam results directly to the Maryland Board of Physicians. Also send a copy to each state that has ever issued you a license. **NOTE: Many states charge a fee for exam transcripts. Contact each state board prior to sending form IML7, as all fees are the responsibility of the applicant.**

Federation of State Medical Boards (See Page 8 if you took a combination of these exams or combined either with the NBME exams)

b. ☒ FLEX-Weighted Average: **All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days). Flex weighted average exams taken in more than one sitting must have current ABMS or AOA Board Certification unless you are currently certified by a member board of the American Board of Medical Specialties.**

c. ☐ FLEX Components 1 and 2: **Examinations must be passed within 5 years of each other.**

d. ☐ USMLE Steps 1, 2, and 3: **Passing scores on all parts must have been completed within a 10-year period beginning with the month and year when the applicant first passed either step 1 or step 2.**

If you took any of the above examinations you must ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Board by accessing their website at www.fsmb.org. *Click transcript requests.*

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e. ☐ **National Board of Medical Examiners** (See Page 8 if you combined this examination with FLEX or USMLE exams)

If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification *and* the Record of Scores. All requests must be made through the NBME website at **http://www.nbme.org** or call 215-590-9592. If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores.

f. ☐ **National Board of Osteopathic Medical Examiners Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.** If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and the complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

g. ☐ **Medical Council of Canada**
Licentiate of the Medical Council of Canada
Please request that verification of your Licenciate Certification and a complete LMCC examination history be sent directly to this Board. Call MCC at 613-521-6012 for instructions and fee information.

CONTINUED ON PAGE 8

Print Your Name: LEROY HARRISON CARHART Date: 3-16-10

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

Passing scores on all parts of hybrid examinations must have been completed within a 10-year period, beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.

h. ☐	USMLE 1 + NBME II + NBME III	n. ☑	FLEX 1 + USMLE 3
i. ☐	USMLE 1 + USMLE 2 + NBME III	o. ☐	FLEX 2 + USMLE 1 + NBME II
j. ☐	USMLE 1 + NBME II + USMLE 3	p. ☐	FLEX 2 + USMLE 1 + USMLE 2
k. ☐	NBME I + USMLE 2 + USMLE 3	q. ☐	FLEX 2 + NBME I + USMLE 2
l. ☐	NBME I + USMLE 2 + NBME III	r. ☐	FLEX 2 + NBME I + NBME II
m. ☐	NBME I + NBME II + USMLE 3		

- If your hybrid exams included any part of the NBME examination, contact NBME at **http://www.nbme.org** or call 215-590-9592 for instructions and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Maryland Board of Physicians.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at www.fsmb.org. REQUEST HAS BEEN MADE

15. Licensing History:

a. ☐ I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.

b. ☑ I have an application for license pending in the following states: IOWA, _____, _____, _____, _____

c. Please list below all licenses ever issued to you by a U. S. state/territory or Puerto Rico. Also list all Canadian licenses and registrations.

d. Has any disciplinary action ever been taken against your license? ☒ No ☐ Yes If yes, please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked
✓ INDIANA	01040632A	✓					
✓ IOWA	23312			✓			
✓ KANSAS	04-24866	✓					
✓ NEBRASKA	15162	✓					
✓ NEW JERSEY	25MA03654100	✓					
✓ OHIO	35.057427	✓					
✓ PENNSYLVANIA	MD035665L	✓					
✓ WISCONSIN	35028-20	✓					

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(If more space is needed, please attach an additional signed and dated sheet.)

16. Check YES or NO.

YES	NO	
☐	☑	Did you successfully complete a medical licensing exam (USMLE, NBME, etc.) within the 15-year period prior to filing this application?
☑	☐	During the past 10 years, have you maintained uninterrupted licensure since you were first issued a license in the United States, its territories, Puerto Rico, or Canada?
☐	☑	Do you have lifetime certification from, or within the past 10 years have you been certified or recertified by, a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada?

If "YES," in which specialty were you certified? _____ Date certified _____

⇒ **If you have answered "NO" to all three of the above questions, you MUST take the Special Purpose Examination. After you submit this application, contact the Federation of State Medical Boards at 817-571-2949 and arrange to take the SPEX in Maryland, and have scores sent to the Maryland Board directly.**

