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

State Form 29495 (R15 / 3-12)
Approved by State Board of Accounts, 2012

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-	Date fee paid (*month, day, year*): 3/27/13
Receipt number: 4258242	Application number:
License number: 01072924A	License issuance date (*month, day, year*): 7/5/13
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*): TURNER, SARAH, JULIA

Check one: ☒ MD ☐ DO

Social Security number *: [redacted]

Address of practice (*number and street or rural route*): 750 BROADWAY, SUITE 350

City, state, and ZIP code: FORT WAYNE, IN, 46835

Telephone number (*daytime*)	Date of birth (*month, day, year*)	Ethnicity **	Race **	Gender **
[redacted]	03/26/1981		CAUCASIAN	☐ Male ☒ Female

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

E-mail address: [redacted]

National Provider Identifier number: 1609162676

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*)
ST. GEORGE'S UNIVERSITY SOM	ST GEORGE'S, GRENADA	06/10/2011
Specialities	**Board certification** (*list ABMS certification*)	
	N/A	

RECEIVED
MAR 27 2013
Indiana Professional Licensing Agency

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: STEP I - NY, STEP II CK - AZ, STEP II CS PA, STEP III - IN

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	7/2009	☑	☐	1
NBME Part III		☐	☐		USMLE Step II, CS	4/2010	☑	☐	1
SPEX		☐	☐		USMLE Step II, CK	9/2010	☑	☐	1
NBOME Part I		☐	☐		USMLE Step III	11/2012	☑	☐	1

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
UNIVERSITY OF CALGARY	CALGARY, ALBERTA, CANADA	9/1999 - 5/2004

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)
ST. GEORGES UNIVERSITY SOM	ST. GEORGES, GRENADA	1/2007 - 6/2011

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?
FORT WAYNE MEDICAL EDUCATION PROGRAM	FORT WAYNE, INDIANA	07/2011	PRESENT	☒ 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)**
FORT WAYNE, INDIANA	6/2011

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)**
FORT WAYNE MEDICAL EDUCATION PROGRAM	RESIDENT PHYSICIAN	7/1/2011 – present

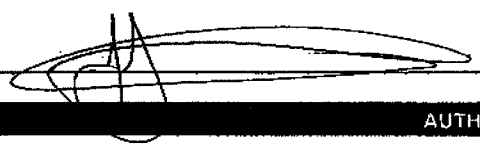
LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS				
STATE	**TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT**	**NUMBER**	**DATE ISSUED**	**CURRENT STATUS**
IN	TEMPORARY MEDICAL PERMIT	11016335A	6/29/2011	ACTIVE

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), 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.

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, registraton 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. Are you now being, or have ever been treated for drug or alcohol abuse or addiction?	☐ 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 convicted of, plead guilty or *nolo contendere* to, or are charges pending: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances? B. Any offense, misdemeanor, or felony in any state, or have entered into a deferral program? *(Except for minor violations of traffic laws resulting in fines.)*	☐ Yes ☒ No ☐ Yes ☒ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or priveleges 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

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*)
	3/8/2013

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.

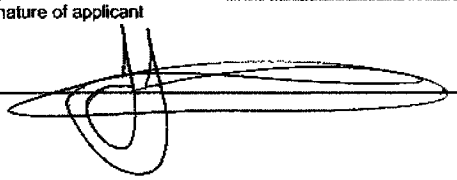
I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

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*)
	3/8/2013

St. George's University
School of Medicine

Be it known that the faculty of the
School of Medicine of St. George's University
in recognition of the successful completion of the required course of study
and by virtue of the authority vested in it by the Trustees
has conferred upon

Sarah J. Turner

the degree of

Doctor of Medicine

with all the honors, rights and privileges
thereunto appertaining and has granted this Diploma as evidence thereof,
signed by the authorized officials of the University and duly sealed.

June 10, 2011

Chancellor

Provost

Dean, School of Medicine

Grenada, W.I.

Dean of Students

Dean of Enrollment Planning

University Registrar

Educational Commission for Foreign Medical Graduates

The ECFMG® certifies that

Sarah Julia Turner

has successfully passed the required examinations, satisfied all the requirements of the Commission, and has been awarded this Certificate.

