



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 01068175B	Date of issuance (month, day, year) 5-11-10	
Receipt number 3244516	Application fee 60.00	Date fee paid (month, day, year) 5-11-10

DO NOT WRITE ABOVE THIS LINE

PRACTITIONERS			
(Please check one box) <input type="checkbox"/> Dentist <input checked="" type="checkbox"/> Physician <input type="checkbox"/> Osteopathic Physician <input type="checkbox"/> Podiatrist <input type="checkbox"/> Veterinarian <input type="checkbox"/> Advanced Practice Nurse <input type="checkbox"/> Physician Assistant			
Name of practitioner Sierra Li'en Washington, MD		Specialty Ob/Gyn	
Telephone number (██████████)	Professional license number 1068175A	Date of birth (month, day, year) 10/24/1976	Social Security number * ██████████
Name of Facility (if applicable) Indiana University Hospital, Department of Ob/Gyn		E-mail address ██████████	
Indiana practice address (number and street (may not be a PO Box), city, state, and ZIP code) Indianapolis, IN 46202			
Drug schedules: (Check all applicable) <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input checked="" type="checkbox"/> 2 Narcotic <input checked="" type="checkbox"/> 3 <input checked="" type="checkbox"/> 3 Narcotic <input checked="" type="checkbox"/> 4 <input checked="" type="checkbox"/> 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 [Signature]	Date (month, day, year) 5/6/2010

RECEIVED
MAY 11 2010
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