17. Character and Fitness Questions (Check either YES or NO)

	YES	NO	
a.	[redacted]		Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, denied your application for licensure, reinstatement, or renewal?
b.			Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment, reprimand, suspension, or revocation. Refer to the document *Grounds for Board Action in Maryland* at the Board's website www.mbp.state.md.us.
c.			Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?
d.			Have you ever withdrawn your application for a medical license or other health professional license?
e.			Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?
f.			Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way?
g.			Have you committed a criminal act to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement?
h.			Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement? Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.
i.			Excluding minor traffic violations, are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?
j.			Do you illegally use drugs?
k.			Do you have any physical or mental condition that currently impairs your ability to practice medicine or that would cause reasonable questions to be raised about your physical, mental, or professional competency?
l.			Have you ever been named as a defendant in a medical malpractice action?
m.			Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?
n.			Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?
o.			Has your employment by any hospital, HMO, other health care facility or institution, or military entity been terminated for disciplinary reasons?
p.			Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
q.			Has the use of drugs and/or alcohol ever resulted in an impairment of your ability to practice your profession?
r.			Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction or any entity of the armed services?

»»» **If you answered "YES" to any of the questions in item 17, on the following page please list all adverse actions taken against you and provide a complete explanation. Attach any supporting documentation that applies (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgements, or final orders). Sign and date all pages submitted.**

7-7-10

18 a. If you answered "YES" to any of the questions in item 17, please provide an explanation below and attach all complaints, pleadings and judgments. Attach additional signed and dated pages as needed.

18 b. If you answered yes to 17L - answer the following questions:

1. Total number of malpractice claims ever filed in which you were named as a defendant? 1
2. Total number of malpractice claims ever paid (settlement / judgment) in which you were named as a defendant? 1
3. Within the last 60 months (5 years) provide the following:
   Total number of medical malpractice claims filed 0 ; paid (settlement / judgment) 0 ; or dismissed 0 ; in which you were named as a defendant.
4. For a claim filed at any time, but paid (settlement / judgment) within the last 60 months (5 years), list each claim by claimants name; describe the disposition of each claim; and provide a copy of the complaint, pleading, and judgment of each medical malpractice claim.

[redacted]

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I have attached the following number of pages to this application: 4

RELEASE AND CERTIFICATION

19. Release:

I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

LEROY HARRISON CARHART, M.D — 3/16/2010

Applicant's Name (Printed) | Applicant's Signature | Date

20. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____

Phone: _____ — Applicant's Signature — Date 3/16/2010

21. I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

Applicant's Signature — Date 3/16/2010

22. Affidavit: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-22 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

Applicant's Signature — Date 3/16/2010

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MAR 31 2010

STATE OF NEBRASKA

CITY/COUNTY OF SARPY

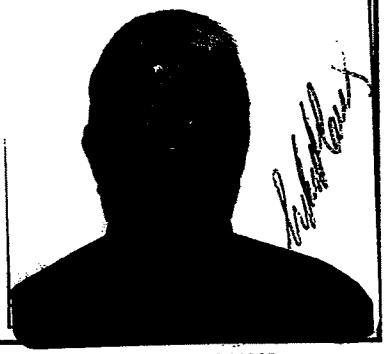
I HEREBY CERTIFY that on this 16 day of MARCH, 2010, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, LeRoy Harrison Carhart (print applicant's name), whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notorial seal. _____ Notary Public

My Commission expires: 8/31/2014

SEAL

GENERAL NOTARY-State of Nebraska
VICKIE E. ROGGE
My Comm. Exp. Aug. 31, 2011



STOP! Completed application and check must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297

CHECKLIST

Please review the checklist before signing page 11. A few minutes spent in review now may save days or weeks of delay in the processing your application.

- [x] I have provided all the personal information requested on this application (page 1)
- [x] My chronology of activities after graduating medical school is legible and the
- [ ] (If applicable) I have enclosed additional sheets for my chronology.
- [x] I have provided all the information about my medical education. (item 10, pa
- [ ] I have indicated how I have met Maryland's requirement for English proficie

Control No: 107155
Carhart Jr., Leroy Harrison
Application Form (Standard)
Received: William Calhoun
Analyst: Carol Johnson

03/31/2010

Graduates of Foreign Medical School

- [ ] My English proficiency requirements were satisfied somewhere other than medical school, so I have requested that documentation of both written and oral proficiency be sent to the Board. (See item 11 on page 4)

I have also enclosed the following documents:

- [ ] A copy of my valid ECFMG certificate (You must take the TOEFL if ECFMG English exam was before January 1, 1974)
- [ ] A copy of my medical school diploma and a certified translation.
- [ ] If applicable a copy of the Certificate of Medical Education and Examinations Taken or Good Conduct or Intern Certificate showing my name, the name of the medical school, and the name of the affiliated university; and a certified translation. (See page 4)

