[redacted]

TARGET SHEET

Board: Medicine

Licensee Full Name:
CATHERINE ANNE CHAPPELL

License No:
MD442077

[redacted]

2864044_LIC_1_02/24/2011

[redacted]

49-101 (REV. 1-10)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

MD442077

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION
For Graduates of ACCREDITED Medical Schools (SCHOOLS IN THE U.S. AND CANADA)

Application Fee: $35.00 not refundable. Make check payable to the "Commonwealth of Pennsylvania."
Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

2433606

Please Print or Type

NAME: CHAPPELL (Last) CATHERINE (First) ANNE (Middle)

Permanent Address: [redacted] (Street)

All correspondence and the license will be mailed to this address unless the Board is notified of a change.

Dallas (City) TX (State) 75208 (Zip Code)

Email address: [redacted]@hotmail.com

Date of Birth: [redacted] (MM DD YYYY) Social Security Number: [redacted]

If your medical/licensure records are listed under another name or names list below:

Are you applying using credentials verification from FCVS? ____ *YES* ✓ *NO*

Have you previously held a Pennsylvania graduate training license?

____ *YES*; My license number is _____ ✓ *NO*

LIST MEDICAL SCHOOL(S) ATTENDED:

University of Texas - Southwestern

DATES OF ATTENDANCE:

From: 08/2003 (MM/YYYY) to 06/2007 (MM/YYYY)

From: _____ (MM/YYYY) to _____ (MM/YYYY)

Date of Graduation: 06/04/2007 (MM/DD/YYYY)

Check licensing examination(s) passed:

( ) FLEX - indicate state where taken: _____ Date taken: Component 1 _____ Component 2 _____
( ) NATIONAL BOARD - PART I _____ PART II _____ PART III _____
(✓) USMLE - STEP 1 ✓ STEP 2 ✓ STEP 3 ✓
( ) LMCC - Canadian
( ) STATE BOARD - indicate state where taken: _____

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48-101 (REV. 01-10)

ACGME Post Graduate Training:

PGY1 Hospital: PARKLAND MEMORIAL Hospital From: 7/1/07 to: 6/30/08

PGY2 Hospital: PARKLAND MEMORIAL Hospital From: 7/1/08 to: 6/30/09

Answer the following questions. If "YES" is answered to #2 through #9, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	Yes	No
1) Do you hold or have you ever held an unrestricted license, certification, or registration (active or inactive, current or expired) to practice medicine and/or surgery in another jurisdiction? **If yes, list the jurisdiction(s) here:** _____		✓
2) Have you withdrawn an application for a license, certificate or registration, had an application for a license denied or refused, or for any disciplinary reason agreed not to reapply for a license, certificate or registration in any profession in any state or jurisdiction?		✓
3) Have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?		✓
4) Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		✓
5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		✓
6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		✓
7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓
8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? **Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.)**	[redacted]	
9) Since May 19, 2002, have any malpractice complaints been filed against you? If yes, the Board requires that you submit a copy of the **entire Civil Complaint** which must include the **docket number**, **filing date**, and the **date you were served**.		✓

SIGNED STATEMENT

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDB/HIPDB must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine

[redacted]

Signature of Applicant

12/22/10

Date

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JAN 11 2011
By

49-101 (REV. 01-10)
State Board of Medicine
P. O. BOX 2649
HARRISBURG, PA 17105-2649

Certification of Moral Character

To be completed by **two** physicians who hold an unrestricted license in good standing in the United States or Canada and have known you for at **least six months**. ORIGINAL SIGNATURES ARE REQUIRED.

Name of Applicant: Catherine Anne Chappell, M.D.

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 6 year(s) ____ month(s).

SIGNATURE: [redacted] Date: 12/29/2010

Print or type name as signed above: George D. Wendel, Jr., M.D.

State in which licensed: Texas License Number: F9061

Name of Applicant: Catherine Ann Chappell, M.D.

