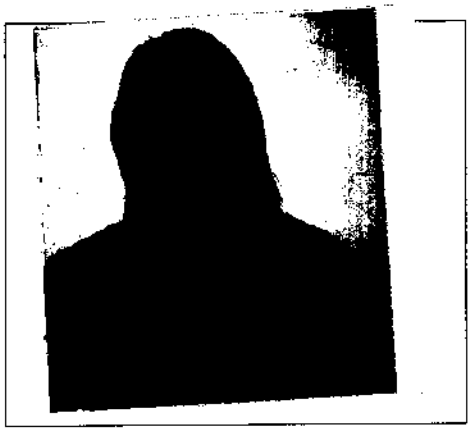
APPLICATION FOR LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

State Form 29495 (R9 / 7-96)
Approved by State Board of Accounts, 1994

Health Professions Bureau
402 W. Washington St., Room 041
Indianapolis, IN 46204
Telephone number: (317) 232-2960

*** 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.**

Application fee: 250 -	Permit fee:
Date fee paid (*month, day, year*): 5-2-02	Date fee paid (*month, day, year*):
Receipt number: 793845	Receipt number:
Application number:	Permit number:
License number: 01056172A	Permit issuance date (*month, day, year*):
License issuance date (*month, day, year*): 5-13-02	



DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*): Willhelm, Carol Lynn
Check one: ☒ MD ☐ DO
Social Security number *: [redacted]
Address (*number and street or Rural Route*): 2041 North Talbott Avenue
City, state, ZIP code: Indianapolis IN 46202
Telephone number (*daytime*): [redacted]
Birthdate (*mo., day, yr.*): 11/03/1971
Birthplace: Chicago IL

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit?
☐ Yes ☒ No - I presently hold one.

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of School	Location	Date of Graduation (*Month, Day, Year*)
Southern Illinois University School of Medicine	Springfield IL	May 22 1999

EXAMINATION

Check appropriate box(es) indicating which examination or combination of examinations you have taken.
(*Please review instruction sheet for address and telephone numbers on how scores may be obtained.*)

☐ FLEX EXAMINATION
☐ Component I ☐ Component II ☐ Other

☐ STATE BOARD EXAMINATION
Examination taken in which state?

☐ NATIONAL BOARD OF MEDICAL EXAMINERS
☐ Part I ☐ Part II ☐ Part III

☐ LMCC EXAMINATION

☒ USMLE EXAMINATION
☒ Step I ☒ Step II ☒ Step III

☐ NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS
☐ Part I ☐ Part II ☐ Part III

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MAY 01 2002
Health Professions Bureau

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Health Professions Bureau

WALK-IN

PRE-MEDICAL / OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED
University of Illinois	Urbana-Champaign IL	August 89 - May 93

MEDICAL / OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED
Southern Illinois University School of Medicine	Springfield IL	August 95 - May 99

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA (*Include ALL internships, residencies and / or fellowships*)			
NAME OF PROGRAM	LOCATION	FROM (*month, year*)	TO (*month, year*)
Indiana University Psychiatry Residency Program	Indianapolis IN	7/99 ~~7/99~~	12/99
Indiana University Family Practice Residency Program	Indianapolis IN	1/00	6/02 projected

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL	
GENERAL LOCATION	DATE
Springfield, Illinois	5/99 - 6/99
Indianapolis, Indiana	6/99 - present

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE
AmA Telemessaging Center Inc 420 N. 1st St Springfield IL	telephone operator	2/99 - 6/99
IU School of Medicine Psychiatry 7/99-12/99 Family Practice 1/00-present Office of House Staff Affairs 1120 South Dr. FH224 Indpls IN 46202-5114	resident physician	7/99 - present

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
IN	temporary medical permit	11009545	6/1999	current
AZ	visiting resident permit	27668	1/7/2002	current

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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 diposition. If malpractice, provide name(s) of plaintiff(s). 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?	☐ 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?	☐ Yes ☒ No
3. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem?	☐ Yes ☒ No
4. Have you ever been charged with drug addiction?	☐ Yes ☒ No
5. Have you ever been convicted of, plead guilty or *nolo contendere* to: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines.*)	☐ Yes ☒ No ☐ Yes ☒ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☒ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☒ No
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	☐ Yes ☒ No

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*)
[signature]	3/26/2002

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, 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 Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau 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.

Date signed (*month, day, year*)	Signature of applicant
March 26, 2002	[signature]

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MAY 01 2002
Health Professions Bureau

Southern Illinois University

Carbondale

School of Medicine

On recommendation of the Chancellor and Faculty,
the Board of Trustees, by virtue of the authority vested in it, has
conferred on

Carol Lynn Willhelm

the degree of

Doctor of Medicine

and has granted this Diploma as evidence thereof
this twenty-second day of May, 1999, Springfield, Illinois.

