# APPLICATION FOR INDIANA CONTROLLED SUBSTANCES REGISTRATION (CSR) FOR PRACTITIONERS

State Form 34617 (R15 / 6-13)
Approved by State Board of Accounts, 2013

**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) |
|---|---|---|
| 01075463B | | 6/5/2015 |
| **Receipt number** | **Application fee** | **Date fee paid (month, day, year)** |
| 5180385 | 60- | 3-9-15 |

**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 | |
|---|---|---|---|
| Katherine W McHugh | | OB/GYN | |
| **Telephone number** | **Professional license number** | **Date of birth (month, day year)** | **Social Security number *** |
| [redacted] | pending | 07/02/1980 | [redacted] |
| **Name of Facility (if applicable)** | | **E-mail address** | |
| | | [redacted] | |

Indiana practice address *(number and street [may not be a PO Box], city, state, and ZIP code)*
550 N. University Blvd Suite 2440, Indianapolis, IN 46202

**Drug schedules:** *(Check all applicable)*
☐ 1 ☑ 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.

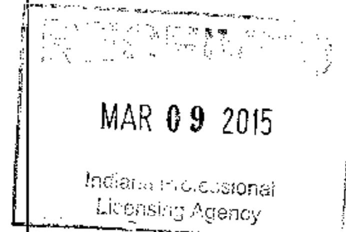
1. Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,
   (1) have you ever been arrested;
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state;
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or
   (5) have you ever pled nolo contendre to any offense, misdemeanor, or felony in any state? ☐ Yes ☑ No
2. 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.

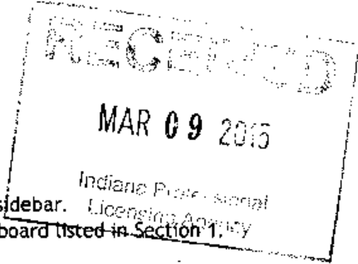
| Signature of practitioner | Date (month, day, year) |
|---|---|
| [signature] | 0202/2015 |

6-5-15 OK



$60

Professional Licensing Agency
402 W Washington St, Room W072
Indpls 46204




UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

# Licensure Verification (UA Form #1)

Applicant: Complete this form as instructed in the left sidebar.
Licensing Board: Complete this form and send it to the board listed in Section 1.

**Applicant:**

Send this form and any applicable fee to each state board you have held a full, temporary, training, or limited license with.

Licensure Verification Information (including fees) is available at http://www.fsmb.org/licensure/uniform-application/.

Copy this form for multiple licenses.

Use the medical board directory located at http://www.fsmb.org/policy/contacts to ensure you list the correct name/address.

## Section 1: Applicant Information

Last name: McHugh Suffix: ______

First name: Katherine

Middle name: Wippermann

Date of birth: 7/2/1980 Social Security number*: [redacted]

*The social security number is to be used for purposes of identification only and may not be used for any other reason.*

**Authorization:** I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of Indiana to provide any and all information pertaining to license number 11016222 to the following Board:

Board name: Darren R. Covington, JD Board of Directors

Mailing address: 402 W Washington St, Room W072

City/State/Zip: Indianapolis, IN 46204-2298

**Applicant signature:** [signature] **Date:** 2/2/15

**Licensing Board:**

Please complete Section 2 of this form.

Send this form to the state board listed in Section 1.

Alternatively, provide electronic verification of licensure to the state board listed in Section 1.

DO NOT SEND THIS FORM OR ANY VERIFICATIONS TO FCVS/FSMB.

## Section 2: Licensure Verification

Name of Licensee: ______ (Last) ______ (First) ______ (Middle) ______ (Suffix)

Issuing State Board: ______ License type: ______

License number: ______ Issue date: ______ Expiration date: ______

Is this license current? ☐ Yes ☐ No If not current, please explain: ______

1. Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? ☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: ______

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state?

☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: ______

**I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.**

AFFIX BOARD SEAL HERE

(If no seal is available, this form must be notarized.)

Signature: ______
Print name: ______
Title: ______
Date: ______
Email: ______

$11.22 (paid online)
Darren R. Covington, JD Board Director
402 W Washington St, Room W072
Indpls, 46204-2298