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 6 year(s) ____ month(s).

SIGNATURE: [redacted] Date: 12/29/2010

Print or type name as signed above: Marlene M.Corton, M.D.

State in which licensed: Texas License Number: K5492

Return Completed Form to Applicant

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JAN 03 2011
By

RECEIVED DIRECT

49-101 (REV. 01-10)
Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381
Email: st-medicine@state.pa.us

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

2413346

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING
Accredited Medical School Graduates

NAME: [redacted] CATHERINE ANNE
Last First Middle

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

This Section to be completed by the program director at the hospital where the graduate training occurred.

If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

NAME OF HOSPITAL WHERE TRAINING WAS COMPLETED: PARKLAND MEMORIAL Hospital

NAME OF SPONSORING INSTITUTION: University of Texas Southwestern

LOCATED IN: Dallas (City) TX (State)

ACGME OK

** resident in good standing and will graduate 6/30/2011

1st Year from 7 / 01 / 07 To 6 / 30 / 11 Specialty Obstetrics & Gynecology Level (PGY) 1-4

2nd Year from ___/___/___ To ___/___/___ Specialty _____ Level (PGY) _____

"I certify that the above named applicant successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified."

The hospital has no seal or stamp to affix to this document. Therefore, I will have this form notarized to verify that this form was completed by this hospital.

[redacted]
Program Director's Signature: George D. Wendel, Jr., M.D.

12/29/2010
Date:

[Seal of Hospital]

[notary seal]

Notary's Signature: _____

Notary's Commission expires on: _____

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE.

243366

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OFFICE OF STUDENT AND ALUMNI AFFAIRS

2010 DEC 22 AM

49-101 (REV. 01-10)
State Board of Medicine
717-783-1400
717-787-2381

VERIFICATION OF MEDICAL EDUCATION
For Graduates of Accredited Medical Schools

SECTION 1: To be completed by applicant:

Name: CHAPPELL (Last) CATHERINE (First) ANNE (Middle)

Name of medical school: University of Texas - Southwestern

Location: Dallas, TX

SUBMIT THE VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN THE COMPLETED FORM DIRECTLY TO THE BOARD IN AN OFFICIAL SCHOOL ENVELOPE.

SECTION 2: To be completed by Dean or Registrar of medical school:

Name of medical student: Catherine A. Chappell

Date student began to attend this medical school: August 18, 2003 (MM/DD/YYYY)

Date of graduation: June 1, 2007 (MM/DD/YYYY)

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I certify that all of the above information is correct.

[Seal of School]

Signature of Dean or Registrar: Val Rodriguez

Date: December 22, 2010

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in an official school envelope.

DO NOT RETURN TO APPLICANT

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Courier Delivery Address
State Board of Medicine
2601 North Third Street
Harrisburg, PA 17110

MD AH

US·MLE
United States
Medical
Licensing
Examination™

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 – Telephone (817) 868-4041

Date: 01/26/2011

Recipient:

Pennsylvania State Board of Medicine
ATTN: Tammy Radel
2601 N Third Street
Harrisburg, PA 17110

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Examinee: Chappell, Catherine
Alt Name(s): Chappell, Catherine Anne

Examinee ID#: 5-156-280-9
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/21/2005	Pass	225	182	91	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	11/29/2006	Pass	235	182	95	75	

Clinical Skills (CS)*

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	12/11/2006	Pass					

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
TEXAS	11/05/2008	Pass	228	187	97	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

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This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

MD AH

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

5500000066502433
Process Date: 02/03/2011
Page: 1 of 1

SELF-QUERY RESPONSE

This self-query was processed under the provisions of:

[X] **Title IV (NPDB)** [X] **Section 1921 (NPDB)** [X] **Section 1128E (HIPDB)**

