APPLICATION FOR A LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

State Form 29495 (R21 / 8-17)
Approved by State Board of Accounts, 2017

RECEIVED
DEC 9 2019

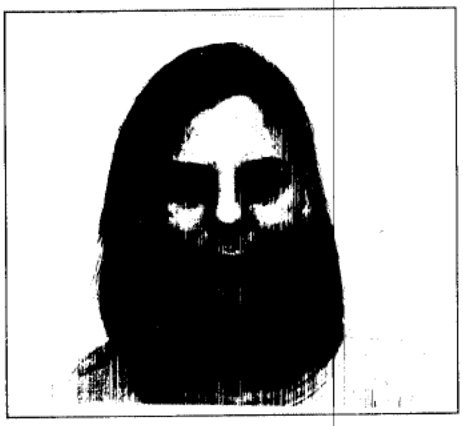
MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $250.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 4-2-2.*
2. *If applying for a temporary permit, please include your fee of $100.00 in accordance with 844 IAC 4-2-2.*
3. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY	
Application fee: 250.00	Date fee paid (*month, day, year*): 12/4/19
Receipt number: 7580065	Application number:
License number: 0108325A	License issuance date (*month, day, year*): 12-11-19
Permit fee:	Date fee paid (*month, day, year*):
Receipt number:	Permit number:
Permit issuance date (*month, day, year*):	



DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*): Jennings, Valerie	Check one: ☑ MD ☐ DO	Social Security number *: [redacted]
Address of practice (*number and street or rural route*): 4199 Gateway Boulevard		
City, state, and ZIP code: Newburgh, IN 47630		
Telephone number (*daytime*): [redacted]	Date of birth (*month, day, year*): [redacted]	Ethnicity **: Caucasian / Race **: Caucasian / Gender **: ☐ Male ☑ Female
Mailing address (*number and street, city, state, and ZIP code*) *[if different from above]*: 4701 English Oak Ct. Champaign, IL 61822		
E-mail address: [redacted]	National Provider Identifier number: 1710243142	ECFMG certificate number: N/A

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*
☒ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641).

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☒ No

Please check the box to be included on the Health Care Volunteer Registry established by IC 25-22.5-15. *(Optional)* ☐

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit? ☐ Yes ☑ No

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

A foreign medical school must meet LCME standards at the time of graduation.

Name of school: University of Illinois	Location: Chicago, IL	Date of graduation (*month, day, year*): 05/4 /2012
Specialties: Obstetrics/Gynecology	Board certification (*list ABMS certification*): Obstetrics/Gynecology	

EXAMINATION HISTORY

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

State where Board Exam was taken: USMLE

Examination	Most Recent Date Taken (month/year)	Results		Number of Attempts	Examination	Most Recent Date Taken (month/year)	Results		Number of Attempts
		Passed	Failed				Passed	Failed	
FLEX Pre-1985					NBOME Part II				
FLEX Component 1					NBOME Part III				
FLEX Component 2					COMLEX-USA Level 1				
LMCC - Single					COMLEX-USA Level 2, CE				
LMCC - Part I					COMLEX-USA Level 2, PE				
LMCC - Part II					COMLEX-USA Level 3				
NBME Part I					COMVEX				
NBME Part II					USMLE Step I	06/2010	✓		1
NBME Part III					USMLE Step II, CS	09/2011	✓		1
SPEX					USMLE Step II, CK				
NBOME Part I					USMLE Step III	09/2013	✓		1

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
University of Illinois	Urbana, IL	08/ 28 /2002 - 05/ 14 /2006
University of Illinois	Urbana, IL	08/ 23 /2006 - 05/ 17 /2008

MEDICAL / OSTEOPATHIC EDUCATION

A foreign medical school must meet LCME standards at the time of graduation.

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
University of Illinois	Chicago, IL	08/ 18 /2008 - 05/ 4 /2012

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA
(Include ALL internships, residencies and / or fellowships)

All programs must have been ACGME accredited at the time of enrollment.

NAME OF PROGRAM	LOCATION	FROM (month, year)	TO (month, year)	ACGME / AOA / RC ACCREDITED?
University of Illinois	Chicago, IL	06/2012	06/2016	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)	
GENERAL LOCATION	DATE (*month, day, year*)
Champaign, IL	6/30/2016 - present

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE (*month, day, year*)
Carle Foundation Hospital - 611 W Park St, Urbana, IL 61801	Attending Physician	08/22/2016 - Current

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
IL	Medical Doctor	036138546	07/01/2015	Active

If your answer is "Yes" to any of questions 1 through 12, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit 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, or surrendered your license?	☐ Yes	☒ No
3. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice medicine in a competent and professional manner?	☐ Yes	☒ No
4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?	☐ Yes	☒ No
5. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*		
(1) have you ever been arrested;	☐ Yes	☒ No
(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	☐ Yes	☒ No
(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	☐ Yes	☒ No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	☐ Yes	☒ No
(5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?	☐ 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
9. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	☐ Yes	☒ No
10. Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?	☐ Yes	☒ No
11. Have you ever been excluded from being a Medicare / Medicaid provider?	☐ Yes	☒ No
12. Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or any other reason during your medical education or post graduate training / residency program?	☐ Yes	☒ No
13. Have you practiced as a MD/DO either clinically or administratively in the last three (3) years?	☒ Yes	☐ No

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	Date signed *(month, day, year)*
[signature]	11/20/19

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, 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 Professional Licensing Agency to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Agency and Board from any and all liability in connection with such disclosure.

