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APPLICATION FOR FLEX EXAM AND FOR INITIAL LICENSE TO PRACTICE MEDICINE IN INDIANA

State Form 29495 (R5/2-91)

AUG 10 1993

HEALTH PROFESSIONS BUREAU 402 WEST WASHINGTON STREET ROOM # 041 INDIANA

HEALTH PROFESSIONS BUREAU

Your social security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.



License / Exam Fee \$200, Date Fee Paid 8-12-93, Receipt Number 23-286-01, License Number 01041899, License Issuance Date 6-30-93

Permit Fee, Date Fee Paid, Receipt Number, Permit Number, Permit Issuance Date

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION: Name (Last, First, Middle, Maiden) Sfutsman, John William, Address P.O. Box 131, City Scottsburg, State IN, ZIP code 47170, Birthdate 02/07/65, Birthplace Scott County, IN

BASIS FOR INITIAL LICENSURE: Applying to take FLEX: Component I, Component II, Both. FLEX EXAMINATION SCORES, NATIONAL BOARD EXAMINATION SCORES, LMCC EXAMINATION SCORES, STATE BOARD EXAMINATION

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY: Name of School Indiana University, Location Indianapolis, IN, Date of Graduation 03/31/91

HAVE YOU PREVIOUSLY TAKEN THE FOLLOWING?: FLEX Component I, FLEX Component II, Pre 1985 FLEX

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

NAME OF SCHOOL	LOCATION	FROM (Mo. Yr.)	TO (Mo. Yr.)
UCSF-Fresno	Valley Medical Center Fresno, CA	06/91	06/92

Do you hold, or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation? Yes No

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

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details. Include the violation, location, date and disposition. If malpractice, provide name of plaintiff. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

- Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? Yes No
- 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? Yes No
- Are you now being, or have you ever been, treated for a drug abuse or alcohol problem? Yes No
- Have you ever been charged with drug addiction? Yes No
- Have you ever been convicted of, pled 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 drug addiction? Yes No
 - To any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines) Yes No
- 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
- 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
- Have you ever had a malpractice judgment against you or settled any malpractice action? Yes No

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED
Indiana University	Bloomington, IN	08/83-05/87

MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED
Indiana University	Indianapolis, IN	08/87-03/91

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL FOR THE LAST 10 YEARS

GENERAL LOCATION	DATE
Fresno, CA	06/91-06/92
Lilongwe, Malawi, Southern Africa	08/92-present

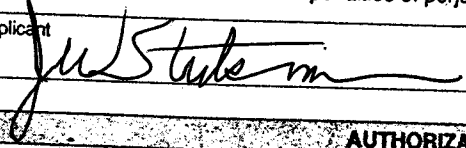
LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL FOR THE LAST 10 YEARS

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE
Valley Medical Center Fresno, CA	Transitional Intern	06/91-06/92
US Peace Corps Lilongwe, Malawi	Anat/Phys Tutor OB/GYN Tutor	09/92-present
Lilongwe School for Health Sciences		

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
07/21/93

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, 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 Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosures.

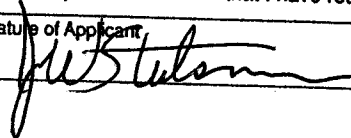
A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Date (Month, Day, Year)
07/21/93

Signature of Applicant



INDIANA UNIVERSITY

SCHOOL OF MEDICINE

Go all to whom these Presents may come, Greeting;

By vote of the Faculty and with the consent of the Board of Trustees, Indiana University hereby confers upon

John William Stutzman

who has completed with all the requirements of the University and has successfully completed the studies provided for graduation in the School of Medicine the degree of

Doctor of Medicine

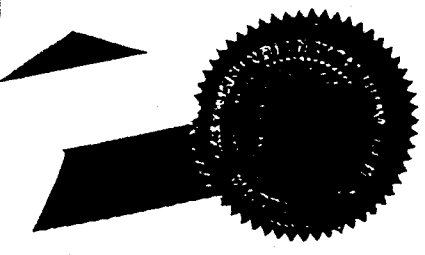
with all the rights and privileges thereto appertaining.

In Testimony Whereof this Diploma is issued and sold with the Seal of the University signed by the President of the University, Vice President and by the Dean of the School of Medicine and attested by the Secretary of the Trustees.

Done at Indiana University, Purdue University at Indianapolis, Indiana this thirty-first day of March 1901.

Walter J. Peabody
 Dean of the School of Medicine
 J. Susan Davis
 Secretary of the Trustees

Thomas S. Clark
 President
 [Signature]
 Vice President



County: Scott
 State: Indiana

Janet K. Wells
 Janet K. Wells, Notary Public

UNIVERSITY OF CALIFORNIA
SCHOOL OF MEDICINE

SAN FRANCISCO

Fresno-Central San Joaquin Valley Medical Education Program

THIS CERTIFIES THAT

John William Stutsman, M.D.
HAS SERVED AS

Transitional Resident
June 24, 1991 ~ June 21, 1992

August 23, 1993

I Certify that this is an Official
Copy of the Certificate issued by
University of California School of
Medicine, San Francisco of the
Fresno-Central San Joaquin Valley
Medical Education Program.

Michael R. Casser
Michael R. Casser
Notary Public
A Resident of Scott Co. IT

My Commission Expires August 13, 1994.



Robert A. Helgeson, MD
PROGRAM CHAIRMAN

Donald D. Stinson MD
ASSOCIATE DEAN, FRESNO



STATE OF INDIANA

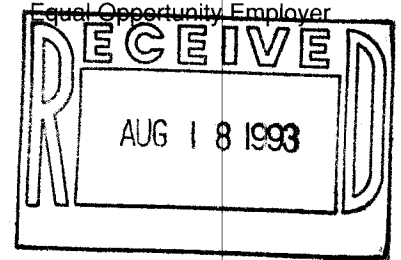
EVAN BAYH, Governor

HEALTH PROFESSIONS BUREAU

402 West Washington Street Room 041
Indianapolis, Indiana 46204
Telephone: (317) 232-2960
Fax: (317) 233-4236

August 16, 1993

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
6000 Western Pl. Suite 707
Fort Worth, TX 76107-4618



The Medical Licensing Board of Indiana requests a disciplinary search concerning the following individual:

NAME AND ADDRESS:

John William Stutsman
P O Box 131
Scottsburg, IN 47170

DATE OF BIRTH: 02-07-65

SOCIAL SECURITY NO. [REDACTED]

MEDICAL SCHOOL OF GRADUATION: INDIANA UNIVERSITY

YEAR OF GRADUATION: 91

Please mail the response to the following address:

Health Professions Bureau
Medical Licensing Board of Indiana
402 W. Washington St.
Room 041
Indianapolis, IN 46204

Attention: Sherry East
Endorsement Coordinator

Signature

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

AUG 23 1993

JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT