



APPLICATION FOR INDIANA CONTROLLED SUBSTANCES REGISTRATION (CSR) FOR PRACTITIONERS

State Form 34617 (R19 / 4-18)

3260423
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
www.pla.IN.gov

- INSTRUCTIONS:**
- The fee for this application is \$60.00, payable to the Indiana Professional Licensing Agency, in accordance with 856 IAC 2-3-9(f).
 - Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.
 - All fees are non-refundable and non-transferable.
 - 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.

FOR OFFICE USE ONLY			
CSR number	01082206D	Date of issuance (month, day, year)	6-18-19
Receipt number	75-78216	Application fee	\$60.00
		Date fee paid (month, day, year)	6-11-19

DO NOT WRITE ABOVE THIS LINE

PRACTITIONERS			
<i>(Please check one box.)</i>			
<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		
Deborah Nucatola	OB-GYN		
Telephone number	Professional license number	Date of birth (month, day, year)	Social Security number *
[REDACTED]	01082206A	05, 10, 1972	[REDACTED]
Name of Facility (if applicable)	E-mail address		
	[REDACTED]		
Indiana practice address (number and street [may not be a PO Box], city, state, and ZIP code)			
8645 Connecticut Street, Merrillville, IN 46410			
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 type="checkbox"/> 4 Limited Practice - Tramadol Only
			<input checked="" type="checkbox"/> 5 (Optometrist Only)

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.

- 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
- 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
- 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 35-28-9? Yes No
- 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
- 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)
	6/16/19

6-17-19
all
done

