Stutsman, John, M.D. **Constit ID: 043820**

PH License: 47011 Date Issued: 5/6/14 11-13-13

TP License: TP 495 TP Approval: MR Date TP Issued: 11/12/13

Application/Fee Received: **6/20/2013** Application Statement and Fingerprint Cards Mailed: 6/21/13

Email: john.stutsman@ppin.org Authorized Person(s): Liz Carroll

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PH Licensure Requirements:

- ✓ FCVS 11/13
- ✓ Application Appendix
- ✓ License Verifications ~~IN~~ ~~TN~~
- ✓ Release and Waiver Form with Photo
- ✓ Category I & II
- ✓ Temporary Permit Request
- ✓ Hospital/ Clinic Affiliation List
- ✓ Hospital/ Clinic Affiliations ~~3-2-1~~
- ✓ References ~~1 2~~
- ✓ NPDB/HIPDB
- ✓ AMA/ AOA Profile
- 5/5/14 ✓ HIV/AIDS Affidavit
- ✓ HIV/AIDS Certificate of Completion
- ✓ CME Form

- ☑ Medical School Entered
- ☑ State Licensure Entered
- ☑ Endorsement Entered
- ☑ Merge Code Changed/Added
- ☑ Board Location Entered

Criminal Background Checks:

7-25 Date fingerprint card & fee received by KBML

7-26 Date mailed to KSP

8-8 Date reports received from KSP/FBI

Board Meeting: Mar/ June/ Sep/ (Dec)

Board Approved Date 12/19/13

Brd Letter Mailed/ Emailed 11-13-13

Due Process/Special Invite Letter _____
(If Applicable)

Special Licensure Item:

Print Form

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

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Temporary Permit Form

KRS 311.575 provides that Temporary permits may be issued **at the discretion of the Executive Director**, provided the applicant for a full license has a **completed application with all supporting documents** on file with the Board, meets all statutory requirements for licensure, and needs to begin working in Kentucky before the next regularly scheduled meeting of the Board. **You must request the Temporary Permit by completing this form; it is not automatically issued.**

Temporary Permits will not be issued to an applicant who has a prior history of disciplinary action taken by a licensing jurisdiction or hospital, a criminal record, a history of substance/chemical abuse or any negative or derogatory information. This also includes any malpractice cases in the last ten years in which you paid a settlement of $100,000 or more.

The Temporary Permit will not be issued until all administrative screening processes are complete including the FCVS Profile. **Do Not make any commitments prematurely. The Board recommends that you do not make any commitments to accept a position in Kentucky until you have a Temporary Permit *in hand*.**

You may request a Temporary Permit by completing this form and returning it directly to the Board:

Name: John W. Stutsman (M.D.) ~~D.O.~~
(please print)

Practice Location in Kentucky: 1025 S. 2nd Street
Louisville, Ky
40203

Temporary Permit should be mailed to: PPINK
200 South Meridian Street, Suite 400
Indianapolis, IN 46225

Please Note: You will not be issued a Temporary Permit to practice in Kentucky without a specific Kentucky practice address listed on this form.

Id Number: 043820

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222
(502) 429-7150
www.kbml.ky.gov

Application for Medical/Osteopathic License

The following information was entered by the applicant as part of the online application on 6/20/2013. Applicant's required addendums will follow this page.

Notice: Failure to truthfully and completely answer any question on this application (electronic or manual), including intentional and inadvertent non-disclosure, will result in a minimum fine of $1,000.00.

Name: Dr. John W Stutsman M.D.

Date of Birth: [redacted]

Birth Place: [redacted]

Gender: [redacted]

Address Information:

Mailing Address: 200 S. Meridian St. Ste. 400
Indianapolis, IN 46225

Practice Address: 200 S. Meridian St. Ste. 400
Indianapolis, IN 46225

Work Number: (317) 637-4343

Home Number:

Email Address: john.stutsman@ppin.org

Practice Information:

Specialty: Obstetrics/Gynecology

Medical Status: Private Practice

Date: 06/20/13

Name: John Stutsman Constit ID: 043820

Category I Questions:

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer 'yes' to any question if the event(s) described in that question has actually occurred. You must answer 'yes' in such circumstance even if you have been advised by an attorney or other person that you may answer 'no'. You must also answer 'yes' in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated 'confidential' by the body involved. After answering 'yes' to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated 'confidential,' attorney has advised that you properly answer 'no'). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer 'yes' to a question, you should err in favor of answering 'yes' and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license. This application may not be altered in any way.

1. Have you ever been dismissed from, resigned while under investigation, been placed on a disciplinary probation or reprimanded at a medical school or a postgraduate training program?
(Academic probation is not reportable.)
No

2. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
No

3. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
No

4. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?
No

5. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
No

6. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
No

7. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
No

Date: 06/20/13

Name: John Stutsman Constit ID: 043820

8. Have you ever been removed, suspended, expelled or disciplined by any professional medical facility, association or society?
No

9. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
No

10. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
No

11. Are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
No

12. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court?
No

13. Are any criminal charges presently pending against you in any of those courts?
No

14. To your knowledge, are you the subject of an investigation for a criminal act?
No

15. In the past ten (10) years have you had to pay a settlement or judgment in a malpractice action or other civil action against your medical practice, or are there any malpractice or other civil actions against your medical practice presently pending in any court?
No

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

Signature: JWS Date: 06/20/13

Date: 06/20/13

Name: John Stutsman Constit ID: 043820

Category II Questions:

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (l) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them. 'Illegal drug use' means the use of an illegally obtained controlled substance or dangerous drug; the term 'illegal drug use' also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?