- [x] I have completed Part 1 of form IML2 (follows Section V of the application) and sent a copy to the institution from which I received my medical degree and, if different, to the institution at which I received English instruction that meets the Maryland requirements.
- [x] I have listed all postgraduate training I have undertaken in the U.S., Canada, or Puerto Rico (page 5); completed Part 1 of form IML3; signed Part 2; printed my name on side B; and sent a form IML3 to the director of each program in which I participated.
- [x] I have listed all hospitals at which I have had privileges or provided services since the completion of postgraduate training and during the five year period prior to filing my application (page 6).
- [x] I have listed all medical licensing examinations I have ever taken (page 7) and sent a copy of the request for transcripts and any fee that may be required to the appropriate administering authority of each exam (see instructions after exam listed on pages 7 and 8).
- [x] I have listed every license/registration I have ever been issued in the U.S., its territories, Puerto Rico, or Canada.(page 8) and have sent a copy of IML7 to each medical board / issuing authority.
- [x] I do not have to take the Special Purpose Exam (page 9) [ ] I must take the SPEX and have made arrangements to do so.
- [x] I have answered all character and fitness questions (page 9), explained all "yes" answers and, if applicable, enclosed all supporting documents (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgments, final orders, etc.)
- [x] I have attached a 2"x 2" passport quality photograph to the last page (page 11) of this application.
- [x] I have read the statements on page 11 of this application; signed and dated items19, 20 (if applicable), 21 and 22; and arranged to have the application notarized.
- [x] I have enclosed my check made out to "Maryland Board of Physicians" (or "MBP") in the amount of either $790.00 (Graduates of LCME-accredited American and Canadian medical schools) or $890.00 (Graduates of International Medical Schools).
- [x] I have attached the following number of pages of documentation to support this application: 4
- [ ] I have signed the application in the presence of a notary and had the application notarized.

RECEIVED MAR 31 2010

STOP! Completed application and check must be mailed to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297.

National Student Clearinghouse®
2300 Dulles Station Blvd., Suite 300, Herndon, VA 20171
PH (703) 742-4200 FX (703) 318-4058
www.studentclearinghouse.org

DegreeVerify Certificate

Transaction ID#:	018049697	**Date Requested:**	04/08/2010 10:20 EST
Requested by:	VICKTORIA RHONEY	**Date Notified:**	04/09/2010 10:29 EST
Status:	Degree Confirmed by E-mail		
Fee:	$10.50		

INFORMATION YOU PROVIDED

Subject Name:	**LEROY**	**HARRISON**	**CARHART**
	First Name	Middle Name	Last Name
Name Used While Attending School: (if different from above)			
	First Name	Middle Name	Last Name
Date of Birth:	[redacted] mm/dd/yyyy		
School Name:	**HAHNEMANN UNIVERSITY**		
Degree Award Year:	**1973**		
Attempt To:	**Verify a degree.**		

INFORMATION VERIFIED

Name On School's Records:	**LEROY HARRISON CARHART**
Date Awarded:	**06/07/1973**
Degree Title:	**DOCTOR OF MEDICINE**
Official Name of School:	**DREXEL UNIVERSITY**
Major Course(s) of Study (and NCES CIP Code, if available):	**MEDICINE**

CJ ✓

Initial Medical Licensure
Supplemental Form
MBP IML2
10/2009 INT

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836

MAR 26 2010

VERIFICATION OF EDUCATION AND ENGLISH LANGUAGE INSTRUCTION

Part 1 APPLICANT: Complete Part 1 and send to the institution which issued your medical degree. If you satisfied Maryland's English language competency requirements somewhere other than your medical school, also send a copy of this form to that institution and ask them to return the completed form directly to the Board.

Name: CARHART, JR LEROY HARRISON
Print last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name

Date of Birth: Month Day Year [redacted] **Social Security Number:** [redacted]

School Attended HAHNEMANN MEDICAL COLLEGE & HOSPITAL
Only medical school, undergraduate school, or high school

Affiliated with (if applicable): _____
Name of institution that conferred your degree, if different from medical college attended

Attended from: 69 to 73 **Date of Graduation:** 6-3-73

MARYLAND BOARD OF PHYSICIANS RECEIVED 2010 APR 15 P 1:08

Part 2 REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual attended this institution during the inclusive dates from

Month Day Year to Month Day Year
09 08 69 to 06 02 73 ; that all academic studies were taught in the

language(s) of English ; that all clinical clerkships were taught in the

language(s) of English ; and that he/she was conferred the degree of

☒ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ Other:_____ (specify)

on Month 06 Day 07 Year 73 after he/she had satisfied all prerequisite obligations.

