APPLICATION FOR INDIANA CONTROLLED SUBSTANCES REGISTRATION (CSR) FOR PRACTITIONERS

State Form 34617 (R17 / 6-15)
Approved by State Board of Accounts, 2015

PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
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.

INSTRUCTIONS: Please type or print all information.

FOR OFFICE USE ONLY

CSR number	0107705IA	Date of issuance (month, day, year)	6/8/16
Receipt number	5600820	Application fee	60.00
Date fee paid (month, day, year)	3/14/16		

PRACTITIONERS

(Please check one box)

☐ Dentist ☑ Physician ☐ Osteopathic Physician ☐ Podiatrist ☐ Veterinarian ☐ Advanced Practice Nurse ☐ Physician Assistant ☐ Optometrist

Name of practitioner	Specialty
Jeffrey Peipert	OB GYN

Telephone number	Professional license number	Date of birth (month, day year)	Social Security number *
[redacted]	Pending	11/7/60	[redacted]

Name of Facility (if applicable)	E-mail address
Indiana University	[redacted]

Indiana practice address (number and street (may not be a PO Box), city, state, and ZIP code)
550 N. University Blvd. UH 2440 Indianapolis, IN 46202

Drug schedules: (Check all applicable)

☑ 1 ☑ 2 ☑ 2 Narcotic ☑ 3 ☑ 3 Narcotic ☑ 4 ☑ 4 Limited Practice - Tramadol Only (Optometrist Only) ☑ 5

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. 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 registration issued pursuant to this application.

Question	Yes	No
1. Has there been an occasion where you have not maintained effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels?	☐	☑
2. Has there been an occasion where you have not been in complete compliance with all state and local laws pertaining to controlled substances?	☐	☑
3. Have you been convicted, pled guilty, or pled *nolo contendere*, under any federal or state laws relating to any controlled substances that has *not* been expunged under IC 35-38-9?	☐	☑
4. Have you had any action, discipline, revocation, or surrender of your Drug Enforcement Registration or entered into any settlement or Memorandum of Understanding (MOU) with respect to said registration?	☐	☑
5. Have you had any action, discipline or revocation or surrender of any professional license in any jurisdiction related to controlled substances?	☐	☑

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 practitioner	Date (month, day, year)
[signature]	02/16/16

3-22-14

RECEIVED
FEB 29 2016
Indiana Professional Licensing Agency

RECEIVED
MAR 14 2016
Indiana Professional Licensing Agency

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

State Form 29495 (R17 / 6-13)

Approved by State Board of Accounts, 2013

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 Indiana Code. 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): 3/8/16
Receipt number: 5596721	Application number:
License number: 01077051A	License issuance date (month, day, year): 6/8/16
Permit fee:	Date fee paid (month, day, year):
Receipt number:	Permit number:
Permit issuance date (month, day, year):	

APPLICANT INFORMATION

Name of applicant (last, first, middle): Peipert, Jeffrey Frank		Check one: ☑ MD ☐ DO	Social Security number *: [redacted]	
Address of practice (number and street or rural route): 550 N. University Blvd, UH 2440				
City, state, and ZIP code: Indianapolis, IN 46202				
Telephone number (daytime): [redacted]	Date of birth (month, day, year): 11/7/1960	Ethnicity **: White	Race **: White	Gender **: ☑ Male ☐ Female
Mailing address (number and street, city, state, and ZIP code) (if different from above):				
E-mail address: [redacted]	National Provider Identifier number: 1497771711	ECFMG certificate number:		

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	Location	Date of graduation (month, day, year)
Emory University School of Medicine	Atlanta, GA	5/1986
Specialties: OB GYN / Medicine	Board certification (list ABMS certification): OB GYN	

