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

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*) 3·1·19
Receipt number 7517924	Application number 3214104
License number 0108220 6A	License issuance date (*month, day, year*) 5·6·19
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*)	Check one:	Social Security number *
Nucatola, Deborah Lynn	☑ MD ☐ DO	[redacted]

Address of practice (*number and street or rural route*)
200 S. Meridian Street, Suite 400

City, state, and ZIP code
Indianapolis, IN 46225-1076

Telephone number (*daytime*)	Date of birth (*month, day, year*)	Ethnicity **	Race **	Gender **
[redacted]	05/10/1972			☐ Male ☑ Female

Mailing address (*number and street, city, state, and ZIP code*) *[if different from above]*
13351 Riverside Drive #172, Sherman Oaks, CA 91423

E-mail address	National Provider Identifier number	ECFMG certificate number
[redacted]	1336166024	n/a

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*)
School of Medicine/SUNY/Downstate Medical Center	Brooklyn, NY	05,21,1998

Specialties	Board certification (*list ABMS certification*)
OB-GYN	none

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: CALIFORNIA

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	6,11,1996	✔		1
NBME Part III					USMLE Step II, CS				
SPEX					USMLE Step II, CK	03,03,1998	✔		1
NBOME Part I					USMLE Step III	12,01,1998	✔		1

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
University of Wisconsin	Madison, Wisconsin	08/27/90-5/22/94

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)
SUNY/Downstate Medical Center	School of Medicine, Brooklyn,NY	8/1/94-5/21/98

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?
Internship/OB-GYN	LAC+USC Healthcare Network,LA,CA	06,1998	6,1999	☑ Yes ☐ No
Residency/OB-GYN	LAC+USC Healthcare Network,LA,CA	07,1999	6,2002	☑ Yes ☐ No
Fellowship/Family Planning	Keck School of Medicine, USC,LA,CA	07,2002	6,2004	☑ Yes ☐ No
				☐ Yes ☐ No

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LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)	
GENERAL LOCATION	DATE (month, day, year)

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)
Planned Parenthood of the Great NW&HI	Medical Director,HI	7,1,2016 to present
Planned Parenthood of Pasadena & San Gabriel Valley	physician	4,1,2016 to present
Family Planning Associates Medical Group	physician	01,01,2016 to present
Eden Surgical Center	Director,Family Planning	01,01,2013 to present
Planned Parenthood Federation of America	Senior director, CS	07,1,2009 to 12,6,2016

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

SECOND PAGE 3

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)	
GENERAL LOCATION	DATE (month, day, year)
Los Angeles, CA	7/1/98-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)
LAC/USC	Director of Family Planning	7,1,2004 to 2,4,2005
Planned Parenthood Santa Barbara,Ventura,& San Luis Obispo	Medical Director	7,1,2004 to 7,15,2015
Kaiser Permanente Panorama City Medical Center	clinical services	2,2,2008 to 2,1,2010
Kaiser Permanente Panorama City Medical Cente	clinical services	8,1,2011 to present
Kaiser Permanente Woodland Hills Medical Center	clinical services	1,22,2009 to 2,1,2010

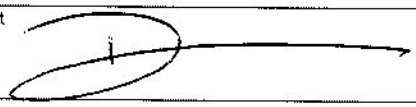
LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
CA	MD	A070101	10/22/1999	active
NY	MD	256206	2/12/2010	active
IL	MD	036.140638	7/31/2016	active
HI	MD	18627	04/11/2016	active

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*)
	2/15/19

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.

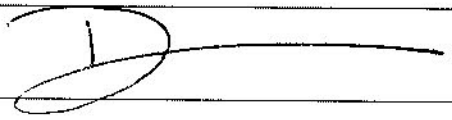
I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

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*)
	2/15/19

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Deborah Hagan
Acting Secretary

Jessica Baer
Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

13351 Riverside Dr # 172
Sherman Oaks, CA 91423-2542

Licensee: License Number:	DEBORAH L NUCATOLA MD 036.140638
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	05/10/2016
Expiration Date:	07/31/2020
License Status:	ACTIVE
License Method:	ENDORSEMENT
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 04/19/2019

Jessica Baer
Director
Division of Professional Regulation

04/19/2019
Date

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

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, NUCATOLA DEBORAH LYNN
was issued license/certificate number 256206 for the practice of MEDICINE on 02/12/2010.