Joseph J. Salomone — Printed Name of Authorized Official
Drexel University — Name of Institution

University Registrar — Title of Authorized Official
215-762-7602 — Telephone Number
215-762-4313 — Fax Number

Joseph J. Salomone MP — Signature of Authorized Official
3/31/10 — Date

SEAL OF THE INSTITUTION

Initial Medical Licensure
Supplemental Form
MBP IML3
10/2009 INT

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O.Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836

Side A

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Part 1 APPLICANT: Complete Part 1 and sign where indicated in the Part 2 instructions. Print your name on top of the reverse page, and send a form to the director of each postgraduate training program you attended. Be sure to copy both sides.

a. Applicant's Name: ~~LEE~~ CARHART (Last Name and Generational Indicator (Jr., Sr., II, III, etc.)) LEROY (First Name) H. (Middle Name)

Address: [redacted]

City: [redacted] State: [redacted]

Date of Birth: Month Day Year [redacted] Social Security Number: [redacted]

b. Name of Institution: HAHNEMAN HOSPITAL

Department and Area of Training: GENERAL SURGERY RESIDENCY

Complete Address: BROAD AND VINE

City: PHILADELPHIA State: PA 19102

FROM: Month 07 Year 74 TO Month 12 Year 75

Part 2 POSTGRADUATE TRAINING PROGRAM DIRECTOR: Please complete Part 2 according to the records available and send directly to the Maryland Board of Physicians at the above address. Please do not send original or copies to me.

Applicant's Signature: See letter following application for explanation of his PGT

1. Did the applicant participate in postgraduate training in your department during the period listed above?
☒ YES ☐ NO If "No," please enter exact dates: _____ to _____

Program Specialty: SURGERY

*If training was part-time, please explain the training schedule after item 8 of this form.

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2. During the time of the applicant's participation, was the postgraduate training program accredited? ☒ YES ☐ NO

Accredited by: ☒ ACGME: Program # 440-41-21-295 ☐ AOA: ID #: _____ ☐ RCPSC

3. Did the applicant participate in all of the components of the training as required by the accrediting body?
☐ YES ☐ NO Comments (attach signed and dated additions as needed): APPLICANT did not complete training @ HAHNEMANN

4. Did the applicant successfully complete all requirements of each year of training?
☐ YES ☐ NO Comments (attach signed and dated additions as needed): APPLICANT did not complete training @ HAHNEMAND

5. During the applicant's year(s) of training, did the applicant have any break in training?
☐ NO ☐ YES Comments (attach signed and dated additions as needed): APPLICANT only completed 6 mos. of training @ HAHNEMANN

(Continued on next page)

Initial Medical Licensure
Supplemental Form
MBP IML3
10/2009 INT

MARYLAND BOARD OF PHYSICIANS
VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Side B

Applicant's Name (print): LEROY CARHART

6. Did the applicant have any physical or mental problem that affected the applicant's ability to practice medicine during the period of training?

☒ NO ☐ YES If "Yes," please give a detailed explanation* _____

7. Was any action taken against the applicant by any training program, hospital, medical board, licensing authority, or court ? Such actions include, but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary actions, etc.

☒ NO ☐ YES If "Yes," please give a detailed explanation* _____

8. In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

☐ YES ☐ NO Comments:* APPLICANT COMPLETED ONLY 6 MOS. OF TRAINING.

Control No: 107155 06/25/2010
Carhart Jr., Leroy Harrison
IML3-Accredited Training Programs
Received: William Calhoun
Analyst: Carol Johnson

RECEIVED
JUN 25 2010

*** If space is not sufficient, please attach a signed and dated detailed explanation.**

Attestation: I attest that the information I have provided regarding the applicant is true, accurate, and complete according to all available records.

JAY VANOFF, D.Ed.
Printed Name of Program Director

(D.I.O.) Chief GME Officer
Title

HAHNEMANN U. HOSPITAL
Hospital

BROAD & VINE STS. PHILA
Address

GRADUATE MEDICAL EDU.
Department

215-762-2609
Telephone Number

Jay Vanoff
Signature

6/21/10
Date

Initial Medical License Supplemental Form
MBP IM 3
10/2009 INT

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O.Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836

Side A

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Part 1 **APPLICANT:** Complete Part 1 and sign where indicated in the Part 2 instructions. Print your name on top of the reverse page, and send a form to the director of each postgraduate training program you attended. Be sure to copy both sides.

a. **Applicant's Name:** CARHART, JR LEROY HARRISON
Last Name and Generational Indicator (Jr., Sr., II, III, etc.) First Name Middle Name

Address: [redacted]

City: [redacted] **State:** [redacted]

Date of Birth: Month Day Year [redacted] **Social Security Number:** [redacted]

b. **Name of Institution:** ATLANTIC CITY MEDICAL CENTER

Department and Area of Training: GENERAL SURGERY, RESIDENT

Complete Address: 1925 PACIFIC AVENUE

City: ATLANTIC CITY **State:** NJ

FROM: Month 01 Year 77 **TO** Month 06 Year 77

Part 2 **POSTGRADUATE TRAINING PROGRAM DIRECTOR:** Please complete Part 2 according to the records available and send directly to the Maryland Board of Physicians at the above address. Please do not send original or copies to me.