Certification of the Original
Patricia A. Calvert
Exp Date 1/31/07

Patricia A. Calvert 5/1/02
Signature Date

Patricia A. Calvert

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MAY 01 2002
Health Professions Bureau

JoAnne E. Anderson
Chancellor

Carl J. Hotto
Dean

SOUTHERN ILLINOIS UNIVERSITY
DEO VOLENTE
CHARTERED 1869

Sid Sanders
President

G. W. Van Metre
Chairman of Board

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

May 13, 2002

Health Professions Service Bureau
Medical Licensing Board of Indiana
402 W. Washington, Room 041
Indianapolis, IN 46204

Dear Sirs,

This letter is to verify that Carol Willhelm, M.D., is a resident in good standing with the Indiana University Family Practice Residency Program.

Dr. Willhelm joined our Family Practice Residency program on January 1, 2000. She completed the first 12 months with our program on December 31, 2000. Her anticipated date of graduation is June 30, 2002.

Please do not hesitate to contact me if you need any further information concerning Dr. Willhelm's status with our residency program.

Sincerely,

Peter Nalin, M.D.
Director, Family Practice Residency

FAMILY PRACTICE RESIDENCY

Family Practice Center
1520 North Senate Avenue
Indianapolis, Indiana
46202-2213

Residency Office:
317-962-8188
Family Practice Center
317-962-8893
Fax: 317-962-6722

AIM

Association of State Medical Board Executive Directors

Physician Profile

Protecting the Public's Health

Arizona Board of Medical Examiners

9545 E. Doubletree Ranch Rd.,
Scottsdale, AZ 85258-5539 480-551-2700
(Toll free Within Arizona: 877-255-2212)

General Information

Carol Lynn Willhelm MD
UNIVERSITY OF ARIZONA HEALTH SCIE
TUCSON ARIZONA 85724
Phone:

License Number: **81480**
License Status: **Resident**
License Date: **01/07/2002**
License Renewed: **05/06/2002**
License Expires: **05/2002**

Education and Training

Note: Information up to the date of initial licensure is verified by the Board. Information provided by the physician after this date is not verified by the Board.

Medical School :
Graduation Date:
Residency: **01/07/2002 - 05/06/2002**
UNIVERSITY OF ARIZONA HEALTH SCIENCES CENTER
TUCSON, ARIZONA
*Specialty: **Resident**

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

Board Investigations and Actions

BOARD ACTIONS: NONE
(while licensed in Arizona)

NON DISCIPLINARY ACTIONS: NONE
(within last five years)

OPEN INVESTIGATIONS: NONE

CASES DISMISSED: NONE
(within last five years)

Malpractice/Criminal Information

MALPRACTICE CASES RESULTING IN PAYMENT: NONE

(within last five years)

CRIMINAL CONVICTIONS/"NO CONTEST" PLEAS: NONE
(within last five years)

Questions? See our Glossary of Terms.

This Board's data has been searched 3734249 times since 12/11/1997

Please read the AIM Disclaimer

Chris Fry

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APR 08 2002

4/3/02

INDIANA UNIVERSITY

SCHOOL OF MEDICINE

April 24, 2002

Health Professions Service Bureau
Medical Licensing Board of Indiana
402 W. Washington, Room 041
Indianapolis, IN 46204

Dear Sirs,

This letter is to verify that Carol Willhelm, M.D., is a resident in good standing with the Indiana University Family Practice Residency Program.

Dr. Willhelm has successfully completed one year of postgraduate training with our residency from January 1, 2000 through June 30, 2000. Her anticipated date of graduation is June 30, 2002.

Please contact me if you need any further information concerning Dr. Willhelm's status with our residency program.

Sincerely,

Peter Nalin, M.D.
Director, Family Practice Residency

FAMILY PRACTICE RESIDENCY

Family Practice Center
1520 North Senate Avenue
Indianapolis, Indiana
46202-2213

Residency Office:
317-962-8188
Family Practice Center
317-962-8893
Fax: 317-962-6722

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

State Form 17598 (R6 / 9-96)
Approved by State Board of Accounts 1996

RECEIVED
MAY 24 1999
Health Professions Bureau

Health Professions Bureau
402 W. Washington St., Rm. 041
Indianapolis, IN 46204
Telephone: (317) 232-2960

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.

