



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

State Form 29495 (R15 / 3-12)

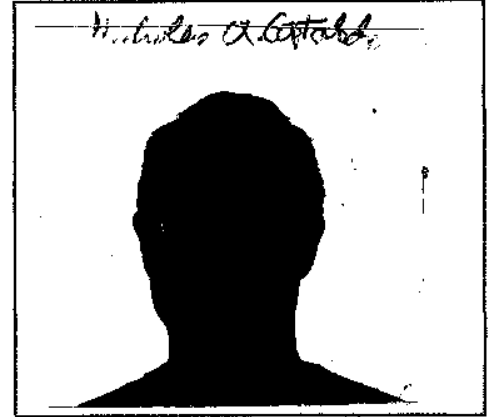
Approved by State Board of Accounts, 2012

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

\* Your Social Security number is being requested by this state agency in accordance with Indiana Code. 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	Date fee paid (month, day, year) 7/2/12
Receipt number 4087274	Application number
License number 01072847A	License issuance date (month, day, year) 6/20/13
Permit fee 100	Date fee paid (month, day, year) 7/2/12
Receipt number 4087227	Permit number 99052577A
Permit issuance date (month, day, year) 7/3/12	



**DO NOT WRITE ABOVE THIS LINE**

APPLICANT INFORMATION				
Name of applicant (last, first, middle) CATALDO, Nicholas Adrian	Check one: <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO	Social Security number * [REDACTED]		
Address of practice (number and street or rural route) 3265 Brook Highland Trace				
City, state, and ZIP code Birmingham, AL 35242				
Telephone number (daytime) ( [REDACTED] )	Date of birth (month, day, year) May 15, 1954	Ethnicity **	Race **	Gender ** <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing address (number and street, city, state, and ZIP code) [if different from above] PO Box 380904, Birmingham, AL 35238-0904				
E-mail address [REDACTED]	National Provider Identifier number 1134387990			

TEMPORARY PERMIT INFORMATION	
Do you desire a temporary permit?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY		
A foreign medical school must meet LCME standards at the time of graduation.		
Name of school Harvard Medical School	Location Boston, MA	Date of graduation (month, day, year) June 4, 1981
Specialties None in medical school	Board certification (list ABMS certification) Obstetrics and Gynecology, Reproductive Endocrinology	



**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: Massachusetts (I,II); Rhode Island (III)

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		<input type="checkbox"/>	<input type="checkbox"/>		NBOME Part II		<input type="checkbox"/>	<input type="checkbox"/>	
FLEX Component 1		<input type="checkbox"/>	<input type="checkbox"/>		NBOME Part III		<input type="checkbox"/>	<input type="checkbox"/>	
FLEX Component 2		<input type="checkbox"/>	<input type="checkbox"/>		COMLEX-USA Level 1		<input type="checkbox"/>	<input type="checkbox"/>	
LMCC - Single		<input type="checkbox"/>	<input type="checkbox"/>		COMLEX-USA Level 2, CE		<input type="checkbox"/>	<input type="checkbox"/>	
LMCC - Part I		<input type="checkbox"/>	<input type="checkbox"/>		COMLEX-USA Level 2, PE		<input type="checkbox"/>	<input type="checkbox"/>	
LMCC - Part II		<input type="checkbox"/>	<input type="checkbox"/>		COMLEX-USA Level 3		<input type="checkbox"/>	<input type="checkbox"/>	
NBME Part I	6/1978	<input checked="" type="checkbox"/>	<input type="checkbox"/>	one	COMVEX		<input type="checkbox"/>	<input type="checkbox"/>	
NBME Part II	4/1981	<input checked="" type="checkbox"/>	<input type="checkbox"/>	one	USMLE Step I		<input type="checkbox"/>	<input type="checkbox"/>	
NBME Part III	3/1982	<input checked="" type="checkbox"/>	<input type="checkbox"/>	one	USMLE Step II, CS		<input type="checkbox"/>	<input type="checkbox"/>	
SPEX		<input type="checkbox"/>	<input type="checkbox"/>		USMLE Step II, CK		<input type="checkbox"/>	<input type="checkbox"/>	
NBOME Part I		<input type="checkbox"/>	<input type="checkbox"/>		USMLE Step III		<input type="checkbox"/>	<input type="checkbox"/>	

**PRE-MEDICAL / OSTEOPATHIC EDUCATION**

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
Harvard College	Cambridge, MA	September 1971-June, 1975
University of California, Berkeley	Berkeley, CA	September, 1975-June, 1976

**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)
Harvard Medical School	Boston, MA	September, 1976-May, 1981

**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?
The Miriam Hospital/Brown Univ. Program in	Providence, RI	July, 1981	June 1982	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ✓
Stanford University Medical Center	Stanford, CA	July, 1982	June, 1985	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ✓
University of California, San Francisco	San Francisco, CA	July, 1991	June, 1993	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No ✓
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**RECEIVED**  
JUL 02 2012  
Indiana Professional  
Licensing Agency

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL  
(If necessary, attach separate pages.)