A. SEARCH RESULT (Based on the subject identification information provided, the reports found are listed below.)

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

B. SUBJECT IDENTIFICATION INFORMATION

Subject Name:	CHAPPELL, CATHERINE ANNE
Gender:	FEMALE
Date of Birth:	[redacted]
Other Name(s) Used:	
Organization Name:	PARKLAND MEMORIAL HOSPITAL
Organization Type:	GENERAL/ACUTE CARE HOSPITAL (301)
Home or Work Address:	[redacted]
City, State, ZIP:	DALLAS, TX 75208
Telephone:	[redacted]
Social Security Numbers (SSN):	
Individual Taxpayer Identification Numbers (ITIN):	
Professional School(s) & Year of Graduation:	UNIVERSITY OF TEXAS SOUTHWESTERN (2007)
Occupation/Field of Licensure (Code):	PHYSICIAN INTERN/RESIDENT (MD) (015)
State License Number, State of Licensure:	BPI-0028287, TX
Specialty:	OBSTETRICS & GYNECOLOGY (50)
Drug Enforcement Administration (DEA) Numbers:	
National Provider Identifiers (NPI):	1144429200
Federal Employer Identification Numbers (FEIN):	
Unique Physician Identification Numbers (UPIN):	

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C. PAYMENT INFORMATION

Credit Card Number:	[redacted]	Expiration Date:	[redacted]
Additional Paper Copies Requested:	1		
NPDB Charge:	$16.00*	NPDB Bill Reference Number:	N24860364
HIPDB Charge:	$16.00*	HIPDB Bill Reference Number:	H24860364
* Each charge will appear separately on your credit card statement.		Transaction Date:	02/03/2011

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended, and Section 1921 of the Social Security Act, as amended by Section 5(b) of the Medicare and Medicaid Patient and Program Protection Act of 1987, and as amended by the Omnibus Budget Reconciliation Act of 1990 and by Section 1128E of the Social Security Act. Information from the NPDB and HIPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB and/or HIPDB are permitted to share that information with anyone they choose.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

5500000066502433
Process Date: 02/03/2011
Page: 1 of 1

To: CHAPPELL, CATHERINE ANNE
[redacted]
DALLAS, TX 75208

From: National Practitioner Data Bank / Healthcare Integrity and Protection Data Bank
Re: Response to Your Self-Query

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended, and Section 1921 of the Social Security Act as well as the Healthcare Integrity and Protection Data Bank (HIPDB) for restricted use under the provisions of Section 1128E of the Social Security Act.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners. Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), HRSA, Division of Practitioner Data Banks.

Section 1921 of the Social Security Act, as amended by Section 5(b) of the Medicare and Medicaid Patient and Program Protection Act of 1987, and as amended by the Omnibus Budget Reconciliation Act of 1990, expanded the scope of the NPDB. Section 1921 was enacted to protect program beneficiaries from unfit health care practitioners and health care entities, and to improve the anti-fraud provisions of Federal and State health care programs. This legislation authorizes the NPDB to collect certain adverse State licensure actions, as well as any negative action or finding that a State licensing authority, peer review organization, or private accreditation organization has concluded against a health care practitioner or health care entity. Regulations governing the NPDB are codified at 45 CFR Part 60.

Section 1128E was established by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996, as amended. The statute established the HIPDB to combat fraud and abuse in health insurance and health care delivery and to improve the quality of patient care. The HIPDB serves as a source of final adverse action information on health care practitioners, providers, and suppliers. The HIPDB collects and releases information related to adverse licensure actions; health care-related convictions and judgments; exclusions from Federal and State health care programs; and other adjudicated actions or decisions. Regulations governing the HIPDB are codified at 45 CFR Part 61. Responsibility for operating the HIPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, and HRSA, Division of Practitioner Data Banks.

