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

State Form 29495 (R20 / 10-16)
Approved by State Board of Accounts, 2016

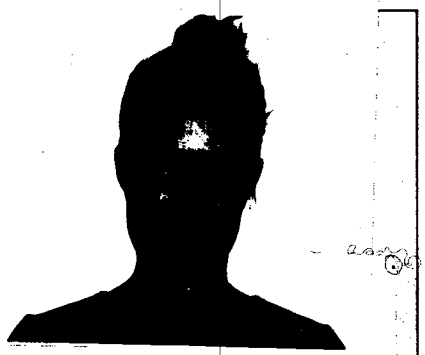
MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

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. *All fees are non-refundable and non-transferable.*
4. *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*) 4/20/2017
Receipt number 5917348	Application number 2428491
License number 01078719A	License issuance date (*month, day, year*) 6-7-2017
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*)	Check one:	Social Security number *
Bernard, Caitlin	☑ MD ☐ DO	[redacted]

Address of practice (*number and street or rural route*): 550 N University Blvd.

City, state, and ZIP code: Indianapolis, IN 46202

Telephone number (*daytime*)	Date of birth (*month, day, year*)	Ethnicity **	Race **	Gender **
([redacted]	08/29/1984	white	white	☐ Male ☑ Female

Mailing address (*number and street, city, state, and ZIP code*) *[if different from above]*: same as above

E-mail address	National Provider Identifier number	ECFMG certificate number
[redacted]	1477871929	N/A

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	Location	Date of graduation (*month, day, year*)
SUNY Upstate Medical University	Syracuse, NY	05/22/2010

Specialties	Board certification (*list ABMS certification*)
Obstetrics & Gynecology	pending

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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: _____

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	06/2008	✓		1
NBME Part III					USMLE Step II, CS	11/2009	✓		1
SPEX					USMLE Step II, CK	12/2009	✓		1
NBOME Part I					USMLE Step III	04/2011	✓		1

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
Binghamton University	Binghamton, NY	08/2002-06/2006

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)
SUNY Upstate Medical University	Syracuse, NY	08/2006-05/2010

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?
SUNY Upstate Medical University	Syracuse, NY	07/2010	06/2014	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)	
GENERAL LOCATION	DATE (*month, day, year*)
Syracuse, NY	07/01/2014-08/31/2014
Eldoret, Kenya	09/01/2014-04/30/2015
Syracuse, NY	05/01/2015-06/25/2015
St Louis, MO	06/26/2015-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*)
SUNY Upstate Medical University	resident	07/01/2010-06/30/2014
Indiana University	visiting faculty in Kenya	09/01/2014-04/30/2015
Washington University in St Louis	fellow	07/01/2015-present

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
NY	Medical Physician & Surgeon	273866	02/24/2014	expired
MO	Medical Physician & Surgeon	2015015484	05/20/2015	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)*
Cathy Bernard	03/16/2017

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)*
Cathy Bernard	03/16/2017

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IN

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

*aka Caitlin Bernard

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, *PARKS CAITLIN BERNARD was issued license/certificate number 273866 for the practice of MEDICINE on 02/24/2014

Our records also indicate the following information:
Date of birth: 08/29/1984
School attended: SUNY UPSTATE MED CTR
Date of graduation: 05/22/10
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
04/11								0000P	00SCT
12/09						0000P			
06/08			0000P						

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EXMS TAKEN=03
A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: NO Last reg period ended: 01/31/16
Address: APT 303 525 PLUM ST
525 PLUM ST SYRACUSE NY 13204-1524
Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Cathy Hanczaryk, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
1784

Cathy Hanczaryk 04/17/17
Office Assistant Three

Governor Eric R. Greitens
State of Missouri

Department of Insurance
Financial Institutions
and Professional Registration
Chlora Lindley-Myers, Acting Director

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

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: http://pr.mo.gov/healingarts.asp

Connie Clarkston
Executive Director

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MAR 21 2017
Indiana Professional Licensing Agency

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 Caitlin Bernard Parks, M.D..