REQUIREMENTS AND INSTRUCTIONS TO THE APPLICANT

A. Mail completed application, along with items listed below, to the Health Professions Bureau.

1. ***FEE:*** *Submit the ten dollar ($10) fee made payable to the Health Professions Bureau. Fees are non-refundable and non-transferable.*
2. ***PROOF OF GRADUATION:*** *You must submit proof of graduation by submitting one of the following documents:*
   (a) ***CERTIFICATE OF COMPLETION*** *An original letter from the Dean of your medical / osteopathic school, stating that you have completed (not expected to) all requirements for graduation and the date when the degree will be or was awarded.*
   (b) ***OFFICIAL TRANSCRIPT*** *An* ***official*** *transcript of grades from the medical / osteopathic school, showing degree has been conferred. Graduates of foreign medical schools must submit notarized copies of all subjects and grades (mark sheets). Include official translation if not in english. (SEE NOTARIZED COPY NOTE)*
   (c) ***DEGREE*** *A notarized copy of your medical / osteopathic degree. Include official translation if not in english. (SEE NOTARIZED COPY NOTE)*
3. ***PHOTOGRAPH*** *Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.*
4. ***HOSPITAL / INSTITUTION CERTIFICATION*** *The Hospital / Institution Certification must be completed by the Hospital / Insitution Chairman Department Head.*

PERMITS ARE NOT AVAILABLE ON A WALK-IN BASIS FROM THE BUREAU. NO EXCEPTIONS.

NOTE: If you change postgraduate programs and wish to renew your temporary permit you must file a new application.

NOTARIZED COPY NOTE: Any notarized copy of an original document must have the notary public make a statement to the fact that the notary has seen the original document.

The Temporary Medical Permit application and requirements MUST be filed with the Health Professions Bureau at least ten (10) days BEFORE THE RESIDENCE/TEACHING IS SCHEDULED TO BEGIN. It is a violation in the State of Indiana to practice without a valid permit or license.

IT IS YOUR RESPONSIBILITY TO NOTIFY THE BUREAU OF YOUR PERMANENT ADDRESS ONCE IT IS ESTABLISHED.

OFFICE USE ONLY

Permit fee	Date fee paid (month, day, year)	Receipt number
$ 10-	6-4-99	607-886-10038
Permit number	**Permit issuance date (month, day, year)**	
1160954S	06 22 99 - 07-01 99	

Applicant

Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.

APPLICANT INFORMATION

Name of applicant (last, first, middle)	Social Security number
Willhelm, Carol, Lynn	[redacted]

Address (number and street or Rural Route number): 126 N Douglas Ave

City, state, ZIP code: Springfield IL 62702

Telephone number (daytime)	Date of birth (month, day, year)	Place of birth
[redacted]	11, 03, 71	Chicago, Illinois

Please indicate what address you want your permit sent to (number and street): IU School of Medicine Fesler Hall, Room 224 1120 South Drive

City, State, ZIP code: Indianapolis IN 46202-5114

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY:

Name of school	Location	Date of graduation (month, day, year)
Southern Illinois University School of Medicine	Springfield IL	05-22-99

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 (month, day, year)
Carol Willhelm	May 11, 1999

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned, requested by the Bureau or any of its authorized representatives in connection with processing my application for a temporary medical permit.

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

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and the Board from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Date signed *(month, day, year)*	Signature of applicant
May 11, 1999	Carol Willhelm

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

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

This is to certify that CAROL L. WILLHELM has been granted

an appointment to serve at Indiana University School of Medicine (6001) 7/3 in

the Department of PSYCHIATRY

located at *(address)* Indianapolis, IN

this appointment is for the month and year beginning JULY 1, 1999 and ending JUNE 30, 2000

Name of Hospital Chairman/Department Head	Title	
Meredith T. Hull, M.D.	Assistant Dean, School of Medicine	
Signature	Date of signature *(month, day, year)*	Telephone number
	APRIL 8, 1999	(317) 274-7108

Southern Illinois University

Carbondale

School of Medicine

On recommendation of the Chancellor and Faculty,
the Board of Trustees, by virtue of the authority vested in it, has
conferred on

Carol Lynn Willhelm

the degree of

Doctor of Medicine

and has granted this Diploma as evidence thereof
this twenty-second day of May, 1999, Springfield, Illinois.

JoAnne E. Applegate
Chancellor

Carl J. Hotto
Dean

SOUTHERN ILLINOIS UNIVERSITY · CHARTERED 1869 · DEO VOLENTE

Sid Sanders
President

G. H. Van Meter
Chairman of Board

ATTESTATION
STATE OF ILLINOIS, COUNTY OF Jackson
I, [illegible], attest that the preceding or attached
Medical School Diploma
presented to me by the document's custodian,
Carol Lynn Willhelm
and to the best of my knowledge, that the photocopied document is neither a public record nor a publicly recordable document, certified copies of which are available from an official source other than a notary public.
OFFICIAL NOTARY SIGNATURE
NAME OF NOTARY TYPED, PRINTED OR STAMPED

RECEIVED
JUN 07 1999
Health professions bureau