APPLICATION FOR A LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

State Form 29495 (R21 / 8-17)
Approved by State Board of Accounts, 2017

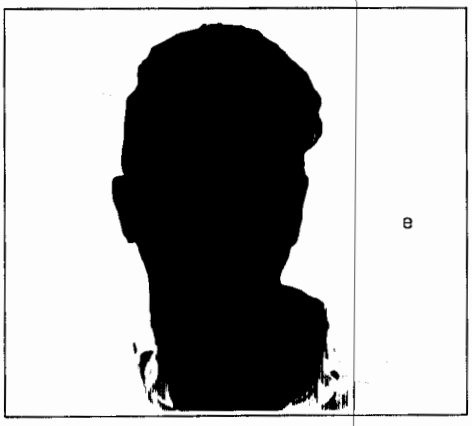
MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

RECEIVED
MAY 16 2018
Professional Licensing Agency

INSTRUCTIONS:
1. *The fee for this application is $250.00, payable to the Indiana Professional Licensing Agency, in accordance with 844 IAC 4-2-2.*
2. *If applying for a temporary permit, please include your fee of $100.00 in accordance with 844 IAC 4-2-2.*
3. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number 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	
Application fee 250.00	Date fee paid (*month, day, year*) 5/16/18
Receipt number 6405656	Application number
License number 0108194A	License issuance date (*month, day, year*) 5/31/18
Permit fee	Date fee paid (*month, day, year*)
Receipt number	Permit number
Permit issuance date (*month, day, year*)	



DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*): Iman Alsaden
Check one: ☑ MD ☐ DO
Social Security number *: [redacted]
Address of practice (*number and street or rural route*): 5841 S. Maryland MC 2050
City, state, and ZIP code: Chicago, IL 60637
Telephone number (*daytime*): ([redacted]
Date of birth (*month, day, year*): June 20th, 1987
Ethnicity **:
Race **:
Gender **: ☐ Male ☑ Female
Mailing address (*number and street, city, state, and ZIP code*) *[if different from above]*
E-mail address: [redacted]
National Provider Identifier number: 1770998841
ECFMG certificate number:

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*
☑ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641).

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)*
☐ Yes ☑ No

Please check the box to be included on the Health Care Volunteer Registry established by IC 25-22.5-15. *(Optional)* ☐

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit? ☐ Yes ☑ No

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

A foreign medical school must meet LCME standards at the time of graduation.

Name of school	Location	Date of graduation (*month, day, year*)
University of Illinois	Chicago	05/08/2014
Specialties: Medical Doctor	Board certification (*list ABMS certification*)	

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.

State where Board Exam was taken: Illinois

Examination	Most Recent Date Taken (month/year)	Results		Number of Attempts	Examination	Most Recent Date Taken (month/year)	Results		Number of Attempts
		Passed	Failed				Passed	Failed	
FLEX Pre-1985					NBOME Part II				
FLEX Component 1					NBOME Part III				
FLEX Component 2					COMLEX-USA Level 1				
LMCC - Single					COMLEX-USA Level 2, CE				
LMCC - Part I					COMLEX-USA Level 2, PE				
LMCC - Part II					COMLEX-USA Level 3				
NBME Part I					COMVEX				
NBME Part II					USMLE Step I	5/25/12	✔		1
NBME Part III					USMLE Step II, CS	7/12/13	✔		1
SPEX					USMLE Step II, CK	10/10/13	✔		1
NBOME Part I					USMLE Step III	2/24/17	✔		1

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
Brown University	Providence, RI USA	8/2005-5/2009

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)
University of Illinois	Chicago, IL	8/2010-5/2014

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 PROGRAM	LOCATION	FROM (month, year)	TO (month, year)	ACGME / AOA / RC ACCREDITED?
University of Chicago	Chicago, IL	7/2014	6/2018	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)	
GENERAL LOCATION	DATE (*month, day, year*)
Chicago, IL	7/2014-Present

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE (*month, day, year*)
University of Chicago 5841 S. Maryland Chicago, IL 60637	Resident Physician	7/2014-Present

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
IL	Physician	125-065813	7/2014	active

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Indiana Professional Licensing Agency

If your answer is "Yes" to any of questions 1 through 12, 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 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. Do you have any condition or impairment *(including a history of alcohol or substance abuse)* that currently interferes, or if left untreated may interfere, with your ability to practice medicine in a competent and professional manner?	☐ Yes	☑ No
4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?	☐ Yes	☑ No
5. *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;	☑ Yes	☐ No
(2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state;	☑ Yes	☐ No
(3) have you ever been convicted of any offense, misdemeanor, or felony in any state;	☑ Yes	☐ No
(4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or	☑ Yes	☐ No
(5) have you ever pled *nolo contendre* 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 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?	☐ Yes	☑ No
13. Have you practiced as a MD/DO either clinically or administratively in the last three (3) years?	☑ 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)*
	8/18/2018

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, 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 medical licensure.

