

JEFFREY DAVID GLAZER

250 E LIBERTY ST SUITE 510

LOUISVILLE KY 40202

44 450 4201437 12/5/12

2325 Cherokee Pkwy  
Louisville KY 40204

1-4-13  
Approved  
1-2-13  
10/11/13

REINSTATEMENT (EXPIRED PAST 3 YEARS)

License Number	Date Expires	Reinstatement Fee Due
01045854A	06/30/2003	\$450.00

Please return this page and your renewal fee to: Indiana Professional Licensing Agency, 402 W. Washington Street Rm. W-072, Indianapolis, IN 46204. Checks should be payable to: "Indiana Professional Licensing Agency."

Please answer all the following questions. If you answer "Yes" to any of the questions you must also submit a signed, detailed statement. Please include violation, date and disposition. Letters from Attorneys, insurance companies and/or court documents are not acceptable in lieu of your statement, but may be included with your statement. Please print your name and license number on all correspondence.

The questions below cover the time period of since you last renewed your license.

YES ☒ NO 1. Has any Health Profession license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending?

YES ☒ NO 2. Have you been denied a license, certificate, registration or permit in any state?

YES ☒ NO 3. Have you been convicted of, plead guilty to a violation of any Federal, State, or are criminal charges pending or have you entered into a deferral program?

☒ YES NO 4. Have you had a malpractice judgment against you or settled a malpractice action? see enclosed

YES ☒ NO 5. Have you been denied staff membership or privileges in any hospital or health care facility or, have staff membership or privileges been revoked, suspended, or subjected to any restriction, probation, or other type of discipline or limitations?

YES ☒ NO 6. Have you been excluded from being a Medicare or Medicaid provider?

YES ☒ NO 7. Have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?

RECEIVED

DEC 05 2012

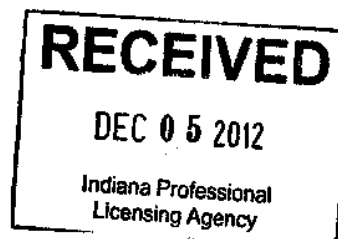
Indiana Professional  
Licensing Agency

I hereby swear or affirm under the penalties of perjury that I understand and have met the continuing education requirements for renewal and have answered the questions true to the best of my knowledge:

SIGNATURE *Jeffrey S. Glen* DATE: 12-1-2012

EMAIL ADDRESS: [REDACTED]

License # 01045854A



MEDICAL MALPRACTICE CASES AGAINST DR. JEFFREY D. GLAZER  
INDIANA MEDICAL LICENSE #1045854A

Robin S. [REDACTED] v. Jeffrey Glazer M.D. Date of claim: 1/10/2003. Date of closure:

May/2003. Outcome: Summary judgment in favor of Dr. Glazer. Case Summary: The patient had her baby delivered by Dr. Glazer who was on call for her obstetrician. The baby did well and she filed a suit four years after delivery, for unknown reasons. She would not answer requests for interrogatories or requests to schedule a deposition, and the courts awarded a summary judgment in my favor.

Lisa W. [REDACTED] v. Jeffrey Glazer M.D. Date of claim 1/6/2006. Date of closure:

Feb/2007. Outcome: Dismissal with prejudice. Case summary: The patient underwent a laparoscopic tubal ligation at which time an unrecognized bowel injury occurred. She underwent a bowel resection and made a full recovery. The patient withdrew her claim after discovery.

Teresa T. [REDACTED] v. Jeffrey Glazer M.D. Date of claim: 6/30/2004 Date of closure: Feb 2011. Outcome: Agreed settlement of \$20,000. Case summary: The patient developed diabetic ketoacidosis following a vaginal hysterectomy and may have suffered a myocardial infarction during that episode. The patient had been cleared and followed by both her endocrinologist and cardiologist (she had had previous myocardial infarctions). She made a full recovery and this settlement was made after 7 years.

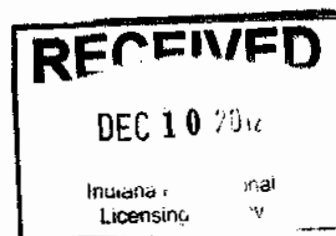
Damita S. [REDACTED] v. Jeffrey Glazer M.D. Date of claim: 3/21/2006. Date of closure:

Approximately April 2011. Outcome: Agreed settlement for the limits of my insurance policy for one case (\$1 million). Case summary: The patient underwent an abdominal hysterectomy, and had a prolonged slow recovery in the hospital, and when she developed worsening vital signs a large fluid collection was noted on CT scan. She was taken to the operating room where a presumed bowel injury was diagnosed and the patient was given a colostomy. She made a slow recovery but has recovered fully, but lives with her colostomy.

