APPLICATION FOR A TEMPORARY MEDICAL PERMIT
(For Postgraduate Training or Teaching)

State Form 17598 (R9 / 2-06)

Approved by State Board of Accounts, 2006

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

* 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.

FOR OFFICE USE ONLY		
Permit fee: 100.00	Date fee paid *(month, day, year)*: 8-21-06	Receipt number: 1426839
Permit number: 11013556A	Permit issuance date *(month, day, year)*: 9-7-06	

APPLICANT INFORMATION		
Name of applicant *(last, first, middle)*: Franklin, Tanya E.		Social Security number *
Address *(number and street or rural route)*: 10108 Winding River Way		
City, state, and ZIP code: Louisville KY 40229		
Telephone number *(daytime)*: (502) 964-3222	Date of birth *(month, day, year)*: 3/29/1977	Place of birth: Corpus Christi TX
Please indicate what address you want your permit sent to *(number and street or rural route)*: Dept. OB/GYN 550 S. Jackson St., 2nd Fl. ACB		
City, State, and ZIP code: Louisville, KY 40202		
Email address: tkelli01@gwise.louisville.edu		

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY		
Name of school: University of Louisville	Location: Louisville KY	Date of graduation *(month, day, year)*: 5/04

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 *(month, day, year)*

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED *(month, day, year)*
Jefferson Comm Coll.	Louisville, KY	7/1997-8/1997
Bellarmine Univ	Louisville, KY	8/1995-5/1999

MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED *(month, day, year)*
Univ of Louisville	Louisville KY	8/1999-5/2004

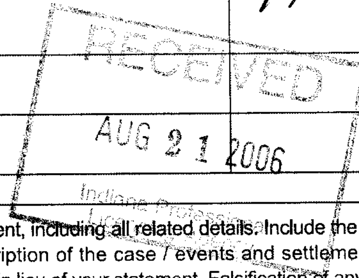
POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA
(Include ALL internships, residencies and / or fellowships)

NAME OF SCHOOL	LOCATION	FROM *(month, year)*	TO *(month, year)*
Univ of Louisville	Louisville KY	7/2004	6/2008
Residency Program			

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL	
GENERAL LOCATION	**DATE (*month, day, year*)**
Louisville KY	6/2004

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL		
NAME AND ADDRESS OF EMPLOYER	**RESPONSIBILITIES**	**DATE (*month, day, year*)**
Univ. of Louisville	Resident Physician	7/1/2004 - Current
Dept OB/GYN		
550 S. Jackson St		
2nd Flr. ACB Louisville KY 40202		

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**
KY	Residency Training License	RD980	7/1/2005	Renewed to 6/30/2007



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), case information, detailed description of the case / events and settlement amount, including court documents, if applicable. 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.

Question	Answer
1. Has disciplinary action ever been taken regarding any 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 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 drug or alcohol abuse?	☐ Yes ☑ No
4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?	☐ Yes ☑ No
5. Have you ever been arrested, convicted of, pled guilty or nolo contendere to, or are formal charges pending:	
A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substance or drug addiction?	☐ Yes ☑ No
B. Any offense, misdemeanor or felony in any state? (*Except for minor 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
9. Have you surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	☐ 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]	8/15/06

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, 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 temporary medical permit.

I hereby release the aforementioned persons, firms, officers, corporations, association, organization, 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 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 signed (month, day, year)	Signature of applicant
8/15/06	Tanya Franklin

HOSPITAL / INSTITUTION CERTIFICATION FOR A TEMPORARY MEDICAL PERMIT OR A TEMPORARY MEDICAL TEACHING PERMIT

(to be completed by the hospital / institution Chairman / Department Head)

This is to certify that Tonya E. Franklin has been granted

an appointment to serve at Floyd Memorial Hosp in

the Department of OBGYN

located at *(address)* 1850 State St., New Albany, In

this appointment is for the month and year beginning Sept. 1, 2006 and ending October 31, 2006

Name of Hospital Chairman/Department Head	Title	
Christine L. Cook MD	Chief + Program Director	
Signature	**Date of signature** *(month, day, year)*	**Telephone number**
C L Cook, MD	8/17/06	(502) 561-7448

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, 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 temporary medical permit.

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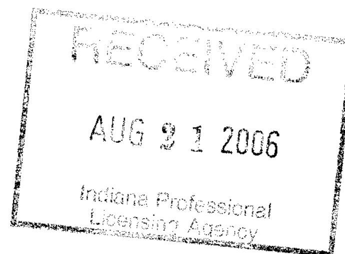
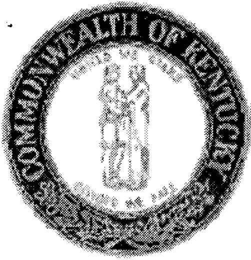
Christine L. Cook MD	Chief + Program Director	
Signature	**Date of signature** *(month, day, year)*	**Telephone number**
C L Cook, MD	8/17/06	(502) 561-7448





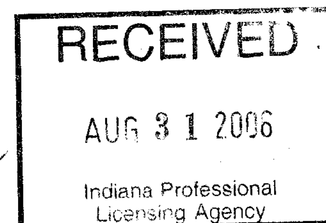
Kentucky Board of Medical Licensure

310 Whittington Parkway, Suite 1B
Louisville KY 40222
Phone: (502) 429-7150 Fax: (502) 429-7158

Name: Tanya E. Franklin M.D.
Address: UL, GME Office, RM518
323 E. Chestnut St.
Louisville KY 40202
License: R0980
Status: Residency
Expiration: 6/30/2007
Practice County: Jefferson
***Area of Practice:** Obstetrics/Gynecology
Type of Practice: Resident/Fellow
Year Licensed in KY: 7/1/2005
Medical School: University of Louisville School of Medicine
Year Graduated: 2004
Disciplinary/Other Actions past 10 yrs: None

*The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

Stephanie A Simpson
Verification Coordinator



Univ Gyne + OB

Check No. 36722
Amount 10

Danny M. Clark, M.D.
President

Ernie Fletcher
Governor

KENTUCKY BOARD OF MEDICAL LICENSURE

Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Telephone (502 429-7150
Fax (502 429-7158
www.kbml.ky.gov

RECEIVED
AUG 23 2006
K.B.M.L.

This is to advise you that the Kentucky Board of Medical Licensure charges **$10.00 each** for a verification of a physician licensed by this Board.

You may pay by check or credit card. Please send your requests via fax to 502/ 429-7158 or email Stephanie.simpson@ky.gov or send to the address listed above. If you have any questions please contact Stephanie Simpson at 502/429-7150.

Please include the following with your request.

Tanya E. Franklin — R0980

First Name, Middle Initial and Last Name — KY License Number

(Please attach a list of names and license numbers for multiple requests.)

Send Verification to:

Professional Licensing Agency
(Name & Street Address) 402 West Washington St. RM. W072
(City, State & Zip) Indianapolis, Indiana 46204

Credit Card Information:

Credit Card # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Exp. Date:
(MM-YY) ☐☐-☐☐

RECEIVED
AUG 31 2006
Indiana Professional Licensing Agency

Credit Card Holder Name:____________

VERIFICATION OF STATE LICENSURE

State Form 7143 (R4 / 2-06)

RECEIVED
AUG 23 2006
K.B.M.L.

PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 232-2960
Fax: (317) 233-4236
www.pla.IN.gov

* Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is mandatory that it be given.

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*)	Date of birth (*month, day, year*)	Social Security number *
Franklin, Tanya E.	3/29/1977	

Address (*number and street or rural route*)		
550 S. Jackson Street, 2nd Floor ACB, Dept. of Ob/Gyn		
City: Louisville	State: KY	ZIP code: 40202

Type of license held	License number	Date of issuance (*month, day, year*)
Residency Training License	R0980	7/1/2005

I hereby authorize the State of Kentucky to furnish the Professional Licensing Agency with the information below.

Signature of applicant	Date signed (*month, day, year*)
[signature]	6/28/06

DO NOT WRITE BELOW THIS LINE

License number	Date of issuance (*month, day, year*)	Date of expiration (*month, day, year*)
Licensed by ☐ Exam ☐ Endorsement ☐ Other	Type of examination	Date of administration (*month, day, year*)

Attach subjects, scores, date of examination, and average.

License is current and in good standing ☐ 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

Signature		Date (*month, day, year*)
Printed name	Title	
State Board	Telephone number ( )	E-mail address

Please affix board seal below