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.

Signature of applicant	Date signed *(month, day, year)*
[signature]	11/20/19

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Indiana Professional Licensing Agency

Copy of original

By authority of the Board of Trustees of the

UNIVERSITY OF ILLINOIS

and upon recommendation of the Senate

at Chicago

Valerie Lauren Jennings

has been admitted to the Degree of

Doctor of Medicine

and is entitled to all rights and honors thereto appertaining
Witness the Seal of the University and the Signatures of its Officers
this sixth day of May, two thousand and twelve.

DENISE GAY
Official Seal
Notary Public - State of Illinois
My Commission Expires May 23, 2020

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Licensing Agency

UNIVERSITY OF ILLINOIS
CHARTERED 1867

Chair of the Board of Trustees

Susan M. Kies
Secretary of the Board of Trustees

Michael Hogan
President of the University of Illinois

Paula Allen-Meares
Vice President, University of Illinois
Chancellor, University of Illinois at Chicago

Copy of original

The University of Illinois at Chicago

College of Medicine

This certifies that

Valerie Lauren Jennings, M.S., M.D.

has completed a program of graduate medical education in

Obstetrics & Gynecology

at the University of Illinois (UIC) College of Medicine at Chicago

June 24, 2012 to June 30, 2016

The following are major affiliated hospitals in the program:

University of Illinois Hospital & Health Sciences System
Advocate Christ Medical Center
MacNeal Hospital

Director of Program

Associate Dean for Graduate Medical Education

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Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Deborah Hagan
Secretary

Cecilia Abundis
Acting Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

December 9, 2019

Professional Licensing Agency
Medical Licensing Board of Indiana
402 West Washington Street,
Room W072
Indianapolis, IN 46204

Licensee:	VALERIE LAUREN JENNINGS MD
License Number:	036.138546
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	07/01/2015
Expiration Date:	07/31/2020
License Status:	ACTIVE
License Method:	ACCEPT EXAM - USMLE
Disciplinary History:	Has not been disciplined

Temporary certificate physician and surgeon no. 125.062425 was issued with a starting date of 07/10/2012. No disciplinary action on file. This was a medical residency training certificate only.

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

SEAL

Cecilia Abundis
Acting Director
Division of Professional Regulation

December 9, 2019
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

AMA Physician Profile

PREPARED FOR

Professional Licensing Agency, Indianapolis, IN

Name and Mailing Address

VALERIE LAUREN JENNINGS
4701 ENGLISH OAK CT
CHAMPAIGN, IL 61822-3354

Primary Office Address

OB/GYN
611 W PARK ST
URBANA, IL 61801-2529
Phone (217) 383-3140

Birth date [redacted]

Physician's major professional activity NOT CLASSIFIED

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)
UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1710243142	04/10/2012	NOT RPTD	NOT RPTD	NOT RPTD	11/15/2019

Current and/or historical medical school

UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF MEDICINE

Degree Awarded: YES
Degree Year: 2012

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AMERICAN MEDICAL ASSOCIATION

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Beginning with the 2016/2017 cycle of the National GME Census post-graduate training segments will include a training type of specialty (residency) or subspecialty (fellowship). Training types for programs reported prior to 2016 will not include this designation.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.

Sponsoring Institution:	UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT CHICAGO
Sponsoring State:	ILLINOIS
Program name:	UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT CHICAGO PROGRAM
Specialty:	OBSTETRICS & GYNECOLOGY
Training Type:	
Dates:	7/2012 - 7/2016 (Being Reverified)

Sponsoring Institution:	UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT CHICAGO
Sponsoring State:	ILLINOIS
Program name:	UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT CHICAGO PROGRAM
Specialty:	OBSTETRICS & GYNECOLOGY
Training Type:	SPECIALTY
Dates:	6/2012 - 6/2016 (Verified)

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 0

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate type: GENERAL

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
TIME LIMITED	Active	01/22/2019	12/31/2019		INITIAL	11/07/2019	Y

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information.

Current and/or historical medical licensure

License No.	MD / DO	Jurisdiction	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported
036138546	MD	IL	07/01/2015	07/31/2020		ACTIVE	UNLTD	11/04/2019
125062425	MD	IL	07/10/2012	07/09/2015		INACTIVE	RES	11/04/2019

Action Notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Department of Justice.

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U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration Date	Last Reported Date	Address

None Reported

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

ECFMG Certfication

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at https://cvsonline2.ecfmg.org/

Profile Information

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission(AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.