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: Pennsylvania

Examination	Most Recent Date Taken (month/year)	Results: Passed	Results: Failed	Number of Attempts	Examination	Most Recent Date Taken (month/year)	Results: Passed	Results: Failed	Number of Attempts
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	6/12/84	☑	☐	1	COMVEX		☐	☐	
NBME Part II	4/1/86	☑	☐	1	USMLE Step I		☐	☐	
NBME Part III	3/4/87	☑	☐	1	USMLE Step II, CS		☐	☐	
SPEX		☐	☐		USMLE Step II, CK		☐	☐	
NBOME Part I		☐	☐		USMLE Step III		☐	☐	

PREMEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED (*month, day, year*)
Brown University	Providence, RI	8/1978 - 5/1982

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*)
Emory University School of Medicine	Atlanta, Georgia	8/1982 - 5/1

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

[illegible]

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?
Pennsylvania Hospital: Intern OBGYN	Philadelphia, PA	1986	1987	☑ Yes ☐ No
Pennsylvania Hospital: Resident OBGYN	Philadelphia, PA	1987	1990	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

[illegible]

GENERAL LOCATION	DATE (month, day, year)
Philadelphia,PA	1986-1990
New Haven, CT	1990 - 1992
Barrington, RI	1992 - 2006
St Louis, MO	2006 - 2016

[illegible]

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE (month, day, year)
University of Pennsylvania School of Medicine	Clinical Instructor	1989 - 1990
Yale University School of Medicine	Clinical Instructor	1990 - 1992
Brown University School of Medicine	Assistant Professor	1992 - 1997
Brown University School of Medicine	Associate Professor	1997 - 2003
Brown University School of Medicine	Professor	2003 - 2006

[illegible]

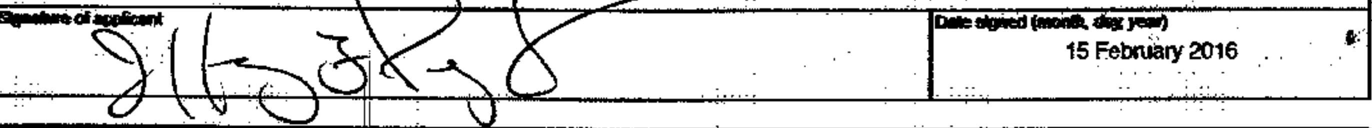
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
MO	Mo State Board of Registration for the Healing Arts	20006002063	2006	Active
IL	Dept of Financial and Professional Regulation: Div of Professional	036.117820	2008	Expired
RI	Rhode Island	(MO08241	1992	Expired

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 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	Yes	No
1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	☐	☑
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?	☐	☑
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 in a competent and professional manner?	☐	☑
4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?	☐	☑
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; (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state?	☐	☑
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?	☐	☑
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?	☐	☑
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	☑	☐
9. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	☐	☑
10. Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?	☐	☑
11. Have you ever been excluded from being a Medicare / Medicaid provider?	☐	☑
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?	☐	☑
13. Have you practiced as a MD/DO either clinically or administratively in the last three (3) years?	☑	☐

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)
	15 February 2016

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)
	15 February 2016

Case Levin vs. Pennsylvania Hospital and Dr. Michael Feinste

This case was brought to trial at the end of August, 1994. When I was a third-year resident at Pennsylvania Hospital in 1988, Mrs. Levin was admitted in labor and subsequently delivered a live born infant with low Apgars who developed spastic quadraplegia and cerebral palsy. Durin the trial the jury selection was made and the trial began with opening statements and then testimony from the nursing staff of Pennsylvania Hospital. During the first day of the trial it was pointed out that a hospital policy for the administration of pitocin had been violated. After this was determined and at the closing of the nursing testimonies, conversations were carried on between the insurance carriers and the lawyers and the decision was made to settle the case out of court and to abort the trial. The settlement amount was in excess of $30,000 but this information is confidential.

Jeffrey F. Peipert, MD

Dana Schenck
2/16/15

11/1/05

Note: I was named in the above case (Levin v. Pennsylvania Hospital).