Brooke M. [REDACTED] v. Jeffrey Glazer M.D. Date of claim 1/22/2008. Date of closure:

January/2010. Outcome: Directed verdict in my favor. Case summary: The patient was seen in 2004 with a large ovarian cyst, she underwent laparoscopy with a laparoscopic ovarian cystectomy and made a satisfactory recovery. She had follow up ultrasounds which showed the ovary was present, but when she developed a cyst on the other ovary, she underwent laparoscopy by a different physician. He did not see the ovary that I operated on, and told her it wasn't there. A suit was filed, and in discovery it was noted that the lawyer did not have an expert witness. After much time the lawyer still could not produce an expert witness and the case was dismissed with the above outcome. The lawyer appealed to the Court of Appeals and the Kentucky Supreme Court who affirmed

the opinion of the lower courts.

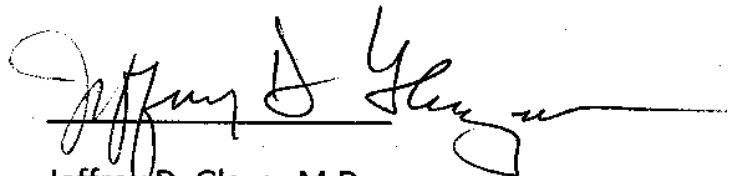


JEFFREY D. GLAZER M.D.

INDIANA LICENSE <sup>010</sup>45854A

MALPRACTICE CASES RESOLVED SINCE 2002

<u>Name of Case</u>	<u>Date</u>	<u>Resolution</u>
M[REDACTED] vs Glazer dismissal by the Court	2011	Summary Judgment and
Damita S[REDACTED] vs Glazer limits of insurance policy (\$1 Million )	2011	Out of Court settlement for
T[REDACTED] vs Glazer \$20,000	2010	Out of Court settlement for
W[REDACTED] vs Glazer	2007	Dismissed with Prejudice
S[REDACTED] vs Glazer dismissal by the Court	2003	Summary Judgement and

  
Jeffrey D. Glazer M.D.

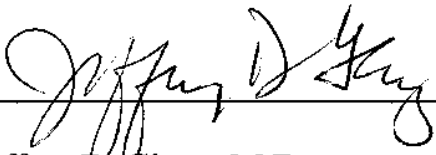


WORK HISTORY OF DR. JEFFREY D. GLAZER  
INDIANA LICENSE NUMBER 01045854

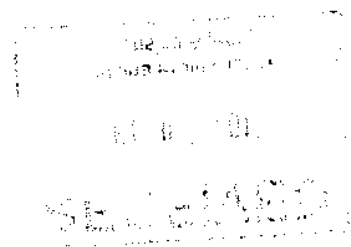
July 1987 to December 2009—Medifem Health P.S.C.--Current address: 2325 Cherokee Parkway, Louisville, KY 40202. Position: Physician, Obstetrics and Gynecology.

August 2008 to present: Veteran's Administration, Louisville, KY.--Address: 800 Zorn Ave. Louisville, KY 40206. Position: Physician, Gynecology.

August 2010 to present: Ft. Knox Ireland Regional and Community Hospital.--Address: 289 Ireland Avenue, Ft. Knox, KY 40121. Position: Physician, Obstetrics and Gynecology.

  
Jeffrey D. Glazer M.D.

Date: 12-1-2012



# COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

EXECUTIVE DIRECTOR  
LaSharn Hughes, MBA



MEDICAL DIRECTOR  
Jim H. McNatt, MD

2 Peachtree St., N.W., 36th Floor • Atlanta, Georgia 30303 • Tel: 404.656.3913 • Fax 404.656.9723  
<http://www.medicalboard.georgia.gov> E-Mail: [Medbd@dch.ga.gov](mailto:Medbd@dch.ga.gov)

December 14, 2012

RE: **Jeffrey Glazer, MD**

TO WHOM IT MAY CONCERN:

This is to certify that the above has been issued a **Physician** license by the Georgia Medical Board.

It is further certified that:

The license number is **28986** and was issued on **October 09, 1986**

The current license status is **Inactive**

The license expiration date is **December 31, 1993**.