Our records also indicate the following information:
Date of birth: 05/10/1972
School attended: SUNY DOWNSTATE MED CTR
Date of graduation: 05/21/98
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
12/98								[redacted]	OOSCA
03/98						[redacted]			
06/96			[redacted]						

EXMS TAKEN=03
A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 04/30/21
Address: 13351 RIVERSIDE DR APT 172
SHERMAN OAKS CA 91423-0000
Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Audrey Bell, Education Program Assistant 1, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Education Program Assistant 1 of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Audrey Bell 04/24/19
Education Program Assistant 1

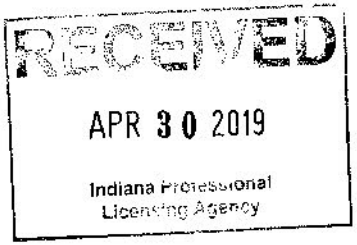
STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
P.O. BOX 3469
HONOLULU, HAWAII 96801

04/25/19

PROFESSIONAL LICENSING AGENCY
402 WEST WASHINGTON STREET
ROOM W072
INDIANAPOLIS IN 46204

RE: VERIFICATION OF LICENSE/EXAM SCORES DATED 04/22/19 FOR
DEBORAH L NUCATOLA

BOARD/COMMISSION:	HAWAII MEDICAL BOARD
LICENSE TYPE:	PHYSICIAN
LICENSE IDENTIFICATION:	MD 18627
METHOD OF LICENSURE:	PASSED USMLE
DATE LICENSED:	04/11/16
LICENSE STATUS:	CURRENT, VALID & IN GOOD STANDING
LICENSE EXPIRATION DATE:	01/31/20
DISCIPLINARY ACTION:	NONE



ACCORDING TO OUR COMPLAINT RECORDS WHICH DATE BACK TO 1985:

✓ NO DEROGATORY INFORMATION IS ON FILE.

__ THE ATTACHED INFORMATION IS ON FILE CONCERNING THIS LICENSEE.

CERTIFIED BY:

AHLANI QUIOGUE
EXECUTIVE OFFICER

VERIFICATION OF STATE LICENSURE

State Form 7143 (R5 / 4-15)

PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 232-2960
Fax: (317) 233-4236
www.pla.IN.gov

* 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.

INSTRUCTIONS: Type and complete the top section. Make copies to send to each state that you hold or have held a license. Have the state(s) send this directly to our office.

Name (*last, first, middle, maiden*)	Date of birth (*month, day, year*)	Social Security number *
NUCATOLA DEBORAH	05,10,1972	[redacted]

Address (*number and street or rural route*)		
13351 RIVERSIDE DR #172		
City	**State**	**ZIP code**
Sherman OAKS	CA	91423

E-mail address: [redacted]

Type of license held	License number	Date of issuance (*month, day, year*)
MS. DIGAL	256206	2,12,2010

I hereby authorize the State of HAWAII to furnish the Professional Licensing Agency with the information below.

Signature of applicant	Date signed (*month, day, year*)
[signature]	4,10,2019

DO NOT WRITE BELOW THIS LINE

License number	Date of issuance (*month, day, year*)	Date of expiration (*month, day, year*)
Licensed by: ☐ Exam ☐ Endorsement ☐ Other	Type of examination	Date of administration (*month, day, year*)
Attach subjects, scores, date of examination, and average.		
License is current and in good standing? ☐ Yes ☐ No	License is or has been invalid? ☐ Yes ☐ No	Any derogatory information? ☐ Yes ☐ No
If license has been encumbered in any way, please provide certified copies of all related documents.		

FORM COMPLETED BY		
Signature		Date (*month, day, year*)
Printed name	Title	
State Board	Telephone number ( )	E-mail address

Please affix board seal below.

RECEIVED
APR 30 2019
Professional Licensing Agency

APR 22 2019

PROFESSIONAL LICENSING AGENCY
402 WEST WASHINGTON STREET
ROOM W072
INDIANAPOLIS IN 46204

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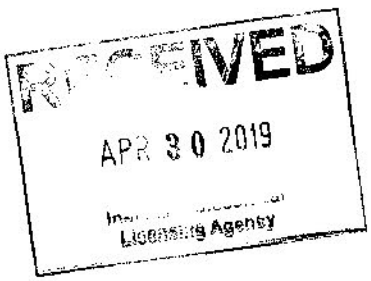

MEDICAL BOARD
OF CALIFORNIA

Protecting consumers by advocating high quality, safe medical care.

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

April 1, 2019

Indiana Physician Assistant Committee
402 West Washington St., Room W072
Indianapolis, IN 46204

To Whom It May Concern:

This is to certify that as of March 28, 2019, the records of the Medical Board of California (Board) indicate the following information:

Physician:	DEBORAH LYNN NUCATOLA
License Number:	A70101
Issued Date:	October 22, 1999
Exam Type:	A Written Examination
Expiration Date:	May 31, 2021
License Status:	CURRENT
Board Discipline and/or Administrative Action:	No

If Board Discipline and/or Administrative Action is indicated, public records may be available at http://www.mbc.ca.gov; or you may contact the Board's Enforcement Program, Central File Room by email at central.fileroom@mbc.ca.gov, by fax at (916) 263-2420 or by mail at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain information concerning the action.

April Alameda

April Alameda
Chief of Licensing