FOR OFFICE USE ONLY

Application fee	Date fee paid (mo/day/yr)	Receipt number
250.00	6/1/2015	S23328
License number	License issuance date (mo/day/yr)	
01075463A	6/4/2015	
Permit fee	Date fee paid (mo/day/yr)	Receipt number
Permit number	Permit issuance date	

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Indiana Professional Licensing Agency

MEDICAL LICENSING BOARD OF INDIANA

ADDENDUM INSTRUCTIONS

Addendum Instructions: Complete the addendums as instructed below. Please type or print your responses.

Return the completed addendums, a printed copy of the UA application, payment and all supporting documentation to the Indiana Board.

Medical Licensing Board of Indiana
402 West Washington Street, Room W072
Indianapolis, IN 46204

☒ **Addendum 1**: The completion of this section of the form is **voluntary** and will **not** affect your application in any way.

☒ **Addendum 2**: These questions must be completed by the applicant. Any "yes" responses to questions 1-12 will need additional documentation as explained in the form.

☒ **Addendum 3:** ***This must be requested by all applicants.*** Follow the instructions to apply for and schedule your fingerprinting appointment. Failure to follow these instructions may delay processing and/or require additional fees to obtain the background check. For more information: http://www.in.gov/pla/3240.htm.

ADDENDUM 1

VOLUNTARY RACE / ETHNICITY / GENDER QUESTIONS**

This information is completely voluntary and will NOT affect your application in any way.

Gender: ☐ Male ☑ Female Race: _____ Ethnicity: _____

** Note: This information is being requested for workforce statistical purposes only; disclosure is voluntary.

Applicant Name: McHugh (Last) Katherine (First) Wippermann (Middle)

Social Security #: [redacted] Email Address: [redacted]

Mailing Address: 4030 N. Pennsylvania St.

City/State/Zip: Indianapolis, IN 46205 Phone#: [redacted]

ADDENDUM 2

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit? ☐ Yes ☑ No **If yes, an additional fee of $100 is required.**

SPECIALITIES / BOARD CERTIFICATION

List specialty: Obstetrics and Gynecology

Board certification (list ABMS certification): _____

ADDITIONAL QUESTIONS

Answer the following questions. If your answer is "Yes" to any of these questions, explain fully in a signed, sworn and notarized affidavit, including all related details. Include the violation, location, date and disposition. If applicable, please submit copies of all court documents and/or arrest records. **If you have malpractice, complete the "Malpractice Liability Claims Information" section of the Online Uniform Application for each claim.** Letters from attorneys or insurance companies are not accepted in lieu of your statement, but may be submitted with your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

☐ Yes ☑ No 1. Has disciplinary action ever been taken regarding any health 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 medicine, 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 ever been treated for drug or alcohol abuse or addiction?

☐ Yes ☑ No 4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?

5. Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,

☐ Yes ☑ No A. have you ever been arrested;
☐ Yes ☑ No B. have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;
☐ Yes ☑ No C. have you ever been convicted of any offense, misdemeanor, or felony in any state;
☐ Yes ☑ No D. have you ever pled guilty to any offense, misdemeanor, or felony in any state;
☐ Yes ☑ No E. have you ever pled nolo contender to any offense, misdemeanor, or felony in any state?

☐ 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 ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?

☐ Yes ☑ No 10. Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?

☐ Yes ☑ No 11. Have you ever been excluded from being a Medicare / Medicaid provider?

☐ Yes ☑ No 12. Were there any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or any other reason during your medical education or post graduate training / residency program?

I understand my failure to answer the above questions truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Signature	[redacted]	[redacted]
	Email Address	Phone#
McHugh	Katherine	Wippermann
Print Name: Last	First	Middle

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar.
Send this to the state board you are applying to for licensure, NOT to FCVS/FSMB.

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to the board you are applying to for licensure. See http://www.fsmb.org/policy/contacts for a directory of state medical boards.

DO NOT SEND THIS FORM TO FCVS/FSMB. Doing so will delay your licensure process.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Applicant's signature (must be signed in the presence of a notary)

McHugh
Applicant's printed last name

Katherine W
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

2/24/2015
Date of signature (must correspond to date of notarization)

-fold up- -fold up-

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

Notary

State of Indiana, County of Marion

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 24 day of February, 2015.