**Board Actions** A review of public records indicates that no public board orders have been docketed.

Certified this day Friday, 14 December, 2012

Composite State Board of Medical Examiners

LaSharn Hughes  
Executive Director

LLH/



# Kentucky Board of Medical Licensure

310 Whittington Parkway, Suite 1B  
Louisville, Kentucky 40222  
Phone (502) 429-7150 Fax (502) 429-7158



**Name:** Jeffrey D. Glazer M.D.  
**Address:** 2325 Cherokee Pkwy.  
**City, State, Zip** Louisville KY 40204  
**Phone:** [REDACTED]  
**License:** 25111  
**Status:** Active Physician  
**Expiration:** 2/28/2013 0:00:00  
**Practice County:** Meade  
**\*Area of Practice:** Obstetrics/Gynecology  
**Type of Practice:** Public Hth/Gov  
**Year Licensed in KY:** 4/7/1987 0:00:00  
**Medical School:** University of Louisville School of Medicine  
**Year Graduated:** 1983  
**Board Action:** None

\*The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: <http://www.abms.org> to determine if the physician has earned a specialty certification from this private agency.



*Stephanie L. Simpson*  
Deputy Director



Rick Scott  
Governor



John H. Armstrong, MD, FACS  
Surgeon General & Secretary

December 21, 2012

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

RE: License Certification for Jeffrey David Glazer

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:	Medical Doctor
LICENSE NUMBER:	ME44465
ORIGINAL CERTIFICATION:	07/27/1984
EXPIRATION DATE:	12/31/1987
CURRENT STATUS OF LICENSE:	AUTHORITY VOID,
AGENCY ACTION:	No

To expedite the verification process, the above format is the standard format for all healthcare practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595, option 5.

Sincerely,

A handwritten signature in cursive script, appearing to read "Susan Harris".

Susan Harris  
Licensing and Auditing Services Unit



**Person Info****Name:**Jeffrey David Glazer**Address Info****Street****Email:****Address:**2325 Cherokee  
Parkway**Phone:****Fax:****City:**Louisville**State:**KY**Zipcode:**40204**Country:**United States**County:**Jefferson**Survey Response Summary**

Question	Answer
----------	--------

**Question Response Summary**

Question	Answer
1.) Since you last renewed, has any professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending in any state?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state?	N
3.) Since you last renewed, have you ever been arrested or convicted for a crime that has not been expunged by an Indiana court?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff membership or privileges in any hospital or health care facility or have staff membership or privileges been revoked, suspended, or subject to any restriction, probation, or other type of discipline - or have you resigned in lieu of discipline or termination?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N

**Person Info****Name:**Jeffrey David Glazer**Address Info****Street  
Address:****Email:****Phone:****Fax:**  
**City:**  
**State:**  
**Zipcode:**  
**Country:**United States  
**County:****Survey Response Summary  
Question Response Summary**

Question	Answer
1.) Since you last renewed, has there been an occasion where you have not maintained effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels?	N
2.) Since you last renewed, has there been an occasion where you have not been in complete compliance with all state and local laws pertaining to controlled substances?	N
3.) Since you last renewed, have you been convicted, pled guilty, or pled nolo contendere, under any federal or state laws relating to any controlled substances that has not been expunged under IC 35-38-9?	N
4.) Since you last renewed, have you had any action, discipline, revocation, or surrender of your Drug Enforcement Registration or entered into any settlement or Memorandum of Understanding with respect to said registration?	N
5.) Since you last renewed, have you had any action, discipline, revocation, or surrender of any professional license in any jurisdiction related to controlled substances?	N

**Person Info****Name:**Jeffrey David Glazer**Address Info****Street****Email****Address:**2325 Cherokee  
Parkway**Phone****Fax:****City:**Louisville**State:**KY**Zipcode:**40204**Country:**United States**County:**Jefferson**Survey Response Summary**

Question	Answer
----------	--------

**Question Response Summary**

Question	Answer
1.) Since you last renewed, has any professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending in any state?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state?	N
3.) Since you last renewed, have you ever been arrested or convicted for a crime that has not been expunged by an Indiana court?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff membership or privileges in any hospital or health care facility or have staff membership or privileges been revoked, suspended, or subject to any restriction, probation, or other type of discipline - or have you resigned in lieu of discipline or termination?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N

**Person Info****Name:**Jeffrey David Glazer**Address Info****Street**2325 Cherokee  
**Address:**parkway**Email:** [REDACTED]**Phone:** [REDACTED]**Fax:**5025587900**City:**louisville**State:**KY**Zipcode:**40204**Country:**United States**County:**Jefferson**Survey Response Summary**  
**Question Response Summary**

