APPLICATION FOR A TEMPORARY MEDICAL PERMIT
(For Postgraduate Training, Teaching, or Fellowship)

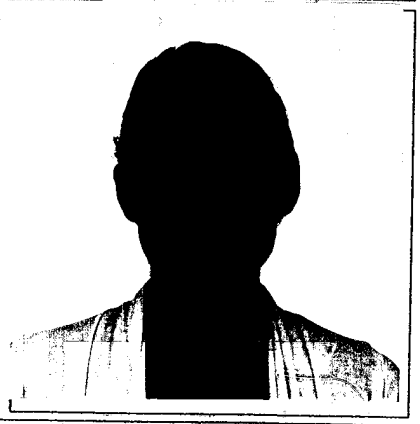
State Form 17598 (R10 / 3-07)
Approved by State Board of Accounts, 2007

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 IC 4-1-8-1. 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

Permit fee	Date fee paid (month, day, year)	Receipt number
100.00	6.10.11	3492037
Permit number	**Permit issuance date (month, day, year)**	
110162224	6.14.11	



Applying for: ☑ Postgraduate training ☐ Teaching ☐ Fellowship

APPLICANT INFORMATION

Name of applicant (last, first, middle): McHugh, Katherine Wippermann
Social Security number *: [redacted]
Address of practice (number and street or rural route): 550 N. University ~~Box~~ Blvd, Rm. 2440
City, state, and ZIP code: Indianapolis, IN 46202
Telephone number (daytime): [redacted]
Date of birth (month, day, year): July 2 1980
Ethnicity **: White
Race **: White
Gender **: ☐ Male ☑ Female
Please indicate what address you want your permit sent to (number and street or rural route) [if different than above]: 142 W 43rd St.
City, state, and ZIP code: Indianapolis, IN 46208
Email address: kwmchugh@iupui.edu
National Practitioner Identifier number:

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of school	Location	Date of graduation (month, day, year)
Indiana University	Indianapolis, IN	May 14, 2011

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: [signature] Date (month, day, year): 5/6/11

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
University of Louisville	Louisville, KY	August 1998 - May 2002
Indiana University	Sellersberg, IN	June 2004 - May 2005

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)
Indiana University	Indianapolis, IN	June 2009 - May 2011
University of Kentucky	Lexington, KY	August 2006 - May 2008

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 SCHOOL	LOCATION	FROM (month, year)	TO (month, year)	ACGME ACCREDITED?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL	
GENERAL LOCATION	DATE (*month, day, year*)
Indianapolis, IN	May 2009 - present

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE (*month, day, year*)
(none)		

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
	(none)			

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 the 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 license, certificate, registration or permit you hold or have held?	☐ Yes ☑ No
2. Have you ever been denied a license, certificate, registration or permit to practice 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 you ever been treated for drug or alcohol abuse?	☐ 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 arrested, convicted of, pled guilty or nolo contendere to, or are formal charges pending: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substance or drug addiction? B. Any offense, misdemeanor or felony in any state? (*Except for minor 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 privileges 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 surrendered your DEA registration at any time or had any limitations placed on your DEA 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 applicant

Date signed (*month, day, year*) 5/5/11

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, 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 temporary medical permit.

I hereby release the aforementioned persons, firms, officers, corporations, association, organization, 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 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 signed *(month, day, year)*	Signature of applicant
5/5/11	

HOSPITAL / INSTITUTION CERTIFICATION FOR A TEMPORARY MEDICAL PERMIT OR A TEMPORARY MEDICAL TEACHING PERMIT

(to be completed by the hospital / institution Chairman / Department Head)

This is to certify that Katherine McHugh has been granted

an appointment to serve at Indiana University School of Medicine in

the Department of Obstetrics and Gynecology

located at *(address)* Indianapolis, IN 46202

this appointment is for the month and year beginning July 1, 2011 and ending June 30, 2012

Name of Hospital Chairman/Department Head	Title	
Peter Nalin, MD	Associate Dean for Graduate Medical Education	
Signature	**Date of signature *(month, day, year)***	**Telephone number**
Peter K Nalin	March 31, 2011	(317) 274-5261

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INDIANA UNIVERSITY

School of Medicine

To 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

Katherine Wippermann McHugh

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

Doctor of Medicine

with all the rights and privileges thereunto appertaining.

In Testimony Whereof, this Diploma is issued, sealed with the Seal of the University, signed by the President of the University, the Chancellor, 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 Fifteenth Day of May, 2011.

Dean of the School of Medicine

Michael A. McRobbie
President

Secretary of the Trustees

Chancellor

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Notarized in the presence of original document

Amanda Feldhaus 6/7/11
Comm Exp May 5, 2018

OFFICIAL SEAL
AMANDA FELDHAUS
NOTARY PUBLIC – INDIANA
My Comm. Expires May 5, 2018

SCHOOL OF MEDICINE
INDIANA UNIVERSITY
Office of Medical Student Affairs

May 16, 2011

RE: Katherine Wipperman McHugh, M.D.
SSN: [redacted]

Dear Administrator,

This letter certifies that **Katherine Wipperman McHugh** matriculated in the Indiana University School of Medicine on 8/13/2007. Dr. McHugh completed all requirements for the Doctor of Medicine degree on 4/30/2011. The Doctor of Medicine degree was conferred upon Dr. McHugh on 05/15/2011.

Should you require any additional information, please do not hesitate to contact us.

Sincerely,

Dennis Deal
Director, Academic Records

cc: Student File

Office of Student Records VanNuys Medical Science Building 124 635 Barnhill Drive Indianapolis, IN 46202-5120
(317) 274-1970 fax (317) 278-4755 http://msa.iusm.iu.edu