LICENSE TYPE:	Medical Physician & Surgeon
LICENSE NUMBER:	2015015484
DATE ISSUED:	5/20/2015
STATUS:	Active
EXPIRATION DATE:	1/31/2018
DISCIPLINARY ACTION:	None

Victoria Honse
Verifications Clerk

03/20/2017
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.

FILED

APR 14 2017

22ND JUDICIAL CIRCUIT
CIRCUIT CLERK'S OFFICE
BY _____ DEPUTY

IN THE CIRCUIT COURT OF St. Louis City, MISSOURI
(County where court is located. City of St. Louis is considered a county.)

In re:

CAITLIN BERNARD PARIS _____
(First Name) (Middle Name) (Last Name) (Jr./Sr./III)
Petitioner *(Enter your full legal name above)*

Case No. 1722-FC00781
(Use number on Petition)

Division No. 14A
(Use number on Petition)

Judgment for Change of Name of Adult Individual

1. Parties Appearing *(Check all that apply)*

   Petitioner CAITLIN BERNARD PARIS _____
   (First Name) (Middle Name) (Last Name) (Jr./Sr./III)

   You are the Petitioner in this case.

   ☒ appears in person.

   ☐ appears by Attorney.

2. The court finds that the change of name would be proper and would not be detrimental to the interests of any other person.

3. The name of Petitioner is changed as follows:

   From CAITLIN BERNARD PARIS _____
   (First Name) (Middle Name) (Last Name) (Jr./Sr./III)

   To CAITLIN _____ BERNARD _____
   (First Name) (Middle Name) (Last Name) (Jr./Sr./III)

   Birth Date 08/29/1989
   (mm/dd/yyyy)

4. Change of Birth Records *(Check one of the two boxes)*

   ☐ It is further ordered that the Division of Health and Senior Services, Bureau of Vital Statistics for the State of Missouri alter the birth certificate of Petitioner to reflect this judgment. This judgment shall be mailed by the Petitioner to the Division of Health and Senior Services.

   ☐ It is further ordered that the State of _____ alter the birth certificate of Petitioner to reflect this judgment. This judgment shall be mailed by the Petitioner to the appropriate state of birth of Petitioner.

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5. Notice *(Check one of the two boxes)*

☒ Notice of the change of name shall be published at least once each week for three consecutive weeks in the following newspaper of general circulation:
St Louis City Monitor

☐ No notice of change of name is to be published because the petitioner is the victim of a crime based upon domestic violence as defined in §455.010, RSMo; or the victim of child abuse as defined in §210.110, RSMo; or the victim of abuse by a family or household member as defined in §455.010, RSMo.

6. Court Costs *(Check one of the two boxes)*

☐ Court costs are waived.

☒ Court costs are to be paid from the court cost deposit(s) previously posted.

7. Waiver of Right to Rehearing *(If case is heard by a Commissioner pursuant to §487.010, RSMo, et seq.)*

We, the undersigned parties, do hereby acknowledge receipt of the findings and recommendations of the commissioner and waive the right to file a motion for rehearing in this case.

☐ Signature of Petitioner's Attorney _____

☒ Signature of Petitioner Caitlin Bernard / Caitlin Bernard

(If heard by a Family Court Judge)

_____
(Judge)

_____
(Date)

(If heard by a Family Court Commissioner)

Findings and Recommendations of Commissioner:

_____ 4-14-17
(Commissioner) *(Date)*

All orders and these findings and recommendations of the Commissioner are confirmed and adopted as the judgment of the court.