GENERAL LOCATION	DATE (month, day, year)
Providence, RI	July, 1981 to June, 1982
San Francisco Bay Area, CA	July, 1982 to April, 2005
Birmingham, AL	April, 2005 to 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)
Miriam Hospital, Providence, RI	Medicine Intern	July, 1981–June, 1982
Stanford University, Stanford, CA	OB/GYN Resident	July, 1982–June, 1985
Kaiser Foundation Hospitals, Oakland, CA	OB/GYN Physician	August, 1985 to January, 1987
County of Santa Clara, San Jose, CA	OB/GYN Physician	March, 1987 to June, 1996
University of California, San Francisco, CA CONTINUED ON	GYN Fellow	July, 1991 to June, 1993

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
CA	Medicine	G50301	6/30/1983	Active
AL	Medicine	MD.26223	8/25/2004	Active
MS	Medicine	10288	4/17/2006	Inactive

**RECEIVED**  
JUL 02 2012  
Indiana Professional  
Licensing Agency

Nicholas A. Cataldo, MD

**PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL SCHOOL**

<b>NAME AND ADDRESS</b>	<b>RESPONSIBILITIES</b>	<b>DATE</b>
The Miriam Hospital, Providence, RI	Intern (Medicine)	July, 1981—June, 1982
Stanford University, Stanford, CA	Resident (OB/GYN)	July, 1982—June, 1985
Kaiser Foundation Hospitals, Oakland, CA	OB/GYN Physician	Aug. 1985—Jan. 1987
County of Santa Clara, San José, CA	OB/GYN Physician	March, 1987—June, 1996
University of California, San Francisco, CA	Fellow (GYN)	July, 1991—June, 1993
University of California, San Francisco, CA	Research	July, 1993 – March, 1997
Stanford University, Stanford, CA	GYN Physician	March, 1997—June, 2004
Planned Parenthood of Alabama, Birmingham, AL	GYN Physician	Aug. 2004 – Mar. 2010
Birmingham Health Care, Birmingham, AL	GYN Physician	May, 2010 – April, 2011
Self-employed consultant, Birmingham, AL	Histories/physicals; GYN physician; research	March, 2010 -- present



If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s), case information, detailed description of case / events and settlement amount, including court documents, if applicable. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Are you now being, or have ever been treated for drug or alcohol abuse or addiction?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Have you ever been convicted of, plead guilty or <i>nolo contendere</i> to, or are charges pending: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances? B. Any offense, misdemeanor, or felony in any state, or have entered into a deferral program? (Except for minor violations of traffic laws resulting in fines.)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10. Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11. Have you ever been excluded from being a Medicare / Medicaid provider?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<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 applicant

*Nicholas A. Catello*

Date signed (month, day, year)

29 JUNE 2012

#### 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

*Nicholas A. Catello*

Date signed (month, day, year)

29 JUNE 2012



**GENERAL AFFIDAVIT**

State of Alabama  
County of Shelby

PERSONALLY came and appeared before me, the undersigned Notary, the within named Nicholas Adrian Cataldo, who is a resident of Shelby County, State of Alabama, and makes this his Statement and General Affidavit upon oath and affirmation of belief and personal knowledge that these matters, facts, and things set forth are true and correct to the best of his knowledge:

**EXPLANATION OF ITEM 8, APPLICATION FOR LICENSURE TO MEDICAL LICENSING BOARD OF INDIANA:**

There were two professional liability settlements paid on my behalf in two matters in which I was named as a defendant. In each case, I was in-training and working under the supervision of attending physicians. One of these events occurred in 1982 and the other about 1984. I do not have any records of the plaintiff names, the other defendants named, the amounts of the settlements, or the exact dates. The incident in 1982 occurred at The Miriam Hospital, Providence, RI: I was working in the emergency room at the time. A patient was seen by me for chest pain, evaluated and discharged; she subsequently returned in cardiac arrest and was not able to be resuscitated. The incident in 1984 occurred at Stanford University Medical Center, Stanford, CA. I performed a thoracentesis on a postpartum patient with a pleural effusion; a portion of the plastic thoracentesis catheter was found lodged in the patient's chest subsequently and she underwent surgery for its removal, recovering uneventfully.

Dated this the 29<sup>th</sup> day of June, 20 12

Nicholas A. Cataldo

Signature of Affiant

SWORN TO and subscribed before me, this the 29<sup>th</sup> day of June, 20 12

[Signature]  
NOTARY PUBLIC





# VNIVERSITAS HARVARDIANA

CANTABRIGIAE IN REPUBLICA MASSACHVSETTENSIVM

**P**RAESES et Socii Collegii Harvardiani consentientibus  
honorandis ac reverendis Inspectoribus in comitiis  
sollemnibus

NICHOLAS ADRIAN CATALDO

ad gradum Medicinae Doctoris cum laude et thesi propria  
admiserunt eique dederunt et concesserunt omnia insignia  
et iura quae ad hunc gradum spectant.

In cuius rei testimonium litteris Academiae sigillo munitis die  
III Iunii anno Domini MDCCCLXXXI Collegiique  
Harvardiani CCCXXXV auctoritate rite commissa nomina  
subscripserunt.

*Derek Curtis Bole*  
PRAESES

*Daniel C. Totera*  
DECANVS ORDINIS MEDICINAE

State of Alabama County of Telfer  
Subscribed and sworn before me on 6/29/12  
(Date)  
*[Signature]*  
(Notary Signature)

*I saw original copy  
6/29/12*





Translation of M.D. diploma

HARVARD UNIVERSITY IN CAMBRIDGE

The President and Fellows of Harvard College with the consent of the Honorable and the Reverend Board of Overseers, in solemn council assembled, have admitted

**NICHOLAS ADRIAN CATALDO**

to the rank of Doctor of Medicine

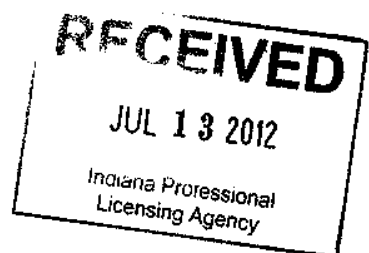
and have given him and conferred upon him and privileges belonging to this rank.

In testimony whereof, to these letters, authenticated by the seal of the University, the President, and Dean, by the authority rightfully committed to them have subscribed their names on the 4th of June in the year 1981 Harvard College the three hundred and forty-four

Derek Curtis Bok  
President

Daniel C. Tosteston  
Dean of the Faculty of Medicine

(Seal)





HARVARD MEDICAL SCHOOL



OFFICE OF THE REGISTRAR

25 SHATTUCK STREET  
BOSTON, MASSACHUSETTS 02115-6092  
Telephone (617) 432-1515

Translation of M.D. diploma

HARVARD UNIVERSITY IN CAMBRIDGE

The President and Fellows of Harvard College with the consent of the Honorable and the Reverend Board of Overseers, in solemn council assembled, have admitted

**NICHOLAS ADRIAN CATALDO**

to the rank of Doctor of Medicine

and have given him and conferred upon him and privileges belonging to this rank.

In testimony whereof, to these letters, authenticated by the seal of the University, the President, and Dean, by the authority rightfully committed to them have subscribed their names on the 4th of June in the year 1981 Harvard College the three hundred and forty-four

Derek Curtis Bok  
President

Daniel C. Tosteston  
Dean of the Faculty of Medicine

(Seal)

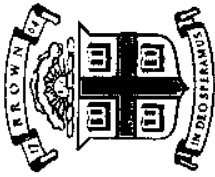




Patient Care  
Education  
Research

# THE MIRIAM HOSPITAL

PROVIDENCE, RHODE ISLAND



*This is to certify that*

**Nicholas A. Catalano, M.D.**

*has satisfactorily served as*

First Year Resident in Medicine — July 1, 1981 - June 30, 1982

*in this hospital performing such duties as are required in this position.*

*In Witness Whereof the undersigned have affixed their signatures  
and the seal of the hospital is hereunto impressed.*



State of Alabama County of Jefferson  
Subscribed and sworn before me on 6/29/82  
[Signature] (Notary Signature)  
I saw original copy 9/8/82  
JP