Reports from the NPDB and HIPDB contain limited summary information and should be used in conjunction with information from other sources in granting clinical privileges or making employment affiliation, contracting, or licensure decisions. The NPDB and HIPDB response may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an adverse licensure action and an exclusion from the Medicare and Medicaid programs). The NPDB and HIPDB is a flagging system and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB and HIPDB is considered confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB and/or HIPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB-HIPDB web site (http://www.npdb-hipdb.hrsa.gov) or contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

Catherine Anne Chappell, MD

[redacted]
Dallas, TX 75208
[redacted]
E-mail: [redacted]

EDUCATION

Ob/Gyn Residency, University of Texas Southwestern/Parkland Memorial Hospital
Dallas, Texas, July 2007 to June 2011 (Anticipated)
M.D., University of Texas Southwestern Medical School
Dallas, Texas, August 2003 to June 2007
B.S., Southwestern University
Georgetown, Texas, August 1999 to May 2003
Major: Biology and Chemistry, Minor: Sociology
Magna Cum Laude Graduate, Phi Beta Kappa
Dean's List and Southwestern Scholars Scholarship all semesters attended

RESEARCH

Chappell C, West AM, Kabbani W, Werner C. Off Label High-Risk HPV-DNA Testing of Vaginal Cytologies at Parkland Hospital. *Journal of Lower Genital Tract Disease* 2010; 14: 352-355.
Oral Presentation at the 2010 ASCCP Biennial Meeting
Winner of the ASCCP/Hologic Young Investigator's Award
"Vaginal and Cervical Cytologies at Parkland Hospital: Comparison of Testing Frequency and Bethesda System Results"
Poster presentation at the 2010 ASCCP Biennial Meeting
"Apoptosis of Lymphocytes Induced mAb CD28.1 is Blocked by Monocytes."
Baylor College of Medicine, Houston, TX, Department of Immunology
Summer Medical and Research Training Program, Summer 2002

PROFESSIONAL ORGANIZATIONS/LEADERSHIP

American College of Obstetrics and Gynecology (Spring 2006 to present)
American Society of Colposcopy and Cervical Pathology (August 2009 to present)
Resident Representative to ASCCP Board of Directors (March 2010 to present)

PRESENTATIONS

1) "Prevention of Maternal to Child Transmission of HIV in Resource-Constrained Settings." Given during UTSW Maternal Fetal Medicine Rounds: January 23, 2007
2) "Preoperative evaluation of Gynecologic Patient with Diabetes." Given during UTSW Urogynecology Rounds: May 26, 2009
3) "Pros and Cons of Elective Oopherectomy." Given during UTSW Urogynecolgy Rounds: August 19, 2009
4) "Lupus in Pregnancy." Given during Obstetrics Grand Rounds: March 2[illegible] 2010

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

February 24, 2011

Attn: Tammy Dougherty
Pennsylvania State Board of Medicine
Tammy Dougherty
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: February 24, 2011
Your Reference Number: ahollinger
FSMB Batch Number: BQ1873569

The following is a report of the search results from the Board Action Data Bank as of February 24, 2011 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of February 24, 2011

Item	Name	DOB	School	Yr/Grad	Request ID
1	CHAPPELL, CATHERINE ANNE	[redacted]		2007	23386413

LICENSE HISTORY
State Board
No License Information Available

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

January 11, 2011

initial

Attn: Tammy Dougherty
Pennsylvania State Board of Medicine
PO Box 2649
Harrisburg, PA 17105

Re: Board Action Query Dated: January 11, 2011
Your Reference Number: L CRANDALL
FSMB Batch Number: BQ1856103

The following is a report of the search results from the Board Action Data Bank as of January 11, 2011 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of January 11, 2011

Item	Name	DOB	School	Yr/Grad	Request ID
1	CHAPPELL, CATHERINE	[redacted]		2007	23222060
	LICENSE HISTORY State Board No License Information Available				
2	PLOWEY, EDWARD	[redacted]		2005	23222061
	LICENSE HISTORY State Board No License Information Available				
3	SHARMA, MADDIE	[redacted]		1986	23222064
	LICENSE HISTORY State Board CONNECTICUT ILLINOIS MASSACHUSETTS MICHIGAN NEW YORK NORTH CAROLINA VIRGINIA WASHINGTON WISCONSIN				