Case # 4052

Term: April 1989

Settled: 1994

Signed:

State of Missouri

Division of Professional Registration
Physician and Surgeon

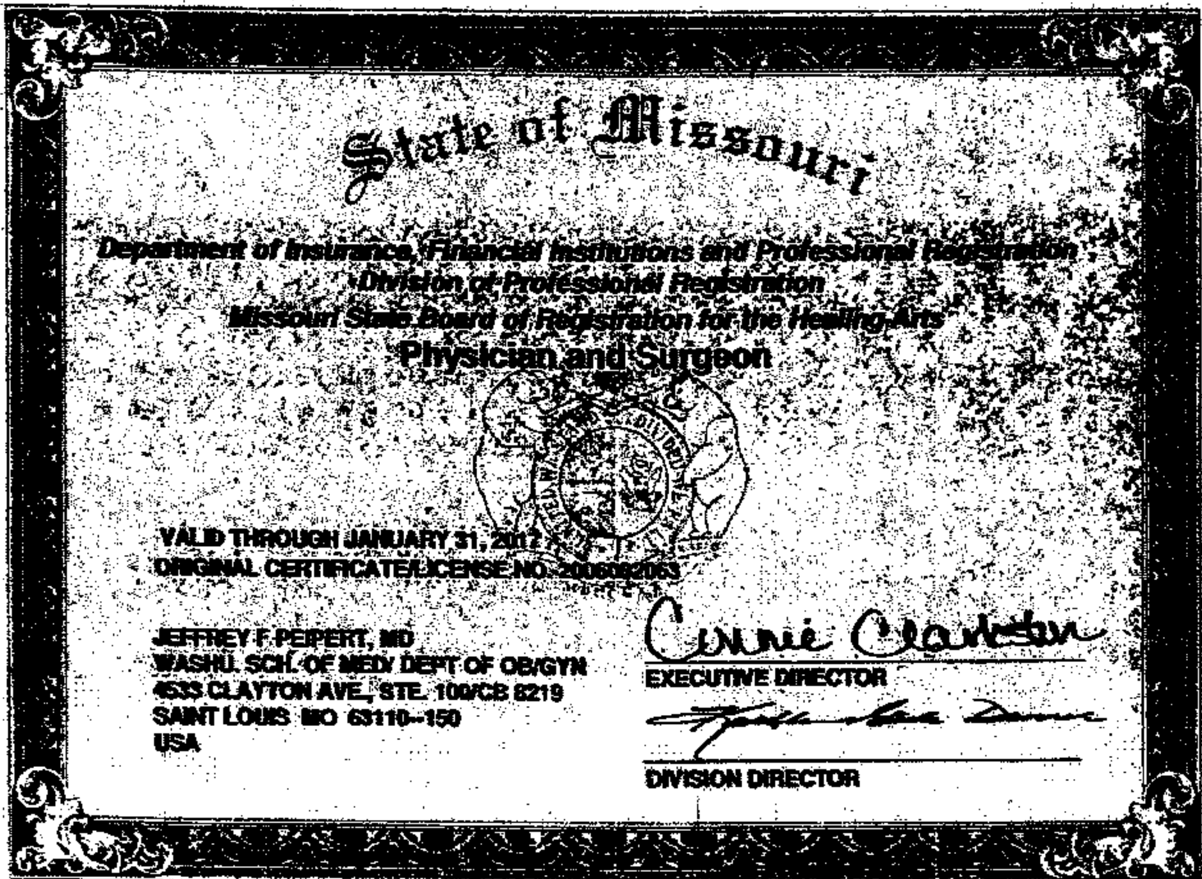
VALID THROUGH JANUARY 31, 2017
ORIGINAL CERTIFICATE/LICENSE NO: [illegible]
JEFFREY F PEIPERT, MD
WASHU SCH. OF MED/ DEPT OF OB/GYN
4533 CLAYTON AVE., STE. 100/CB 8219
SAINT LOUIS MO 63110-150
USA

This is a true copy of the original.