Notary Public Signature: Teresa A. Davis-Wallace

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: 01/01/2016

Uniform Application for Physician Licensure

UA Username kwmchugh
FCVS Status No FCVS Packet

Date Submitted

Printed By Applicant

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name	McHugh
First Name	Katherine
Middle Name	Wippermann
Suffix	
Maiden Name	Wippermann

M.D. [X] **D.O.** [ ]

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All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business

[X] **Public Access**
[X] **Mailing**

Street 550 N. Unviersity Blvd
Suite 2440

City Indianapolis **State/Province** IN **Zip Code** 46202
Country USA
Telephone [redacted]
Fax
Email [redacted]
Alternate Phone

Home

[ ] **Public Access**
[ ] **Mailing**

Street 550 N. Unviersity Blvd
Suite 2440

City Indianapolis **State/Province** IN **Zip Code** 46202
Country USA
Telephone [redacted]
Fax
Email [redacted]
Alternate Phone

Submitted on 2/2/15 Sent to IMB on 3/5/15

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

07/02/1980	Danville	Pennsylvania	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F (Gender) [redacted] (Social Security Number) 1366725319 (NPI) Are you a U.S. Citizen? [X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1 **School Name** Indiana University School of Medicine Indianapolis
Address 1120 South Drive
City Indianapolis
State/Province IN
ZIP Code 46202-5114
Country USA
Attendance Dates **From (mm/yyyy)** 07/2009 **To (mm/yyyy)** 06/2011
Graduation Date 6/15/2011
Degree MD

2 **School Name** University of Kentucky College of Medicine
Address A.B. Chandler Medicial Center
800 Rose Street (MN-150)
City Lexington
State/Province KY
ZIP Code 40536-0084
Country USA
Attendance Dates **From (mm/yyyy)** 08/2006 **To (mm/yyyy)** 07/2008
Graduation Date 7/31/2008
Degree MD

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5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			

Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1 **Hospital Name** Indiana University
Hospital Address 550 N. University Blvd

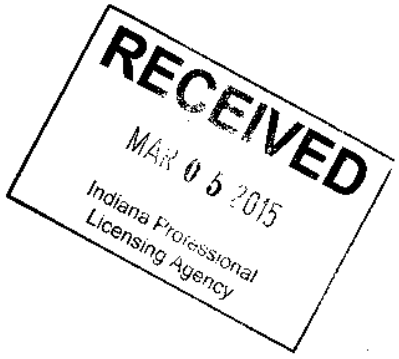
City Indianapolis
State/Province Indiana
ZIP Code 46202
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Obstetrics and Gynecology

From: 07 /2011 **To:** 7 /2014 **Successfully Completed?** ☐ **Yes** ☐ **No** **In Progress** ☒

Month Year Month Year



7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		10/2008	☒ P	☐ F	2
USMLE Step 2		08/2010	☒ P	☐ F	1
USMLE Step2 CS		11/2010	☒ P	☐ F	1
USMLE Step 3		07/2012	☒ P	☐ F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1 **State/Province** IN **Practitioner Type** (MD, DO, etc.) MD **Type of License** (Full, Temporary, etc.) Training License

License Number 11016222 **Status** Active **Issue Date** 7/1/2011

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2011 To: Month: Year: In Progress ☒	**Practice/Employment Name** Indiana University OB/GYN Residency (or list non-working time as indicated above) **Practice/Employment Address** 550 N. University Blvd Suite 2440 **City** Indianapolis **State/Province** Indiana **ZIP Code** 46202 **Country** USA **Position and Department** Resident Physician-OB/GYN **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. All fields are required to be answered. Please have your information available before reviewing this section. If you do not have any such claims or suits, please indicate so with, "I do not have any malpractice liability claim information."

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

STATE OF INDIANA

Michael R. Pence

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Digitally Certified Proof of Licensure

RE: Katherine Wippermann McHugh

I, Nicholas W. Rhoad, Executive Director of the Indiana Professional Licensing Agency and custodian of the records therein, hereby certify that the attached is the digitally certified proof of licensure, as requested, and as it appears in the files of the Indiana Professional Licensing Agency on the date/time certified.

This digital certification follows the requirements of Indiana's Electronic Digital Signature Act (Indiana Code 5-24-1-1 et seq.) and rules developed by the Indiana State Board of Accounts, 20 IAC 3-1 et seq. to establish a valid digital electronic signature

If you have the need to verify the authenticity of the digital certification as of the date and time stamp below, go to https://secure.in.gov/apps/pla/verify.htm and use our free web service to "Verify an Electronic Certified Record". Simply browse to the location you saved the secure pdf document sent to you and upload to validate.

Nicholas W. Rhoad

Nicholas W. Rhoad, Executive Director
Mon Feb 02 11:22:37 AM EST 2015

STATE OF INDIANA

Michael R. Pence

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Official Proof of Licensure
Digitally Certified Record

Personal Information

Name:	Katherine Wippermann McHugh
Address:	142 W. 43rd Street Indianapolis, IN 46208
Date of Birth:	07/02/1980

License Information

Number Issued:	11016222A
License Type:	Medical Residency Permit
Status:	Active
Issue date:	06/14/2011
Expiration Date:	06/30/2015
Obtained By:	Application
Disciplinary Action:	None

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams.

For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at www.in.gov/pla/boards.htm

Digitally Certified on: Mon Feb 02 11:22:37 AM EST 2015

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 complete 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 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

Secretary of the Trustees

Pres

Chan

True Copy of Original
notarized 2/24/15
Venus A. Davis Wallace
Comm #576846
Exp 01/01/2016
Marion Co.