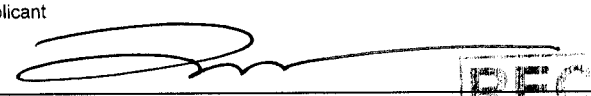
I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

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 disclosure.

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.

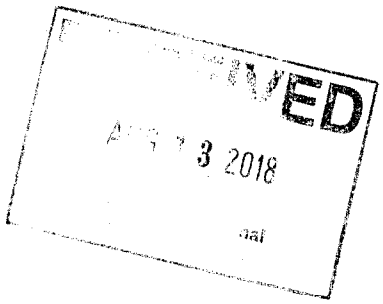
Signature of applicant	Date signed *(month, day, year)*
	8/18/2018

Explanation of positive responses

Iman Alsaden

Application for State of Indiana Medical License

August 8th, 2018



In March 2010 I was convicted of disturbing the peace in St. Bernard parish just outside of New Orleans, LA. On the advice of my lawyer I did not appear in court and plead guilty to my charge. Since I had no offenses prior and was rebuilding houses as a volunteer in the community my punishment was a fine of $100 dollars. Since then I have not been charged with or convicted of any crimes.

This is a sworn affidavit.

8/8/2018

Iman Alsaden

8/9/2018

- See attached certificate

JURAT WITH AFFIANT STATEMENT

State of Illinois
County of Cook
} ss.

☑ See Attached Document (Notary to cross out lines 1–7 below)
☐ See Statement Below (Lines 1–7 to be completed only by document signer[s], not Notary)

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AUG 13 2018
Professional Title Agency

1
2
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4
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6
7

Signature of Document Signer No. 1

Signature of Document Signer No. 2 (if any)

Subscribed and sworn to (or affirmed) before me
this 9th day of August, 2018, by
Date *Month* *Year*

Iman M Al Saden
Name of Signer No. 1

Name of Signer No. 2 (if any)

ISABEL DELGADO
Official Seal
Notary Public - State of Illinois
My Commission Expires Mar 14, 2022

Isabel Delgado
Signature of Notary Public

Notary Public
Any Other Required Information (Residence, Expiration Date, etc.)

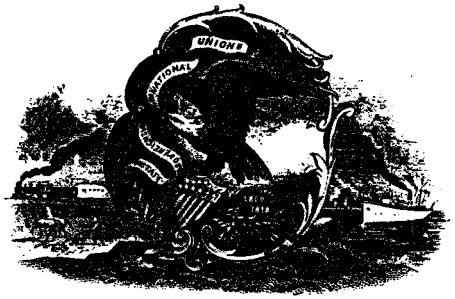
Place Notary Seal/Stamp Above

OPTIONAL

This section is required for notarizations performed in Arizona but is optional in other states. Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: Explanation of Positive Responses
Document Date: August 8th, 2018 Number of Pages: one
Signer(s) Other Than Named Above: NO other signers



By authority of the Board of Trustees of the

UNIVERSITY OF ILLINOIS

and upon recommendation of the Senate

at Chicago

Iman Al- Saden

has been admitted to the Degree of

Doctor of Medicine

and is entitled to all rights and honors thereto appertaining
Witness the Seal of the University and the Signatures of its Officers
this eleventh day of May, two thousand and fourteen.

UNIVERSITY OF ILLINOIS
LEARNING & LABOR
CHARTERED 1867

Chair of the Board of Trustees

President of the University of Illinois

Secretary of the Board of Trustees

Chancellor, University of Illinois at Chicago
Vice President, University of Illinois

Adrianne Dade, M.D.,
Residency Program Director

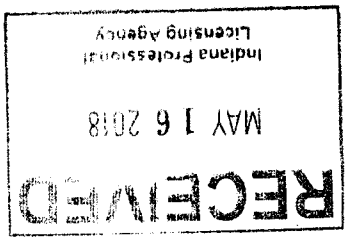
Julia Simon, M.D.,
Associate Program Director

MC 2050
5841 S. Maryland Avenue
Chicago · Illinois 60637
Phone: 773-834-0598
Fax: 773-702-0840

THE UNIVERSITY OF CHICAGO

THE CHICAGO LYING-IN HOSPITAL
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
EDUCATION OFFICE

March 19, 2018



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

Iman Alsaden, M.D

To Whom It May Concern:

This letter is to verify the postgraduate training of Iman Alsaden, M.D. Dr. Alsaden began her residency training at the University of Chicago, Obstetrics and Gynecology residency program on June 24, 2014. Dr. Alsaden will complete her training in good standing on June 30, 2018, at that time she will receive a certificate of completion.