Applicant's Signature: [signature]

1. Did the applicant participate in postgraduate training in your department during the period listed above?*

☐ YES ☑ NO If "No," please enter exact dates: Jan. 1976 to June 1977

Program Specialty: General Surgery - Resident

*If training was part-time, please explain the training schedule after item 8 of this form.

2. During the time of the applicant's participation, was the postgraduate training program accredited? ☑ YES ☐ NO

Accredited by: ☑ ACGME: Program # _____ ☐ AOA: ID #: _____ ☐ RCPSC

3. Did the applicant participate in all of the components of the training as required by the accrediting body?

☑ YES ☐ NO Comments (attach signed and dated additions as needed): _____

4. Did the applicant successfully complete all requirements of each year of training?

☑ YES ☐ NO Comments (attach signed and dated additions as needed): _____

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APR 6 2010

5. During the applicant's year(s) of training, did the applicant have any break in training?

☑ NO ☐ YES Comments (attach signed and dated additions as needed): _____

(Continued on next page)

Initial Medical Licensure
Supplemental Form
MBP IML3
10/2009 INT

MARYLAND BOARD OF PHYSICIANS
VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Side B

Applicant's Name (print): LeRoy Harrison Carhart, Jr.

6. Did the applicant have any physical or mental problem that affected the applicant's ability to practice medicine during the period of training?

☒ NO ☐ YES If "Yes," please give a detailed explanation* _____

7. Was any action taken against the applicant by any training program, hospital, medical board, licensing authority, or court ? Such actions include, but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary actions, etc.

☒ NO ☐ YES If "Yes," please give a detailed explanation* _____

8. In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

☒ YES ☐ NO Comments:*

Control No: 107155
Carhart Jr., Leroy Harrison
IML3-Accredited Training Programs
Received: William Calhoun
Analyst: Felicia Jackson

04/06/2010

RECEIVED
APR 6 2010

*** If space is not sufficient, please attach a signed and dated detailed explanation.**

Attestation: I attest that the information I have provided regarding the applicant is true, accurate, and complete according to all available records.

Zia Salam, MD, FACE, FACP
Printed Name of Program Director

Program Director
Title

AtlantiCare Regional Medical Center
Hospital

1925 Pacific Ave., Atlantic City, NJ
Address

Internal Medicine Residency
Department

(609) 441-8074
Telephone Number

Zia Salam MD
Signature

4/1/10
Date

STATE OF INDIANA

MITCHELL E. DANIELS

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Digitally Certified Proof of Licensure

RE: LEROY HARRISON CARHART

I, Frances Kelly, Executive Director of the Indiana Professional Licensing Agency and custodian of the records therein, hereby certify that the attached is the digitally certified proof of licensure, as requested, and as it appears in the files of the Indiana Professional Licensing Agency on the date/time certified.

This digital certification follows the requirements of Indiana's Electronic Digital Signature Act (Indiana Code 5-24-1-1 et seq.) and rules developed by the Indiana State Board of Accounts, 20 IAC 3-1 et seq. to establish a valid digital electronic signature

If you have the need to verify the authenticity of the digital certification as of the date and time stamp below, go to https://secure.in.gov/apps/pla/verify.htm and use our free web service to "Verify an Electronic Certified Record". Simply browse to the location you saved the secure pdf document sent to you and upload to validate.

Frances Kelly, Executive Director
Mon Mar 01 02:48:19 PM EST 2010

UNITED STATES POSTAL SERVICE®
Electronic Postmark

STATE OF INDIANA

MITCHELL E. DANIELS

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Official Proof of Licensure
Digitally Certified Record

Personal Information

Name:	LEROY HARRISON CARHART
Address:	[redacted]
Date of Birth:	[redacted]

License Information

Number Issued:	01040632A
License Type:	Physician
Status:	Active
Issue date:	07/30/1992
Expiration Date:	06/30/2011
Obtained By:	Endorsement
Disciplinary Action:	None

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams.

For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at www.in.gov/pla/boards.htm

Digitally Certified on: Mon Mar 01 02:48:19 PM EST 2010

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CHESTER J. CULVER
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PATTY JUDGE
LT. GOVERNOR

IOWA BOARD OF MEDICINE
MARK BOWDEN
EXECUTIVE DIRECTOR

June 18, 2010

Verification of Licensure

Maryland Board of Physicians
4201 Patterson Ave, 4th Fl
P.O. Box 2571
Baltimore, MD 21215

This is to certify that the records of the Iowa Board of Medicine indicate the following information regarding this physician.

NAME:	Leroy Harrison Carhart, MD
DATE OF BIRTH:	[redacted]
LICENSE NUMBER:	23312
LICENSE TYPE:	Permanent
ISSUE DATE:	10/15/1982
EXPIRATION DATE:	10/01/2011
HOW OBTAINED:	State Structured Exam
STATUS:	Active
DISCIPLINARY ACTION:	No
HISTORY OF INVESTIGATION:	*See below*

This license information was last updated on: 06/18/2010

The above format is prepared for all physicians regulated by this board. All physicians are considered in good standing unless otherwise noted. **If disciplinary action has been indicated or if a history of investigation exists, a copy of that information will be provided to your office in a separate mailing within ten business days.**

Sincerely,

E R. W

Eric Way
Licensing Assistant

400 SW 8th STREET, SUITE C, DES MOINES, IA 50309-4686
PHONE:515-281-5171 FAX:515-242-5908 www.medicalboard.iowa.gov

KANSAS
BOARD OF HEALING ARTS

Mark Parkinson, Governor
Kathleen Selzler Lippert, Acting Executive Director

www.ksbha.org

March 25, 2010

Maryland Board of Physicians
4201 Patterson Avenue
PO Box 2571
Baltimore, MD 21215-0095

This is to certify that: Leroy Harrison Carhart, MD has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

License Number:	04-24866
Date of Birth:	[redacted]
Profession:	Medical Doctor (MD)
License Designation:	MD Active License
License Status:	Current
Original License Date:	12/10/1993
Expiration Date:	06/30/2010
Disciplinary Action:	None
Pending Complaints:	None

Unless otherwise indicated, this licensee has not been subject to disciplinary proceeding by the Kansas Board of Healing Arts.

Verified by:

Sandra Fienhage

Sandra Fienhage
Senior Administrative Assistant

235 S.W. Topeka Blvd., Topeka, KS 66603-3068 • (785)-296-7413 • 1-888-886-7205 • Fax: 785-296-0852
TTY (Hearing Impaired) 711 or 1-800-766-3777 voice/TTY • e-mail: healingarts@ksbha.ks.gov

Please reply to: Licensure Unit
PO Box 94986, Lincoln, NE 68509-4986
Phone (402) 471-2118
FAX (402) 471-8614

Nebraska Department of Health and Human Services

Division of Public Health

State of Nebraska

Dave Heineman, Governor

CERTIFICATION OF LICENSE

Maryland Board of Physicians
4201 Patterson Avenue
P.O. Box 2571
Baltimore, MD 212150095

PROFESSION NAME: Physician

Number: 15162 Status: Active
Issuance Date: 10/17/1979 Expiration Date: 10/01/2010

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MAR 29 2010

Name: LeRoy Harrison Carhart, MD
Address: [redacted]

Credential Obtained by: Reciprocity

Exam Type: Exam Score:

School/Graduation Date: HAHNEMANN MED COL 06/07/1973

Date of Birth: [redacted]
Place of Birth:

Disciplinary Action: Nondisciplinary Assurance of Compliance 05/25/1993

NOT A BAR TO LICENSURE — Nondisciplinary OVER 3 yrs ago.

To expedite the certification process, the Licensure Unit is using the above format. There is no derogatory information in the professional's records if the Disciplinary Action section above is left blank.

Helen L. Meeks

Helen L. Meeks, Administrator
Licensure Unit

March 25, 2010

You may verify licenses under the following Internet Web Site Address: http://www.dhhs.ne.gov/lis/lisindex.htm

(SEAL)

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183, Trenton, NJ 08625-0183

PAULA T. DOW
Attorney General

SHARON M. JOYCE
Acting Director

March 25, 2010

Maryland Board of Physicians
4201 Patterson Ave
P.O. Box 2571
Baltimore, MD 21215-0095

For overnight deliveries:
140 East Front St.
PO Box 183 , 3rd Floor
Trenton, NJ 08608
(609) 826-7100
(609) 826-7101 FAX

To Whom It May Concern:

The New Jersey State Board of Medical Examiners has been requested by Leroy H Carhart to forward a letter of good standing regarding the Medical Doctor's license to practice in the State of New Jersey.

A review of the Board's files indicates that Leroy H Carhart was issued a New Jersey license 25MA03654100 on or about 08/08/1979 and is currently Retired-Paid with an expiration date of 06/30/2011. A review of the Board's files further indicates that no public disciplinary action has been taken against this Medical Doctor.