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Medical School Verification (UA Form #2)

Applicant: Complete this form as instructed in the left sidebar.
Dean or Designated Med School Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

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

Name if different when diploma awarded: _____

Name of medical school: University of Kentucky College of Medicine

Date of birth: 07/02/1980 Social Security number*: 303-04-4063

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

Waiver for Release of Information: I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

Board name: Darren R. Covington, JD, Board Director

Mailing address: 402 W. Washington St., Room W072

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

Applicant signature: _____ **Date**: 2/2/15

Dean or Designated Official:

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the state board listed in Section 1.

DO NOT MAIL THIS FORM TO FCVS/FSMB.

If transcripts are not in English, an original, certified, and official English translation is required.

Section 2: Medical School Verification

Medical school name: University of Kentucky College of Medicine

School name if different when the above applicant attended: _____

Medical school address (including city, state or province, zip code, and country as applicable):
138 Leader Ave.
Lexington, KY 40506

Hours of undergraduate education required for admission into your school: Bachelor's degree

Total weeks of education applicant attended your school: 78

Applicant's attendance dates: From 07/31/06 to 05/02/2008

Graduation date: NA (indicate N/A if not applicable) Degree: NA (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

Applicant Name: McHugh, Katherine Wippermann

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes ☒ No ☐

If yes, please select the reason(s), indicate the dates of the interruption(s) or extension(s), and indicate whether the interruption(s)/extension(s) was/were approved or unapproved

	From Month/Year	To Month/Year	Approved	Unapproved
☐ Personal/Family			☐	☐
☐ Academic remediation			☐	☐
☐ Health			☐	☐
☐ Financial			☐	☐
☐ Participation in joint degree program (e.g., MD/PhD)			☐	☐
☐ Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
☒ Other: Transferred out	06/30/09	NA	☒	☐

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes ☐ No ☒

If yes, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
☐ Academic probation		
☐ Probation for unprofessional conduct/behavioral reasons		
☐ Probation for other reason(s) (please specify):		

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes ☐ No ☒

If yes, please attach documentation/information of the circumstances and outcome(s).

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Yes ☐ No ☒

If yes, please attach documentation/information of the circumstances and outcome(s).

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes ☐ No ☒

If yes, please attach documentation/information of the nature of the limitations or special requirements.

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.

Signature: _____ Beth Hartmann, Registrar

Print name: University of Kentucky College of Medicine

Title:

Date: 3/25/15

Phone number: 859 323 2456 Fax number: 859 323 2076

Email: med.registrar@uky.edu

AFFIX INSTITUTIONAL SEAL HERE

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

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.
Program Director or Designated Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

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

Name if different when diploma awarded: _____

Name of postgraduate training program: Indiana University Ob/GYN Residency

Date of birth: 07/02/1980 Social Security number*: 303-04-4063

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

Waiver for Release of Information: I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: Darren R. Covington, JD, Board Director
Mailing address: 402 W. Washington St., Room W072
City/State/Zip: Indianapolis, IN 46204-2298

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

Dean or Designated Official:

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/ transitional.

Make copies and attach additional pages if necessary.

Send this form to the board listed in Section 1 with any added documentation, if applicable.

DO NOT MAIL THIS FORM TO FCVS/FSMB.

Section 2: Postgraduate Training Verification

Institution name: Indiana University
Institution address: 550 N. University Blvd, Ste 2440
Institution city / state or province / zip code: Indianapolis, IN 46202
Affiliated medical school name: Indiana University SOM
Institution / school name if different when the applicant attended: _____

Postgraduate year (e.g., 1, 2, 3, etc.): 1 ☒ Internship ☐ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Ob/Gyn

Attendance dates: From 07/01/2011 to 06/30/2012

Successfully completed*? ☒ Yes ☐ No ☐ In progress with expected completion date of _____

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Applicant Name: ______________________________

Postgraduate year (e.g., 1, 2, 3, etc.): 2-3 ☐ Internship ☒ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: ______________

Specialty/Subspecialty: OB/GYN

Attendance dates: From 07/01/2012 to 06/30/14

Successfully completed*? ☒ Yes ☐ No ☐ In progress with expected completion date of ______

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Postgraduate year (e.g., 1, 2, 3, etc.): 4 ☐ Internship ☒ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other: ______________

Specialty/Subspecialty: OB/GYN

Attendance dates: From 07/01/2014 to ______________

Successfully completed*? ☐ Yes ☐ No ☒ In progress with expected completion date of 6/30/2015

**In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?*

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

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Please explain any "Yes" response on an additional page or in the blank sidebar area above.

Unusual Circumstances

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? ☐ Yes ☒ No

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.

Marion Co.
Venus A. Davis-Walker (signature)
Venus A. Davis-Walker
notarized 3/4/14
Comm# 576846
Exp 01/01/2016

AFFIX INSTITUTIONAL SEAL HERE
(If no seal is available, this form must be notarized.)

Signature: (signature)
Print name: Abigail Litwiller, MD
Title: Residency Program Director
Date: 3/2/15
Phone number: 317-948-5923 Fax number: 317-948-7454
Email: obrespgm@iupui.edu

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