Question	Answer
1.) Since you last renewed, has there been an occasion where you have not maintained effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels?	N
2.) Since you last renewed, has there been an occasion where you have not been in complete compliance with all state and local laws pertaining to controlled substances?	N
3.) Since you last renewed, have you been convicted, pled guilty, or pled nolo contendere, under any federal or state laws relating to any controlled substances that has not been expunged under IC 35-38-9?	N
4.) Since you last renewed, have you had any action, discipline, revocation, or surrender of your Drug Enforcement Registration or entered into any settlement or Memorandum of Understanding with respect to said registration?	N
5.) Since you last renewed, have you had any action, discipline, revocation, or surrender of any professional license in any jurisdiction related to controlled substances?	N

**Person Info****Name:**Jeffrey David Glazer**Address Info****Street  
Address:****Email:****Phone:**

**Fax:**  
**City:**  
**State:**  
**Zipcode:**  
**Country:**United States  
**County:**

**Survey Response Summary**  
**Question Response Summary**

Question	Answer
1.) Since you last renewed, has there been an occasion where you have not maintained effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels?	N
2.) Since you last renewed, has there been an occasion where you have not been in complete compliance with all state and local laws pertaining to controlled substances?	N
3.) Since you last renewed, have you been convicted, pled guilty, or pled nolo contendere, under any federal or state laws relating to any controlled substances that has not been expunged under IC 35-38-9?	N
4.) Since you last renewed, have you had any action, discipline, revocation, or surrender of your Drug Enforcement Registration or entered into any settlement or Memorandum of Understanding with respect to said registration?	N
5.) Since you last renewed, have you had any action, discipline, revocation, or surrender of any professional license in any jurisdiction related to controlled substances?	N

**Person Info****Name:**Jeffrey David Glazer**Address Info****Street**2325 Cherokee  
**Address:**parkway**Email:****Phone:****Fax:**5025587900**City:**louisville**State:**KY**Zipcode:**40204**Country:**United States**County:**Jefferson**Survey Response Summary**

Question	Answer
----------	--------

**Question Response Summary**

Question	Answer
1.) Since you last renewed, has any health profession license, certificate, registration or permit you hold or have held been denied, surrendered, disciplined or are formal charges pending in any state?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state?	N
3.) Since you last renewed, and except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been convicted of, pled guilty to, or pled nolo contendere to any offense, misdemeanor, or felony in any state?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff membership or privileges in any hospital or health care facility or have staff membership or privileges been revoked, suspended, or subject to any restriction, probation, or other type of discipline - or have you resigned in lieu of discipline or termination?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N

STATE OF INDIANA  
ONLINE RENEWAL RECORD

Renewal Submission Date:

August 19, 2019

**Person Info**

Name:

Jeffrey David Glazer

License Number:

01045854A

**Address Info**

Street Address:

2325 Cherokee parkway

City:

louisville

State:

KY

Zipcode:

40204

County:

Jefferson

Phone:

[REDACTED]

Email:

[REDACTED]

**Question Response Summary**

1.) Since you last renewed, has any health profession license, certificate, registration or permit you hold or have held been disciplined or are formal charges pending in any state or U.S. territory?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state or U.S. territory?	N
3.) Since you last renewed, and except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been convicted of, pled guilty to, or pled nolo contendere to any offense, misdemeanor, or felony in any state or U.S. territory?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff memberships or privileges in any hospital or clinic or have staff membership or privileges been revoked, suspended, or subjected to any restriction, probation, or other type of discipline or limitations?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N
<b>Citizenship Status: You should only indicate one 'Yes' response to the statement below.</b>	
Pursuant to IC 12-32-15 and IC 12-32-1-6, I swear under the penalty of perjury that:	
I am a United States Citizen	Y
I am a Qualified Alien as defined under 8 U.S.C. 1641	N

**Survey Response Summary**

01.) What is your employment status?	Actively working in a position that requires a medical license
02.) What is your race? Mark one or more boxes.	White
03.) Are you Hispanic or Latino origin?	N
04.) Where did you complete your medical degree?	Kentucky
05.) Where did you complete your residency training?	Another State (not listed)
06.) Which of the following best describes the area of practice in which you spend most of your professional time? Please select only one response.	Obstetrics and Gynecology
07.) Do you use telemedicine to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; the delivery of health care services using electronic communications and information technology, including: secure videoconferencing, interactive audio-using store and forward technology, or remote patient monitoring technology between a provider in one (1) location and a patient in another location)?	N
08.) What is the street address of your primary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A"	1201 Arington Ave
09.) In what city is your primary practice location? If this does not apply, please indicate "N/A"	Indianapolis
10.) In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A"	IN
11.) What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"	46219
12.) Which of the following categories best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable."	Other
13.) Estimate the average number of hours per week spent in direct patient care at your primary practice location. If this does not apply, please select "not applicable."	13 – 16 hours per week
14.) Estimate the percentage of Indiana Medicaid patients at your primary practice location. If this does not apply, please select "not applicable."	Not applicable
15.) Are you accepting new Indiana Medicaid patients at any or all of your practice locations?	N
16.) If you selected no on the previous question, but you are enrolled as an Indiana Medicaid provider, please describe barriers to participation. If this does not apply, please indicate "N/A".	N/A