Steven E. Minnick MD
Chair, Board of Trustees

Emmanuel Castanis M.D.
President and Chief Executive Officer

Certificate Number	0-778-240-2
Medical Science	
USMLE Step 1	July 18, 2009
USMLE Step 2 CK	September 22, 2010
Clinical Skills	
USMLE Step 2 CS	April 5, 2010

Date Issued June 24, 2011

Fort Wayne Medical Education Program

Family Medicine Residency
Senior Electives • Junior Clerkships
Continuing Medical Education

Fort Wayne Medical Society Foundation, Inc.
Lutheran Hospital
Parkview Hospital
St. Joseph Hospital

REGIONAL ASSOCIATES
Adams Memorial Hospital
DeKalb Health
Dupont Hospital
Kosciusko Community Hospital
Parkview Huntington Hospital
Parkview Noble Hospital
Parkview Whitley Hospital

July 1, 2013

Indiana Professional Licensing Agency
402 West Washington Street Room W072
Indianapolis IN 46204

To Whom It May Concern:

This letter is to certify that on June 30, 2013, Sarah J. Turner, MD, met the residency requirements needed to complete her first two years of graduate medical education training. Dr. Turner began her graduate training with the Family Medicine Residency Program in Fort Wayne, Indiana, on July 1, 2011. Dr. Turner is currently a third year resident with a projected graduation date of June 30, 2014.

The Fort Wayne Family Medicine Residency is part of the Fort Wayne Medical Education Program and is dually accredited by the Accreditation Council for Graduate Medical Education and the American Osteopathic Association.

Sincerely,

Zachry L. Waterson, DO, Director
Family Medicine Residency

750 Broadway, Suite 250, Fort Wayne, Indiana 46802 - (260) 422-6573 - FAX (260) 399-4242

APPLICATION FOR INDIANA CONTROLLED SUBSTANCES REGISTRATION (CSR) FOR PRACTITIONERS

State Form 34617 (R14 / 6-07)
Approved by State Board of Accounts, 2007

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	Date of issuance (*month, day, year*)
01072924R	7/5/13

Receipt number	Application fee	Date fee paid (*month, day, year*)
4254232	60 -	3/27/13

DO NOT WRITE ABOVE THIS LINE

PRACTITIONERS

(Please check one box)

☐ Dentist ☒ Physician ☐ Osteopathic Physician ☐ Podiatrist ☐ Veterinarian ☐ Advanced Practice Nurse ☐ Physician Assistant

Name of practitioner	Specialty
SARAH JULIA TURNER	FAMILY MEDICINE

Telephone number	Professional license number	Date of birth (*month, day year*)	Social Security number *
(347) 924 7397	11016335A	03/26/1981	[redacted]

Name of Facility (*if applicable*)	E-mail address
FORT WAYNE MEDICAL EDUCATION PROGRAM	[redacted]

Indiana practice address (*number and street [may not be a PO Box], city, state, and ZIP code*)
750 BROADWAY, SUITE 350, FORT WAYNE, IN 46802

Drug schedules: (Check all applicable)
☑ 2 ☑ 2 Narcotic ☑ 3 ☑ 3 Narcotic ☑ 4 ☑ 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.

1. Have you ever been convicted of, or plead guilty or nolo contendere to: a violation of any federal, state, or local law relating to the use, manufacturing, distribution, or dispensing of controlled substances or are formal charges pending? ☐ Yes ☒ No
2. Have you ever been convicted of, or plead guilty or nolo contendere to: any offense, misdemeanor, or felony, in any state (except minor traffic laws/fines) or are formal charges pending? ☐ Yes ☒ No
3. Have you ever had any action, discipline or revocation on your DEA (US Drug Enforcement Administration) registration or entered into a Memorandum of Understanding (MOU) on said 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 practitioner	Date (*month, day, year*)
[signature]	3/8/2013

RECEIVED
MAR 27 2013
Indiana Professional Licensing Agency

2015

Person Info

Name: Sarah Julia Turner

Address Info

Street Address: 14704 Brindle Crossing
Email: [redacted]
Phone: [redacted]
Fax:
City: Roanoke
State: IN
Zipcode: 46783
Country: United States
County: Allen

Survey Response Summary

Question	Answer

Question Response Summary

Question	Answer
1.) Since you last renewed, has any professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending in any state?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state?	N
3.) Since you last renewed, have you ever been arrested or convicted for a crime that has not been expunged by an Indiana court?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff membership or privileges in any hospital or health care facility or have staff membership or privileges been revoked, suspended, or subject to any restriction, probation, or other type of discipline - or have you resigned in lieu of discipline or termination?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N

2015 CSR

Person Info

Name: Sarah Julia Turner

Address Info

Street Address:

Email:

Phone:

Fax:
City:
State:
Zipcode:
Country: United States
County:

Survey Response Summary
Question Response Summary

Question	Answer
1.) Since you last renewed, 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?	N
2.) Since you last renewed, has there been an occasion where you have not been in complete compliance with all state and local laws pertaining to controlled substances?	N
3.) Since you last renewed, 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?	N
4.) Since you last renewed, have you had any action, discipline, revocation, or surrender of your Drug Enforcement Registration or entered into any settlement or Memorandum of Understanding with respect to said registration?	N
5.) Since you last renewed, have you had any action, discipline, revocation, or surrender of any professional license in any jurisdiction related to controlled substances?	N

Collins, Zharia

From: Moran, Donna on behalf of Group 03
Sent: Thursday, January 12, 2017 10:08 AM
To: Collins, Zharia
Subject: FW: Sarah J. Turner, MD

1/12/2017

From: Jackson, Erica E [mailto:EJackson3@Lutheran-Hosp.com]
Sent: Thursday, January 12, 2017 8:55 AM
To: Group 03 <pla3@pla.IN.gov>
Subject: Sarah J. Turner, MD

I am requesting an Indiana license and CSR change of address on the following provider:

Sarah J. Turner, MD

SS# [redacted]
DOB [redacted]/1981
IN License # 01072924A
IN CSR # 01072924B

CSR Old Address:
Fort Wayne Medical Education Program
750 Broadway suite 350
Fort Wayne, IN 46802

CSR New Address:
St Joseph Medical group, Inc
2622 Lake Ave
Fort Wayne, IN 46805

IN license old address:
Roanoke, IN 46783

IN License New Address:
Fort Wayne, IN 46805

If you have any questions please feel free to call me at 260-479-3516

Thank you so much for your help in this matter.

Thanks

Erica Jackson | Credentialing Coordinator | MedPartners | 6920 Pointe Inverness Way, Suite 200
Fort Wayne, IN 46804 | **Phone: 260.479.3516** | **Fax: 260.479.3520** | **ejackson3@lhn.net**

Disclaimer: This electronic message may contain information that is Proprietary, Confidential, or legally privileged or protected. It is intended only for the use of the individual(s) and entity named in the message. If you are not an intended recipient of this message, please notify the sender immediately and delete the material from your computer. Do not deliver, distribute or copy this message and do not disclose its contents or take any action in reliance on the information it contains.

Disclaimer: This electronic message may contain information that is Proprietary, Confidential, or legally privileged or protected. It is intended only for the use of the individual(s) and entity named in the message. If you are not an intended recipient of this message, please notify the sender immediately and delete the material from your computer. Do not deliver, distribute or copy this message and do not disclose its contents or take any action in reliance on the information it contains.

Person Info

Name: Sarah Julia Turner

Address Info

Street Address: 2622 Lake Ave

Email: [redacted]

Phone [redacted]

Fax:

City: Fort Wayne

State: IN

Zipcode: 46802

Country: United States

County: Allen

Survey Response Summary

Question	Answer

Question Response Summary

Question	Answer
1.) Since you last renewed, has any health profession license, certificate, registration or permit you hold or have held been denied, surrendered, disciplined or are formal charges pending in any state?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state?	N
3.) Since you last renewed, and except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been convicted of, pled guilty to, or pled nolo contendere to any offense, misdemeanor, or felony in any state?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff membership or privileges in any hospital or health care facility or have staff membership or privileges been revoked, suspended, or subject to any restriction, probation, or other type of discipline - or have you resigned in lieu of discipline or termination?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N

2017 CSR

Person Info

Name: Sarah Julia Turner

Address Info

Street Address:

Email:

Phone:

Fax:
City:
State:
Zipcode:
Country: United States
County:

Survey Response Summary
Question Response Summary

Question	Answer
1.) Since you last renewed, 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?	N
2.) Since you last renewed, has there been an occasion where you have not been in complete compliance with all state and local laws pertaining to controlled substances?	N
3.) Since you last renewed, have you been convicted, pled guilty, or pled nolo contendere, under any federal or state laws relating to any controlled substancesthat has not been expunged under IC 35-38-9?	N
4.) Since you last renewed, have you had any action, discipline, revocation, or surrender of your Drug Enforcement Registration or entered into any settlement or Memorandum of Understanding with respect to said registration?	N
5.) Since you last renewed, have you had any action, discipline, revocation, or surrender of any professional license in any jurisdiction related to controlled substances?	N