*Richard Sulman*

Physician-in-Chief

*James C. [Signature]*

President

# Stanford University Medical Center

STANFORD UNIVERSITY HOSPITAL / STANFORD UNIVERSITY SCHOOL OF MEDICINE



THIS IS TO CERTIFY THAT

*Nicholas Adrian Cataldo, M.D.*

HAS SERVED AS

*Resident in Gynecology & Obstetrics July 1, 1982 - June 30, 1985*  
*Chief Resident in Gynecology & Obstetrics July 1, 1984 - June 30, 1985*



*Pent Ueland* \_\_\_\_\_  
Department Chairman

*Sheldon S. King* \_\_\_\_\_  
Dean of the School of Medicine

*David Kom* \_\_\_\_\_  
Dean of the School of Medicine

Director of Hospital

State of Alabama County of Jefferson  
Subscribed and sworn before me on July 2, 1985  
(Date)

*[Signature]*  
(Notary Signature) *4/12/85*  
I saw original copy. *4/12/85*

UNIVERSITY OF CALIFORNIA  
SCHOOL OF MEDICINE  
SAN FRANCISCO

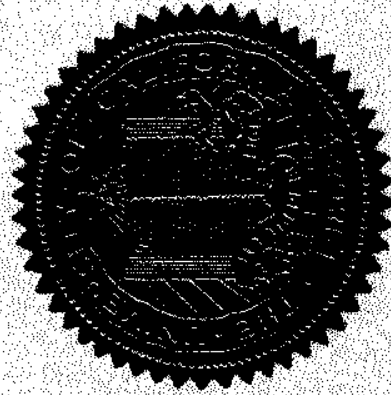
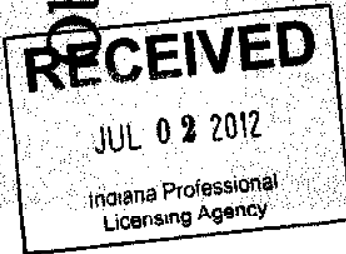
THIS CERTIFIES THAT

*Nicholas A. Cataldo, M.D.*

HAS SERVED AS A FELLOW IN

Obstetrics, Gynecology and Reproductive Sciences  
(Reproductive Endocrinology)

July 1, 1991 - June 30, 1993



*Robert B. Jaffe, M.D.*  
PROGRAM DIRECTOR

*Robert B. Jaffe, M.D.*  
DEPARTMENT CHAIR

*Frederic T. Delam*

DEAN, SCHOOL OF MEDICINE

State of Alabama County of Jefferson  
Subscribed and sworn to before me on 6/29/93  
John R. [Signature] Notary Public  
(Notary Signature)  
I saw original copy 6/29/93  
BT

TELEPHONE: (601) 987-3079



FAX: (601) 987-4159

## MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

### VERIFICATION OF MEDICAL LICENSURE

July 02, 2012

This is to certify that the records of the Mississippi State Board of Medical Licensure indicate the following information:

Physician Name: **Nicholas Adrian Cataldo** Degree: **M.D.**  
Date of Birth: **05/15/1954**  
Primary Practice Location: **263 Chastaine Circle**  
**Birmingham, AL 35209**  
MD/DO School: **Harvard Medical School Boston** Year of Graduation: **1981**  
Specialty: **OBSTETRICS AND GYNECOLOGY (Not Primary Source Verified)**  
License Number: **19288**  
Issue Date: **April 17, 2006** Reinstated Date:  
Expiration Date: **June 30, 2010** Date of Expiration Prior  
Public Record: **NO** to Reinstatement:

This license information was last updated on: 06/29/2012

If public record is indicated, submit a request for records to the following email address:  
mboard@msbml.state.ms.us.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Vann Craig" with a stylized flourish at the end.

H. Vann Craig, M.D.  
Executive Director

**MEDICAL BOARD OF CALIFORNIA**

Licensing Program  
2005 Evergreen Street, Suite 1200  
Sacramento, CA 95815  
(916) 263-2382 FAX (916) 263-2944  
[www.mbc.ca.gov](http://www.mbc.ca.gov)



July 02, 2012

**TO WHOM IT MAY CONCERN:**

This is to certify that on the date of this letter the records of the Medical Board of California (Board) indicate the following information:

PHYSICIAN: NICHOLAS ADRIAN CATALDO  
LICENSE NUMBER: G50301  
ISSUED: June 30, 1983  
EXAM TYPE: A Written Examination  
EXPIRATION DATE: May 31, 2013  
STATUS: RENEWED/CURRENT  
BOARD DISCIPLINE: No

This license information was last updated on: 06/29/2012

Further public records pertaining to the above licensee may be available from the Board's Web site at [www.mbc.ca.gov](http://www.mbc.ca.gov).