17.) Estimate the percentage of patients on a sliding fee scale at your primary practice location. If this does not apply, please select "not applicable."	Sliding fee patients account for 21% - 30% of my practice
18.) What is the street address of your secondary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A".	3511 Lincoln Way W.
19.) In what city is your secondary practice location? If this does not apply, please indicate "N/A".	south Bend
20.) In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	IN
21.) What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate "N/A".	46628
22.) Which of the following categories best describes the practice setting at your secondary practice location? If this does not apply, please select "not applicable."	Not applicable
23.) Estimate the average number of hours per week spent in direct patient care at your secondary practice location. If this does not apply, please select "not applicable."	1 – 4 hours per week
24.) Estimate the percentage of Indiana Medicaid patients at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
25.) Estimate the percentage of patients on a sliding fee scale at your secondary practice location. If this does not apply, please select "not applicable."	Sliding fee patients account for 11% - 20% of my practice
26.) What is the street address of your tertiary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
27.) In what city is your tertiary practice location? If this does not apply, please indicate "N/A".	n/a
28.) In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
29.) What is the 5-digit ZIP code of your tertiary practice location? If this does not apply, please indicate "N/A".	n/a
30.) Which of the following categories best describes the practice setting at your tertiary practice location? If this does not apply, please select "not applicable."	Not applicable
31.) Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
32.) Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
33.) Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
34.) Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.	None of the above
35.) Please indicate the population groups to which you provide services:	Pregnant women



# 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	01045854C	Date of issuance (month, day, year)	12.19.13
Receipt number	4804366	Application fee	60.00
		Date fee paid (month, day, year)	12.19.13

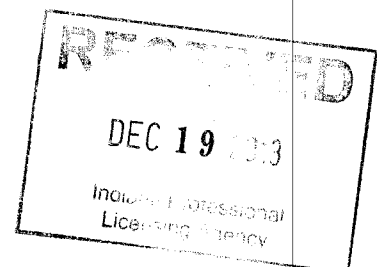
DO NOT WRITE ABOVE THIS LINE

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		Specialty	
Jeffrey Glazer M.D.		Obstetrics/Gynecology	
Telephone number	Professional license number	Date of birth (month, day, year)	Social Security number *
( [REDACTED] )	01045854	05/01/1957	[REDACTED]
Name of Facility (if applicable)		E-mail address	
[REDACTED]		[REDACTED]	
Indiana practice address (number and street (may not be a PO Box), city, state, and ZIP code)			
200 S. Meridian Street Suite 400 Indianapolis IN 46225			
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. 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 contendere to any offense, misdemeanor, or felony in any state?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)
	12/16/2013





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

State Form 34617 (R18 / 2-10)

Approved by State Board of Accounts, 2016

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	01045854D	Date of issuance (month, day, year)	7/6/17
Receipt number	5991521	Application fee	60.00
		Date fee paid (month, day, year)	7/5/17

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	<input type="checkbox"/> Optometrist
Name of practitioner		Specialty	
Jeffrey Glazer		OBGYN	
Telephone number	Professional license number	Date of birth (month, day, year)	Social Security number*
	01045854	05/01/57	
Name of Facility (if applicable)		E-mail address	
Whole Woman's Health of South Bend			
Indiana practice address (number and street (may not be a PO Box), city, state, and ZIP code)			
3511 Lincoln Way West, South Bend, IN 46628			
Drug Schedules: (Check all applicable)			
<input checked="" type="checkbox"/> 1	<input checked="" type="checkbox"/> 2	<input checked="" type="checkbox"/> 3 Narcotic	<input checked="" type="checkbox"/> 4
<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8
<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12
(Optometrist Only)			
<input type="checkbox"/> 4 Limited Practice - Trained Only			
<input type="checkbox"/> 5			

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has there been an occasion where you have not maintained effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Has there been an occasion where you have not been in complete compliance with all state and local laws pertaining to controlled substances?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Have you been convicted, pled guilty, or pled nolo contendere, under any federal or state laws relating to any controlled substance that has not been expunged under IC 35-38-9?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Have you had any action, discipline, revocation, or surrender of your Drug Enforcement Registration or entered into any settlement or Memorandum of Understanding (MOU) with respect to said registration?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Have you had any action, discipline or revocation or surrender of any professional license in any jurisdiction related to controlled substances?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)
Jeffrey Glazer	6-26-17