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@state.pa.us
www.dos.state.pa.us/med

January 31, 2011

CATHERINE ANNE CHAPPELL 9849
[redacted]
DALLAS TX 75208

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

EVALUATOR: AARON

RE: DISCREPANCY NOTICE – Unrestricted (American)

Dear Doctor:

The Board has received your application for an unrestricted medical license. The items listed below are needed to complete your application. A license cannot be issued until all items are received, approved and the application is complete. **You may not practice in the Commonwealth of Pennsylvania as a Physician and Surgeon until a license has been issued by the Board.**

- **BOTH** the National Practitioner Data Bank **AND** the Healthcare Integrity and Protection Data Bank self query disclosure information (**www.npdb-hipdb.com**) – **NPDB & HIPDB** reports are required. **Must provide original documents of both reports.**

APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS WILL REQUIRE UPDATES OF CERTAIN DOCUMENTS.

You may check the status of your application online at www.mylicense.state.pa.us. Click on the link duplicate licenses/address changes/application status. First time users will be required to register and create a user ID and password. Your registration code to register is: 57oJP4me

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@state.pa.us
www.dos.state.pa.us/med

January 19, 2011

CATHERINE ANNE CHAPPELL 9849
[redacted]
DALLAS TX 75208

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

EVALUATOR: AARON

RE: DISCREPANCY NOTICE – Unrestricted (American)

Dear Doctor:

The Board has received your application for an unrestricted medical license. The items listed below are needed to complete your application. A license cannot be issued until all items are received, approved and the application is complete. **You may not practice in the Commonwealth of Pennsylvania as a Physician and Surgeon until a license has been issued by the Board.**

1/31

- USMLE scores **must be received DIRECTLY from the Federation of State Medical Boards, Inc. in an official agency envelope. (817-868-4000)**

- **BOTH** the National Practitioner Data Bank **AND** the Healthcare Integrity and Protection Data Bank self query disclosure information **(www.npdb-hipdb.com) – NPDB & HIPDB** reports are required. **Must provide original documents of both reports.**

APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS WILL REQUIRE UPDATES OF CERTAIN DOCUMENTS.

You may check the status of your application online at www.mylicense.state.pa.us. Click on the link duplicate licenses/address changes/application status. First time users will be required to register and create a user ID and password. Your registration code to register is: 57oJP4me

Person Info
Name:CATHERINE ANNE CHAPPELL
Address Info

Email: [redacted]@HOTMAIL.COM
Street Address: [redacted]
Phone [redacted]
Fax
CityPittsburgh
StatePA
Zipcode15213
Country82
CountyAllegheny

Survey Response Summary
Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to	N

the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
Have you met your current CE requirements?	Y

Education Information

Edit

Profession:	School:	Credit Hours:	Education Type:
Medicine	UNIV OF TEXAS SOUTHWESTERN		
From:	To:		
	6/1/2007		

Employment Information

No employment records

remarks

Remarks:

Continuing Education Information

No CE Course records

Person Info
Name: CATHERINE ANNE CHAPPELL
Address Info
Street Address [redacted] **Email** [redacted]@upmc.edu
Phone [redacted]
Fax
City Pittsburgh
State PA
Zipcode 15206
Country 82
County Allegheny

Survey Response Summary	
Question	**Response Summary**
Are you submitting a name change with this renewal?	N
Have you completed your current CE requirements?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?	N
If you answered yes to the above question, please provide the profession and state or jurisdiction.	
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	
Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only.	

