APPLICATION FOR LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

State Form 29495 (R6 / 3-92)
Approved by State Board of Accounts, 1992

94001316

Health Professions Bureau
402 W. Washington St., Rm. O41
Indianapolis, Indiana 46204
Telephone Number: (317) 232-2960

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

Application fee	#250
Date fee paid (month, day, year)	4-6-94
Receipt number	142-286-01/03
Application number	
License number	01042939
License issuance date (month, day, year)	7-28-94

Permit fee	
Date fee paid (month, day, year)	
Receipt number	
Permit number	1886
Permit issuance date (month, day, year)	4-14-94

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name (last, first, middle, maiden)			* Social Security number	
GLOVER, KATHLEEN				
Address (number and street or Rural Route)		City	State	ZIP code
		Yellow Springs	Ohio	45387
Telephone number (daytime)	Birthdate (month, day, year)	Birthplace		
		Cleveland, Ohio USA		

TEMPORARY PERMIT INFORMATION

Do you desire a permit?	Do you currently possess an Indiana permit?	If Yes, enter your permit number here
☑ Yes ☐ No	☐ Yes ☑ No	

EXAMINATION

Check appropriate box indicating which examination you have taken.

☐ FLEX EXAMINATION: Request that scores be sent directly to this office. Contact the Federation of State Medical Boards, 6000 Western Place, Suite 707, Fort Worth, TX 76107-4618. Telephone: (817) 735-8445.

☑ NATIONAL BOARD EXAMINATION: Request that your official scores be sent directly to this office. M. D. s contact the National Board of Medical Examiners Office, 3930 Chestnut Street, Philadelphia, PA 19104. Telephone: (215) 349-6400. D. O. s contact the National Board of Osteopathic Medical Examiners, 2700 River Road, Suite 407, Des Plaines, IL 60018. Telephone: (312) 635-9955.

☐ LMCC EXAMINATION: Request that your official scores be sent directly to this office. Contact the Medical Council of Canada, 1867 Alta Vista Drive, Case Postale, Box 8234, Ottawa, Canada KIG 3H7 Telephone: (613) 521-6012.

☐ STATE BOARD EXAMINATION : You must have the state board complete the "VERIFICATION OF STATE LICENSURE" form and attach the subjects, scores, date of examination and average.

Examination taken in which state?

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of School	Check one:	Location	Date of Graduation (Month, Day, Year)
WRIGHT STATE UNIVERSITY	☑ MD ☐ DO	Dayton, Ohio	1988 - June 11

HAVE YOU PREVIOUSLY TAKEN THE FLEX EXAMINATION?

	If Yes, how many times?	Date of most recent test (month, year)	Where taken (state or country)
FLEX Component I ☐ Yes ☑ No			
FLEX Component II ☐ Yes ☑ No			
Pre 1985 FLEX ☐ Yes ☑ No			

Include ALL internships, residencies and/or fellowships.

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA

NAME OF SCHOOL	LOCATION	FROM (Mo. Yr.)	TO (Mo. Yr.)
WRIGHT STATE INTEGRATED INTERNAL MEDICINE Program	DAYTON, OHIO	7/88	6/89

Do you hold, or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation? ☑ Yes ☐ No

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.

STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
OHIO	MEDICAL (M.D)	35-05-9888	1992	Active

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☑ No
2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☑ No
3. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem? ☐ Yes ☑ No
4. Have you ever been charged with drug addiction? ☐ Yes ☑ No
5. Have you ever been convicted of, pled guilty or *nolo contendre* to:
   A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☑ No
   B. To any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines)* ☐ Yes ☑ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☑ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☑ No
8. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☑ No

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED
PURDUE UNIVERSITY	LAFAYETTE, INDIANA	1967-1975
AKRON UNIVERSITY	AKRON, OHIO	1982-1983

MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED
WRIGHT STATE UNIVERSITY	DAYTON, OHIO	1983-1988.

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL FOR THE LAST 10 YEARS	
GENERAL LOCATION	DATE
626 Oman Circle Yellow Springs, Ohio	1983 – Present

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL FOR THE LAST 10 YEARS		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE
See attached - Please.		

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of Applicant: Kathleen [signature], MD. Date: 3/26/94.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for medical licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Date (Month, Day, Year): 3/26/94.

Signature of Applicant: Kathleen [signature] MD

mailed 5/3/94

RECEIVED

VERIFICATION OF STATE LICENSURE

State Form 7143 (R2 / 10-91)

PRIVACY NOTICE
This State agency is requesting disclosure of your Social Security number under IC 4-1-8-1. Disclosure is mandatory, and this form will not be processed without it.

HEALTH PROFESSIONS BUREAU
Indiana Government Center South
402 W. Washington St., Rm 041
Indianapolis, Indiana 46204
Telephone: (317) 232-2960

INSTRUCTIONS: Type and complete the top section. Make copies to send to each state that you hold or have held a license. Have the state(s) send this directly to our office.

Name *(Last, first, middle, maiden)* GLOVER, KATHLEEN		Health Profession License Held M.D.	Social Security Number *
Address *(Number, street, or / rural route)*		City Yellow Springs	State OHIO / ZIP code 45387
License number 35-05-9888	Date of Issuance *(month, day, year)* 1992		Date of Birth *(month, day, year)*

I hereby authorize the State of OHIO, to furnish the Health Profession Bureau of Indiana with the information below.

Signature Kathleen Glover

* Required pursuant to IC 4-1-8-1

DO NOT WRITE BELOW THIS LINE

License number 59888	Date of Issuance *(month, day, year)* 5/15/90	Licensed by ☐ Exam ☐ Endorsement ☐ Other	
Type of Examination	Date of Administration *(month, day, year)*		Please Affix Board Seal

Attach subjects, scores, date of examination and average.