_____ 4/14/17
(Judge) *(Date)*

A certified copy of this judgment is to be mailed to the following person(s): *(Check all applicable boxes)*

☐ _____
(Print Name of Petitioner's Attorney)

_____
(Street)

_____
(City, State, Zip)

_____
(Telephone Number with Area Code)

☒ Caitlin Bernard
(Print Name of Petitioner)

245 Union Blvd #517
(Street)

St Louis MO 63108
(City, State, Zip)

[redacted]
(Telephone Number with Area Code)

STATE UNIVERSITY OF NEW YORK

UPSTATE MEDICAL UNIVERSITY

ON THE RECOMMENDATION OF THE FACULTY AND BY
VIRTUE OF THE AUTHORITY VESTED IN THEM THE TRUSTEES OF THE UNIVERSITY
HAVE CONFERRED ON

CAITLIN BERNARD

THE DEGREE OF

DOCTOR OF MEDICINE

AND HAVE GRANTED THIS DIPLOMA AS EVIDENCE THEREOF
GIVEN IN THE CITY OF SYRACUSE IN THE STATE OF NEW YORK IN THE
UNITED STATES OF AMERICA ON THE TWENTY-SECOND DAY OF MAY
TWO THOUSAND AND TEN

This is an exact copy of the original

STATE OF MISSOURI
CITY OF ST. LOUIS

Subscribed and sworn to before me
this 24 day of May, 2017, by Caitlin Bernard

Leah Kinnamon, Notary Public
My Commission Exp. September 22, 2017

Caitlin Bernard 5/29/17

LEAH KINNAMON
Notary Public - Notary Seal
STATE OF MISSOURI
St. Louis City
My Commission Expires: Sept. 22, 2017
Commission # 13872437

Chairman, SUNY Board of Trustees

Chairman, College Council

STATE UNIVERSITY OF NEW YORK — TO LEARN — TO SEARCH — TO SERVE — 1948

Chancellor of the State University of New York

President, Upstate Medical University

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Graduate Medical Education

UPSTATE
MEDICAL UNIVERSITY

May 30, 2017

Medical Licensing Board of Indiana
402 W. Washington St., Room W072
Indianapolis, IN 46204-2298

Re: Caitlin Bernard, MD

Dear Board Members;

Caitlin Bernard, MD, served as a Resident in Obstetrics and Gynecology at SUNY Upstate Medical University from 7/1/2010 to 6/30/2014. Her training was successfully completed on 6/30/2014.

If you desire any further information, please do not hesitate to contact my office at (315) 464-7617. Thank you.

Sincerely,

William D. Grant, Ed.D
Associate Dean

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JUN 05 2017
Indiana Professional
Licensing Agency

State University of New York
Upstate Medical University
Syracuse, New York

RI
M...
Incl...
Licensing

This is to certify that

Caitlin Parks, M.D.

has served as

Resident in Obstetrics and Gynecology

from July 1, 2010 to June 30, 2014

Gregory L. Eastwood MD
President

Chair

MD

Program Director

Carl D Bernard 4/20/17

DANA SCHENCK
Notary Public - Notary Seal
STATE OF MISSOURI
Commissioned for Jefferson County
My Commission Expires: July 19, 2020
Commission # 12492636

Dana Schenck 4/20/17

THE UNIVERSITY OF THE STATE OF NEW YORK

EDUCATION DEPARTMENT

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Indiana Professional Licensing Agency

BE IT KNOWN THAT

CAITLIN BERNARD PARKS

HAVING GIVEN SATISFACTORY EVIDENCE OF THE COMPLETION OF PROFESSIONAL AND OTHER REQUIREMENTS PRESCRIBED BY LAW IS QUALIFIED TO PRACTICE

MEDICINE AND SURGERY

IN THE STATE OF NEW YORK

IN WITNESS WHEREOF THE EDUCATION DEPARTMENT GRANTS THIS LICENSE UNDER ITS SEAL AT ALBANY, NEW YORK THIS TWENTY-FOURTH DAY OF FEBRUARY, 2014.

PRESIDENT OF THE UNIVERSITY AND COMMISSIONER OF EDUCATION

LICENSE NUMBER
273866

DEPUTY COMMISSIONER FOR THE PROFESSIONS

8494649

Carl D Bernard 4/20/17

DANA SCHENCK
Notary Public - Notary Seal
STATE OF MISSOURI
Commissioned for Jefferson County
My Commission Expires: July 19, 2020
Commission # 12492636

Dana Schenck 4/20/17