Date Submitted: Tuesday, November 15, 2016

Education Info

No education records

Employment Information

No employment records

Person Info
Name: CATHERINE ANNE CHAPPELL
Address Info
Street Address: [redacted]
Phone [redacted]
Fax
City Pittsburgh
State PA
Zipcode 15224
Country 82
County Allegheny
Email: [redacted]@upmc.edu

Survey Response Summary	
Question Response Summary	
Are you submitting a name change with this renewal?	N
Have you met your current CE requirements?	Y
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	N
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	N
If you answered yes to the above questions, please provide the profession and state or jurisdiction.	
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
If yes, are you currently participating in the Pennsylvania Professional Health Monitoring Program?	
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	

Date Submitted: Monday, December 08, 2014

Education Info

No education records

Employment Information

No employment records

Medicine- Medical Physician and Surgeon-Accredited School Graduate

AA0000922704

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649

APPLICANT INFORMATION

PERSONAL INFORMATION							
Last Name	CHAPPELL		First Name	CATHERINE			
Middle Name	ANNE		Suffix				
Full Name	CATHERINE ANNE CHAPPELL						
SSN	[redacted]	Date Of Birth	[redacted]	Age	37	Gender	FEMALE

ADDRESS DETAILS			
Street Address	[redacted]		
City/State/Zip	PITTSBURGH PA 15206		
County	Allegheny	Country	United States

CONTACT DETAILS			
Phone number	[redacted]	Mobile Phone number	
Primary Email Address	[redacted]@upmc.edu	Secondary Email Address	[redacted]@gmail.c

CHECKLIST ITEMS

Checklist name	Status	Submitted Date	Expiration Date
Application	Pending Review	10/27/2018	
Application Fee	Completed	10/27/2018	
Child Abuse CE	Completed	10/27/2018	

LEGAL QUESTIONS

	Questions	Answer	Document Uploaded	File Name
1	Are you submitting a name change with this renewal?	N	No	
2	First Name		No	
3	Middle Name		No	
4	Last Name		No	
5	You must submit a copy of a legal document verifying the name (s). The following are acceptable name change verification documents: (1) Marriage Certificate: (2) Divorce decree which indicates the retaking of your maiden name: (3) Other "legal" document indicating the retaking of a maiden name: (4) For a "legal" name change, a copy of the court document must be provided.		No	
6	With the exception of the one you are currently renewing, do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y	No	

7	Please provide the profession and state or jurisdiction.	Physician-Texas	No	
8	Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N	No	
9	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
10	Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
11	Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N	No	
12	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N	No	
13	Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N	No	
14	Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N	No	
15	Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N	No	
16	Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N	No	
17	Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]	No	
18	Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N	No	
19	Have you previously reported the complaint to the Board?		No	
20	Provide the docket number:		No	
21	Upload a copy of the entire Civil Complaint, which must include the filing date and the date you were served.		No	
22	Have you completed at least 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids?	Y	No	
23	Do you hold a DEA number or use the registration number of another person or entity to prescribe controlled substances?		No	
24	Have you registered with the Pennsylvania Prescription Drug Monitoring Program?	Y	No	

25	I will be retiring from practice but desire to place my license on active-retired status which will allow me to treat immediate family members. I am exempt from the CME requirements, except for completion of the 2 hours of Board-approved continuing education in child abuse recognition and reporting and 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids. Renewal must be completed and fee required.	N	No	
26	Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y	No	
27	Upload an explanation or reason for an exemption request.		No	
28	Have you met your continuing education requirements? Please review the continuing education requirements posted on the Board's website at www.dos.pa.gov/med. Click on General Board Information. If you qualify for an exemption of the continuing education requirements, answer yes to the question. You are required to retain your official continuing education certificates of completion earned for this license renewal period until December 31, 2020.	Y	No	

Licenses/Certificates/Permits/Registrations in Any State/Jurisdiction

Profession	State/Jurisdiction
Physician	Texas

CONFIRMATION

☑ All fees are non-refundable. Please check to continue with your transaction. (10/27/2018 14:15:00)