Very truly yours,

BOARD OF MEDICAL EXAMINERS

William V. Roeder
Executive Director

WVR/dd/mac/sh

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

VERIFICATION OF LICENSURE

This is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 3/4/2010:

Identification Information

Name and Address:	Dr. LEROY HARRISON CARHART [redacted]
Date of Birth:	[redacted]
Place of Birth:	
School of Graduation:	**Hahnemann Medical College of Philadelphia**
Date of Graduation:	06/07/73

License Information

Type of License:	Doctor of Medicine
License Number:	35. 057427
How Issued:	End Flex
Original Licensure Date:	09/23/1988
Expiration Date:	04/01/2011
Status:	ACTIVE
Formal Disciplinary Action:	No

Richard A. Whitehouse
Executive Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

March 2, 2010

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	LEROY HARRISON CARHART
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD035665L
ORIGINAL LICENSURE DATE:	09/27/1974
EXPIRATION DATE:	12/31/2010
STATUS:	Active

The license is in good standing and the records indicate no derogatory information.

SEAL

Basil L. Merenda
Commissioner
Bureau of Professional and Occupational Affairs

Jim Doyle
Governor

Celia M. Jackson
Secretary

WISCONSIN DEPARTMENT OF REGULATION & LICENSING

1400 E Washington Ave
PO Box 8935
Madison WI 53708-8935
Email: web@drl.state.wi.us
Voice: 608-266-2112
FAX: 608-267-0644
TTY: 608-267-2416

CERTIFICATION

DATE: 03/25/2010

I, Cathy Pond, do hereby certify that I am the Division Administrator in the Department of Regulation and Licensing, a department of the government of the State of Wisconsin; that I am the custodian of the records relating to Medicine and Surgery and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	LEROY H CARHART
WAS ISSUED LICENSED NO:	35028 - 020
ON:	12/15/1993
CREDENTIAL TYPE:	MEDICINE AND SURGERY
LICENSE EXPIRATION DATE:	10/31/2011

Credential Holder History

Date	Code	Description
06/07/1973	GRADUATED FROM	HAHNEMANN MED COL-PHILADELPHIA
12/15/1993	ENDORSED FROM	ENDORSED FLEX

According to our records, this credential holder has not been disciplined.

The information above is the only certification information provided by this Department. To expedite the certification process, the above format is the standard format for all professions regulated by this Department.

SEAL

Cathy Pond
Division Administrator

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

1. **License Number D0071127** Dr. LeRoy Harrison Carhart

2.	Individual National Provider Identifier NPI: 1902028715 ☐ I do not have an NPI This is the NPI entered in the field for Rendering NPI on a claim (10 digit number) NPI Information

3. EMAIL ADDRESS: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

janine0@aol.com

☐ I do not have an email address

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2010 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. Non-Public Address: This address is for Board use only and is where your license will be mailed. However, if no public address is listed, this address will also be made available to the public.

Street [redacted]
Street (2)
Street (3)
City [redacted]
State
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode
Country [redacted]

4b. Public Address: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street	1002 West Mission Avenue
Street (2)	
Street (3)	
City	Bellevue
State	Nebraska If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	68005
Country	United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction [redacted] Yes [redacted] No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2008. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.

[redacted] Yes [redacted] No

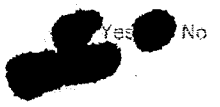
a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?



f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

k. Do you illegally use drugs?

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?

[redacted] Yes [redacted] No

o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

[redacted] Yes [redacted] No

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

[redacted] Yes [redacted] No

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

○ **a. CME met.** I have earned 50 credit hours of Category 1 continuing medical education during the two (2) years prior to this renewal.

◉ **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2008 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

○ **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8. Ethnicity and Race: (Select all that apply)

[redacted]lispanic or Latino
[redacted]American Indian or Alaska native
[redacted]Asian
[redacted]Black or African American
[redacted]Native Hawaiian or other Pacific Islander
[redacted]White
[redacted]Other

9. Are you employed by the Federal Government?

○ Yes ◉ No

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer ***Yes*** to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

[redacted] Yes [redacted] No

b. In an accredited fellowship (subspecialty) training program?

[redacted] Yes [redacted] No

11. Which best describes your current area(s) of concentration:

Primary Concentration [redacted]

Secondary Concentration [redacted]

12. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification None

Secondary Certification None

13. Please indicate below how the hours in your typical work week are allocated. The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	[redacted]	hours per week
b. Research		hours per week
c. Teaching		hours per week
d. Administration & Other		hours per week
Total Hours		hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next 2 years?