JEFFREY F PEIPERT, MD
WASHU. SCH. OF MED/ DEPT OF OB/GYN
4533 CLAYTON AVE., STE. 100/CB 8219
SAINT LOUIS MO 63110--150
USA

DANA SCHENCK
Notary Public - Notary Seal
STATE OF MISSOURI
Commissioned for Jefferson County
My Commission Expires: July 19, 2016
Commission # 12492636

Dana Schenck
2/15/16



State of Missouri

Department of Insurance, Financial Institutions and Professional Registration
Division of Professional Registration
Missouri State Board of Registration for the Healing Arts
Physician and Surgeon

VALID THROUGH JANUARY 31, 2017
ORIGINAL CERTIFICATE/LICENSE NO: 2006002063

JEFFREY F PEIPERT, MD
WASHU. SCH. OF MED/ DEPT OF OB/GYN
4533 CLAYTON AVE., STE. 100/CB 8219
SAINT LOUIS MO 63110--150
USA

Connie Clarkston
EXECUTIVE DIRECTOR

DIVISION DIRECTOR

[illegible] University

[illegible]

[illegible]

[illegible]

Doctor of Medicine

[illegible]

[illegible] SCHENK
Notary Public [illegible]
STATE OF MISSOURI
[illegible]

Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Kathleen (Katie) Steele Danner, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
website: www.pr.mo.gov/healingarts.asp

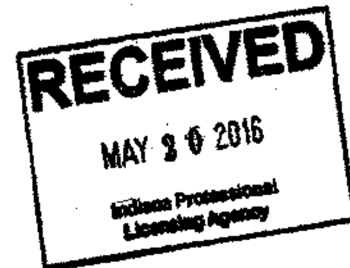
Connie Clarkston
Executive Director

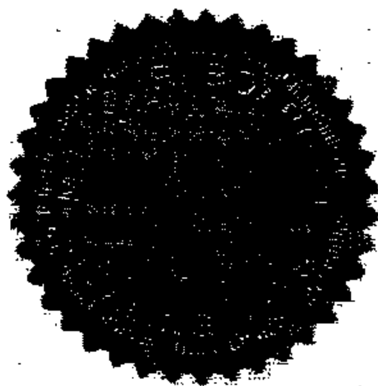
To:

Indiana Medical Licensing Board
402 West Washington Street Rm W072
Indianapolis, IN 46204

This is to certify that the records of the Missouri Board of Healing Arts indicate the following information regarding Jeffrey F Peipert, M.D..

LICENSE TYPE:	Medical Physician & Surgeon
LICENSE NUMBER:	2006002063
DATE ISSUED:	2/1/2006
STATUS:	Active
EXPIRATION DATE:	1/31/2017
DISCIPLINARY ACTION:	None





Victoria Honse
Verifications Clerk

05/16/2016
Date

This is the only form that will be used by the Missouri State Board of Registration for the Healing Arts for the purpose of license verification.

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Bruce Rauner
Governor

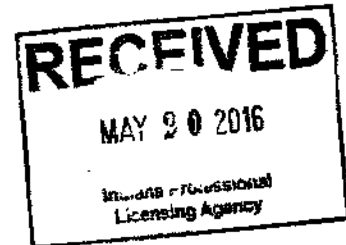
Bryan A. Schneider
Secretary

Jay Stewart
Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

IN MEDICAL LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 W WASHINGTON ST RM W072
INDIANAPOLIS, IN 46204

Licensee:	JEFFREY F PEIPERT
License Number:	036.117820
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	03/09/2007
Expiration Date:	07/31/2011
License Status:	NOT RENEWED
License Method:	ENDORSEMENT-NBME
Disciplinary History:	Has not been disciplined



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.