Sincereiy,

Adrianne Dade, M.D.
Assistant Professor and
Residency Program Director

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Bruce Rauner
Governor

Bryan A. Schneider
Secretary

Jessica Baer
Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

August 11, 2018

IN MEDICAL LICENSING BOARD
PROFESSIONAL LICENSING AGENCY
402 W WASHINGTON ST RM W072
INDIANAPOLIS, IN 46204

Licensee:	IMAN MAHDI ALSADEN MD
License Number:	036.145255
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	03/07/2018
Expiration Date:	07/31/2020
License Status:	ACTIVE
License Method:	ACCEPT EXAM-USMLE
Disciplinary History:	Has not been disciplined

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Indiana Professional Licensing Agency

Temporary certificate physician and surgeon no.125.065813 was issued with a starting date of 06/24/2014. No disciplinary action on file. This was a medical residency training certificate only.

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

SEAL

Jessica Baer
Director
Division of Professional Regulation

August 11, 2018
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

APPLICATION FOR INDIANA CONTROLLED SUBSTANCES REGISTRATION (CSR) FOR PRACTITIONERS

State Form 34617 (R18 / 2-16)
Approved by State Board of Accounts, 2016

RECEIVED
SEP 07 2018
Indiana Professional Licensing Agency

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*)	
0108109 4B	9/13/18	
Receipt number	**Application fee**	**Date fee paid (*month, day, year*)**
7396943	60.00	9/7/18

DO NOT WRITE ABOVE THIS LINE

PRACTITIONERS

(Please check one box)

☐ Dentist ☒ Physician ☐ Osteopathic Physician ☐ Podiatrist ☐ Veterinarian ☐ Advanced Practice Nurse ☐ Physician Assistant ☐ Optometrist

Name of practitioner	Specialty	
IMAN ALSADEN	OB/GYN	
Telephone number	**Professional license number**	**Date of birth (*month, day year*)** / **Social Security number ***
[redacted]		06/20/1987 / [redacted]

Name of Facility *(if applicable)*: Planned Parenthood Merrillville Health Center

E-mail address: [redacted]

Indiana practice address *(number and street [may **not** be a PO Box], city, state, and ZIP code)*: 8645 CONNECTICUT ST., MERRILLVILLE, IN 46410

Drug schedules: *(Check all applicable)*

☐ 1 ☒ 2 ☒ 2 Narcotic ☒ 3 ☒ 3 Narcotic ☒ 4 ☒ ~~4 Limited Practice Tramadol Only~~ (Optometrist Only) ☒ 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?	☐ Yes	☒ 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?	☐ Yes	☒ No
3. 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?	☐ Yes	☒ 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?	☐ Yes	☒ No
5. Have you had any action, discipline or revocation or surrender of any professional license in any jurisdiction related to controlled substances?	☐ 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]	9/5/2018

9-13-18

STATE OF INDIANA
ONLINE RENEWAL RECORD

Renewal Submission Date:	August 15, 2019

Person Info

Name:	Iman Alsaden
License Number:	01081094A

Address Info

Street Address:	2811 W. Shakespeare
City:	Chicago
State:	IL
Zipcode:	60647
County:	Cook
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
Citizenship Status: You should only indicate one 'Yes' response to the statement below.	
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.	Other
03.) Are you Hispanic or Latino origin?	N
04.) Where did you complete your medical degree?	Illinois
05.) Where did you complete your residency training?	Illinois
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"	250 e. superior chicago, il 60647
09.) In what city is your primary practice location? If this does not apply, please indicate "N/A"	chicago
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"	IL
11.) What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"	60611
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."	Hospital – Inpatient
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."	25 – 28 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."	I do not accept Indiana Medicaid
15.) Are you accepting new Indiana Medicaid patients at any or all of your practice locations?	Y
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."	Not applicable
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".	8645 Connecticut St.
19.) In what city is your secondary practice location? If this does not apply, please indicate "N/A".	Merrillville, IN
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".	46410
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."	Office/Clinic – Multi Specialty Group
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."	5 – 8 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."	Indiana Medicaid accounts for 31% - 50% of my practice
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."	Not applicable
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".	4410 109th St.
27.) In what city is your tertiary practice location? If this does not apply, please indicate "N/A".	Overland Park, KS
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".	KS
29.) What is the 5-digit ZIP code of your tertiary practice location? If this does not apply, please indicate "N/A".	66122
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."	Office/Clinic – Multi Specialty Group
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."	5 – 8 hours per week
32.) Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. If this does not apply, please select "not applicable."	I do not accept Indiana Medicaid
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.	Labor and delivery services,Post-natal services,Pre-natal services
35.) Please indicate the population groups to which you provide services:	Adolescents (ages 10-19),Adults,Pregnant women

STATE OF INDIANA
ONLINE RENEWAL RECORD

Renewal Submission Date:	August 15, 2019

Person Info

Name:	Iman Alsaden
License Number:	01081094B

Address Info

Street Address:	2811 W. Shakespeare
City:	Chicago
State:	IL
Zipcode:	60647
County:	Cook
Phone:	[redacted]
Email:	[redacted]

Question Response Summary

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

Survey Response Summary