[redacted] Yes [redacted] No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

[redacted] Yes [redacted] No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) 0

b. Number of locations outside of Maryland (if none, enter 0) 2
If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?

◉ Yes ○ No ○ Don't know

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) 0

b. Number of hospitals outside of Maryland (if none, enter 0) 0

18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name Bellevue Health & Emergency Clinic, Inc.

b. Street Address 1002 West Mission Avenue

c. Street2

Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City Bellevue

e. State Nebraska

f. Zip Code 68005

g. Jurisdiction Non-Maryland

h. Employer Tax ID NONE What is Employer tax ID?

Enter "None" if you do not have an Employer tax ID

i. Please select one of the following related to the NPI used for billing insurers:

◉ **I use an Organizational NPI for billing. Please Enter >** 1700055704

○ **I use my Individual NPI for billing.** **Organizational NPI**

○ **I do not bill public or private insurers.**

j. You indicated in Question 13a, **34** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? [redacted]

If none, enter 0. Hours

k. Setting Free Standing Medical Facility

l. Private/Public Private-For profit

m. Practice Solo

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.

If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 1

Number of mid-level medical providers at this location. 0

Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

19. Secondary Practice / Office Location

If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

a. Organization Name: Affiliated Women's Services, Inc

b. Street Address: 2215 Distributor Drive

c. Street2: Enter suite or room number (Ex. Suite 101 or Room 101)

d. City: Indianapolis

e. State: Indiana

f. Zip Code: 46241

g. Jurisdiction: Non-Maryland

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h. Employer Tax ID: NONE What is Employer tax ID?

Enter None if you do not have an Employer tax ID

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i. Please select one of the following related to the NPI used for billing insurers:

- ○ **I use an Organizational NPI for billing. Please Enter >** Organizational NPI
- ○ **I use my Individual NPI for billing.**
- ◉ **I do not bill public or private insurers.**

---

j. You indicated in Question 13a, **34** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? [redacted] Hours

If none, enter 0.

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k. Setting: Freestanding Physician Office

l. Private/Public: Private-For profit

m. Practice: Solo

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.

If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 1

Number of mid-level medical providers at this location. 1

Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

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20. Information Technology (Primary Practice / Office Location)

Please answer all Primary Practice Information Technology questions

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in question 18.

[redacted] Yes [redacted] No A. To obtain information about treatment alternatives or recommended guidelines?

[redacted] Yes [redacted] No B. To send prescriptions electronically to a pharmacy?

If you answered **Yes** to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. %

[redacted] C. To generate reminders for you about preventive services needed for your patients?

[redacted] D. To access patient notes, medication lists, or problem lists?

[redacted] E. For clinical data and image exchanges **WITH OTHER PHYSICIANS?**

[redacted] F. For clinical data and image exchanges **WITH HOSPITALS AND LABORATORIES?**

[redacted] G. To communicate about clinical issues with patients by email?

[redacted] H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

21. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

[redacted] Yes, all electronic [redacted] Yes, part paper and part electronic [redacted] No [redacted] Don't know

21a. If **No**, please indicate your most significant reason for not using electronic medical records.

[redacted] Capital cost outlays [redacted] Risk of privacy breaches [redacted] Retiring soon

[redacted] Overburdened staff [redacted] Lack of technology standards [redacted] Not my decision

[redacted] Physician resistance to adoption [redacted] Intangible benefits

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. ◉ Yes ○ No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) ○ Yes ◉ No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? Yes No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)? ◉ Yes ○ No

c1. If **Yes**, are you accepting new Medicare patients? ◉ Yes ○ No

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

[redacted] Yes [redacted] No [redacted] NA

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

[redacted] hours per week. [redacted] If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?

[redacted] Yes [redacted] No

26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you

verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

[redacted]reby certify:

[redacted] Not Applicable (Do not complete below)

[redacted] I do not practice in Maryland.

[redacted] I do not employ anyone in my practice in Maryland.

[redacted] I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date

Enter as MM/DD/YYYY Enter as MM/DD/YYYY

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime *

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

☐ Chemical ☐ Biological ☐ Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

APPLICATION PACKET FOR EXEMPTION FROM LICENSE FEE

28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

Please check the first 3 boxes to certify and affirm your renewal application.

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers,

government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☑ d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2010.

29. Please provide your electronic signature (type your name) below:

Name	LeRoy H Carhart
Today's Date	9/9/2010
Last four digits of Social Security Number:	[redacted]

30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

○ Credit Card ◉ Send Check ○ 3rd Party Check 3rd Party Payer:

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started	9/9/2010
Date Application Submitted	9/9/2010
Confirmation Number	10924D0071127
Payment Method	Send Check
Amount Due	$512.00