License is current and in good standing	License is or has been invalid	Any derogatory information
Expires 9/30/94 ☐ Yes ☐ No	☐ Yes ☑ No	☑ Yes ☐ No

If license has been encumbered in any way, please provide certified copies of all related documents.

FORM COMPLETED BY:

Name	Title		
Debra L. Jones	Chief, C.M.E. Records & Renewal		
Signature Debra L. Jones		State Board Ohio State Medical Bd	Date *(month, day, year)* 4/1/94

STATE MEDICAL BOARD OF OHIO 94 MAR 8 PH

Please be advised Kathleen Glover's license is current and in good standing. We do not have any derogatory information. The above was marked yes by mistake. The Ohio license has been renewed since we completed this form and will expire 09/30/96.

Sincerely,

Debra L. Jones

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

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MAY 1 2 1994
HEALTH PROFESSIONS BUREAU

VERIFICATION OF STATE LICENSURE

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Name (*Last, first, middle, maiden*): GLOVER, KATHLEEN

Health Profession License Held: M.D.

Social Security [illegible] *

Address (*Number, street, or rural route*):

City: Yellow Springs | State: OHIO | ZIP code: 45387

License number: 35-05-9888

Date of Issuance (*month, day, year*): 1992

Date of Birth (*month, day, year*):

I hereby authorize the State of OHIO, to furnish the Health Profession Bureau of Indiana with the information below.

Signature: [signature]

* Required pursuant to IC 4-1-8-1

DO NOT WRITE BELOW THIS LINE

License number: 59888

Date of Issuance (*month, day, year*): 5/15/90

Licensed by: [handwritten] ☐ Exam ☐ Endorsement ☐ Other

Please Affix Board Seal

Type of Examination:

Date of Administration (*month, day, year*):

Attach subjects, scores, date of examination and average.

License is current and in good standing: Expires 9/30/94 ☐ Yes ☐ No

License is or has been invalid: ☐ Yes ☑ No

Any derogatory information: ☑ Yes ☐ No

If license has been encumbered in any way, please provide certified copies of all related documents.

FORM COMPLETED BY:

Name: Debra L. Jones

Title: Chief, C.M.E. Records & Renewal

Signature: [signature]

State Board: Ohio State Medical Bd

Date (*month, day, year*): 4/1/94

STATE MEDICAL BOARD OF OHIO
94 MAR 18 PM 3:07

RECEIVED
JUN 1 1994
HEALTH PROFESSIONS
BUREAU

Wright State University

By authority of the Board of Trustees and on recommendation
of the Faculty hereby confers upon

Kathleen Glover

the Degree of

Doctor of Medicine

With all the honors, rights and privileges belonging thereto.
In Testimony Whereof this Diploma is granted, bearing the Seal of the University
and the signatures of its Duly Authorized Officers at Dayton, Ohio,
this eleventh day of June, nineteen hundred and eighty-eight.

Chair, Board of Trustees

President of the University

M.D.
Dean

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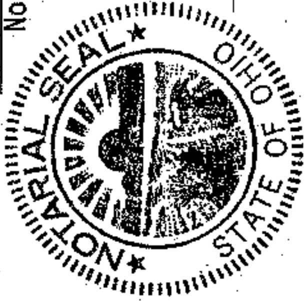
MAY 1 2 1994

HEALTH PROFESSIONS

This is a true copy of the original.

Notary Public



KATHLEEN E. SEIBERT, Notary Public
In and for the State of Ohio
My Commission Expires Sept. 30, 1996

Wright State University

School of Medicine and Affiliated Hospitals

Hereby Certify that

Kathleen Glover, M.D.

Has served as

Resident

in

Internal Medicine

July 1, 1988 - June 30, 1989

Dean, School of Medicine

Program Director

STATE MEDICAL BOARD OF OHIO
77 S. High St., Columbus, Ohio 43266-0315

EXPIRATION DATE 09/30/94 | IDENTIFICATION NUMBER 35-05-9888

1992 – 1994

KATHLEEN [illegible] MD
626 [illegible]
YELLOW SPR[illegible]

Has met the requirements of the [illegible] is duly registered and entitled to practice in The State of Ohio [illegible] expiration date.

AUDIT NUMBER 032082

Kathleen [illegible], M.D. 3/28/94

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APR 6 1994
HEALTH PROFESSIONS BUREAU

Anita L. Crosswhite - March 28, 1994

ANITA L. CROSSWHITE, Notary Public
In and For the State of Ohio
My Commission Expires May 29, 1997

Personal Information

Kathleen Glover, M.D.

Yellow Springs. Ohio 45387

Formal Education

Wright State University Internal Medicine Residency 1988-1989
Wright State University, M.D. 1988
Purdue University, B.A. 1975

Professional Experience

The Dartmouth Hospital (Psychiatric Hospital)
5350 Lamme Road
Dayton, Ohio 45439
513-299-9511
11/89 to present
Medical Consultant
Contact: Dr. Wayne Anable

Planned Parenthood of West Central Ohio
6 West High Street
Springfield, Ohio 45502
513-325-6416
7/90 to present
Staff Physician
Contact: Deb Mills

Springfield Board of Health
529 E. Home Road
Springfield, Ohio 45503
513-390-5601
3/93 to present
S.T.D. Clinic-Staff Physician
Well Child Clinic-Staff Physician
Contact: Judy Rhoads

Ohio Reformatory for Women
1479 Collins Avenue
Marysville, Ohio 43040
513-642-1065
7/92 to present
Staff Physician
Contact: Dr. John Bradley (x229)