A handwritten signature in black ink that reads 'Curtis J. Worden'.

Curtis J. Worden  
Chief of Licensing



**STATE OF ALABAMA MEDICAL LICENSURE COMMISSION**  
 POST OFFICE BOX 887 MONTGOMERY, ALABAMA 36101-0887 Phone: (334)242-4153

JAMES E. WEST, M.D., CHAIRMAN/EXECUTIVE OFFICER + KAREN SILAS, EXECUTIVE ASSISTANT

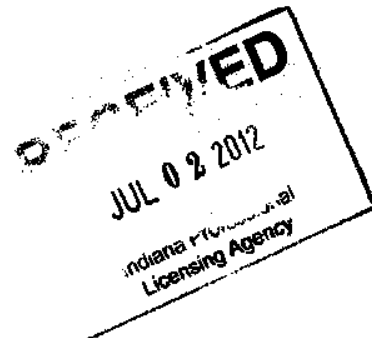
MEDICAL LICENSING BOARD OF INDIANA  
 402 WEST WASHINGTON STREET  
 ROOM 072  
 INDIANAPOLIS , IN 46204

**VERIFICATION OF ALABAMA MEDICAL LICENSURE**

Name of Licensee (as it appears in our records)

**Nicholas Adrian Cataldo**

**Date of Birth:** 05/15/1954  
**License#:** MD.26223  
**Current Status:** ACTIVE  
**Date Issued:** 08/25/2004  
**Basis of License:** NBME/CA  
**Expiration Date:** 12/31/2012  
**Medical School:** Harvard Medical School  
**Location:** Boston  
**Date From/To:** 9/76-6/81



**Disciplinary Actions:**

- [SEAL]  NO  
 Yes, See Attached  
 Other, See Attached

Signature: James E. West, M.D.  
 James E. West, M.D.  
 Chairman  
 Medical Licensure Commission of Alabama

Date: 06/29/2012

To expedite the verification process, the above is the standard format used by the Medical Licensure Commission of Alabama. Verification information can also be obtained by accessing our web site at <http://www.albme.org>.

Completed by: Rebecca Taylor  
 Verification Clerk

ALABAMA MEDICAL LICENSURE COMMISSION  
P.O. BOX 887  
MONTGOMERY, ALABAMA 36101-0887

**CERTIFICATE OF REGISTRATION  
2012**

This is to certify that annual registration has been made  
and license to practice medicine in the State of Alabama  
has been granted for the year ending December 31, 2012

License # MD.26223  
Date Issued: 08/25/2004

Amount Paid: \$300.00  
Receipt # 881576

Nicholas Adrian Cataldo MD  
P.O. Box 380904  
Birmingham, AL 35238-0904

*James E. West, MD*  
CHAIRMAN

**\*Duplicate\***

**Detach along this line**

ALABAMA MEDICAL LICENSURE COMMISSION

Nicholas Adrian Cataldo MD  
P.O. Box 380904  
Birmingham, AL 35238-0904

is entitled to practice medicine in  
Alabama. Registration expires  
December 31, 2012

LICENSE# MD.26223

*James E. West, MD*  
CHAIRMAN

State of Alabama County of Tallapoosa  
Subscribed and sworn before me on 6/29/12

*James W. ...*  
(Notary Signature)

I saw a copy of original 6/29/12 JP

**RECEIVED**  
JUL 02 2012  
Indiana Professional  
Licensing Agency



ALABAMA MEDICAL LICENSURE COMMISSION  
P.O. BOX 887  
MONTGOMERY, ALABAMA 36101-0887

**CERTIFICATE OF REGISTRATION  
2012**

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Nicholas Adrian Cataldo MD  
P.O. Box 380904  
Birmingham, AL 35238-0904

*James E. West, MD*  
CHAIRMAN

**\*Duplicate\***

**Detach along this line**

ALABAMA MEDICAL LICENSURE COMMISSION

Nicholas Adrian Cataldo MD  
P.O. Box 380904  
Birmingham, AL 35238-0904

Is entitled to practice medicine in  
Alabama. Registration expires  
December 31, 2012

LICENSE# MD.26223

*James E. West, MD*  
CHAIRMAN

N. Castaldo 6/29/12

Duplicate - for Indiana Board