#11
Jay Stewart
Director
Division of Professional Regulation

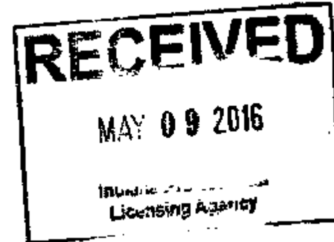
May 17, 2016
Date

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

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

May 04, 2016



Indiana Professional Licensing Agency
402 West Washington St., Rm. W072
Indianapolis, IN 46204

TO WHOM IT MAY CONCERN:

VERIFICATION OF LICENSURE

This is to certify that the records of the Connecticut Department of Public Health indicate that:

Jeffrey F. Peipert

Was issued Connecticut:	Physician/Surgeon License
Date of Issuance:	03/16/1990
License Number:	30653
Expiration Date:	11/30/1990
Status of License:	INACTIVE, LAPSED DUE TO NON-RENEWAL
Past or Pending Disciplinary History:	No

Disciplinary History

Past or pending public disciplinary action:

There has been no public disciplinary action	X
Public action taken, see attached	______

Past or pending confidential action taken:

There has been no confidential disciplinary action	X
Complaint under investigation, see attached	______
Confidential action taken, see attached	______
Other, see attached	______

Sincerely,

Stephen B. Carragher

Stephen B. Carragher
Public Health Services Manager
Practitioner Licensing and Investigations Section

Printed by: LuAnn Hunt

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Rhode Island
Department of Health
Three Capitol Hill
Providence, RI 02908-5097

www.health.ri.gov

OFFICE OF HEALTH PROFESSIONS REGULATION

April 18, 2016

This letter will serve to certify that the official records of the Office of Health Professions Regulation indicate that:

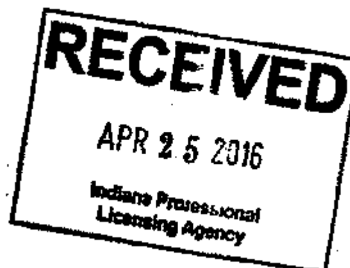
JEFFREY F. PEIPERT
WOMEN & INFANTS HOSPITAL
101 DUDLEY STREET
PROVIDENCE RI 02905

Holds a license to practice as a **Allopathic Physician (MD)** in the state of Rhode Island, license (**MD08241**). The status of this license is **Expired - Must Reinstate**, with an expiration date of **06/30/2006**. The original license issue date was **07/09/1992.**

There are no disciplinary restrictions on this license.

If additional information is required regarding this license, please contact the Office at (401) 222-3855.

Licensing Aide
Office of Health Professions Regulation



(SEAL)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
POST OFFICE BOX 2649
HARRISBURG, PA 17105-2649
www.dos.pa.gov

04/11/2016

VERIFICATION/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:	PEIPERT, JEFFREY
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE #:	MD039868E
LICENSE STATUS:	Inactive
LICENSE ISSUE DATE:	08/11/1987
LICENSE EXPIRATION DATE:	12/31/1992
DISCIPLINARY HISTORY:	NO Disciplinary Action Exists

Ian J. Harlow, Commissioner
Bureau of Professional and Occupational Affairs

Penn Medicine

Pennsylvania Hospital Office of Academic Affairs

April 4, 2016

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

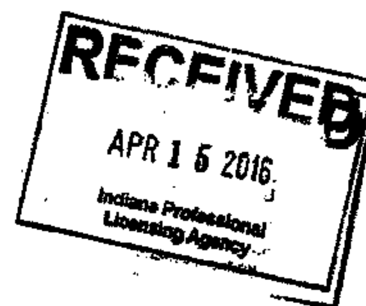
Re: Residency Training Verification ~ Jeffrey F. Peipert, MD

To Whom It May Concern:

According to our records, Jeffrey F. Peipert, MD completed a residency in Obstetrics and Gynecology from June 18, 1986 through June 30, 1990 at Pennsylvania Hospital.

The Office of Academic Affairs is not involved in the daily activities of physicians; therefore, we cannot provide information on clinical or technical skills, character or educational background.

Please contact me if you have any questions.



Sincerely,

Dominic Marchiano, MD
Designated Institutional Official &
Program Director, Obstetrics & Gynecology

800 Spruce Street, 2 Pine West
Philadelphia, PA 19107
Office 215-829-5933 Fax 215-829-6596