[redacted]

2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition, which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?

[redacted]

3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?

[redacted]

4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?

[redacted]

5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.

[redacted]

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

Signature: JWS Date: 06/20/13

Print Form

FCVS Packet ID # 287816

Kentucky Board of Medical Licensure
Application Appendix

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Applicant Name Stutsman, John W. M.D.
Last First MI Degree

Applicant Signature _____ **Date:** 07/22/2013

Medical School:

List name, location and dates of attendance of every college and medical school you have attended:

Name	City/State/Country	Dates (From – To)	Degree
Indiana University School of Medicine	Indianapolis/IN/Marion	08/1987-03/1991	Doctor of Medicine
Indiana University	Bloomington, IN/Monroe	08/1983-05/1987	Bachelor of Science

State or Professional Licensure:

List **ALL** states and Canadian provinces where you currently hold or have ever held **ANY** type of medical/osteopathic license. In addition, you must also complete the "Licensure Verification Form" and forward it to ALL of those states. The verifying entity must forward all documentation directly to the Kentucky Board of Medical Licensure. Please note some state boards charge a fee for this information. Contact the state board where you currently hold or have held a license to determine their requirements.

Original (Full Unrestricted) Licensing State Indiana Date License Issued 09/30/1993

State Licensed: Tennessee License # MD0000030836 License Type Medical Doctor

State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

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State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

State Licensed: _____ License # _____ License Type _____

COPY THIS PAGE TO LIST ADDITIONAL STATE LICENSES

Print Form

Instructions: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to the Kentucky Board of Medical Licensure.

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Kentucky Board of Medical Licensure
Affidavit and Authorization for Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

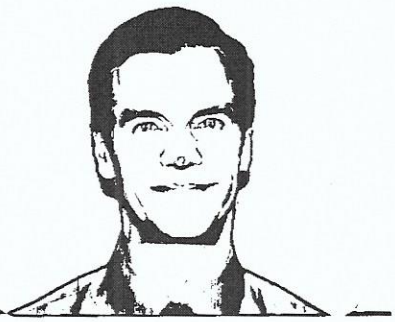
I acknowledge that I have read and understand the Application for Medical/Osteopathic Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Kentucky Board of Medical Licensure, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.



Applicant's Signature (must be signed in the presence of a notary)

John W. Stutsman

Applicant's Printed Name (Last, First MI, Suffix)

7/23/13

Date of Signature

NOTARY

Dated 7/23/13 Signed Kimya Deann Kidd

State of Indiana County of Marion

Subscribed and Sworn to before me this 23rd day of, July 20 13

My commission expires: 6/04/20

(PLEASE AFFIX NOTARY SEAL HERE)

NOTARY PUBLIC SEAL STATE OF INDIANA

KIMYA DEANN KIDD
Marion County
My Commission Expires
June 4, 2020

Print Form

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation List

Physicians Name John W. Stutsman, M.D. M.D. / D.O.

List all hospitals, clinic, etc., other than training (see below) where you have practiced medicine within the last five (5) years and send Addendum 4A to each. If you have more than 20 affiliations in the past 5 years, you will only be required to list and verify the last 20 affiliations. (This should include moonlighting, administrative and all locum tenens assignments.) **If you have been in training or are still in training this form still needs to be completed, please mark "in training" on the form and submit.**

Dates (From – To)	Hospitals/Clinic/ Office Name	Complete Address	Indicate Locum Tenens, Moonlighting or Type of Privileges
07/2010 - Present	Planned Parenthood of Indiana & Kentucky	200 S. Meridian, #400 Indianapolis IN 46225	Staff Privileges
07/2003-Present	IU School of Medicine Wishard Memorial Hospital	1001 W. 10th Street Indianapolis, IN 46202	Full Privilege
07/2003-Present	IU Health University Medical Center	550 University Blvd Rm 2440 Indianapolis, IN 46202	Full Privileges

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Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application (with the exception of training as that is verified via the FCVS). If you have more than 20 affiliations in the past 5 years, you will only be required to verify the last 20 affiliations. Your signature below is your authority to release any and all information in your files, favorable or otherwise regarding yourself.

Name: John W. Stutsman (Please print) M.D./D.O. _____ (Signature)

Name and Address of Facility: PPINKY; 200 S. Meridian Street, Indianapolis, IN 46225

To Reference Source: Please complete this form, sign, and return directly to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith.

1. Position and Department of the above applicant? Medical Director
2. Affiliation Dates: From July 2010 To Present (July, 2013)
3. Were any limitations imposed on this physician? No If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action.
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? No If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action.
5. Was the above physician terminated from employment? No If yes, please explain in detail.

Derogatory Information, if any: None

Comments, if any: _____

Signature, Date, Title M. Elizabeth Carroll, 7/22/13; Vice President Pt Services
Printed Name M. Elizabeth Carroll
Facility Planned Parenthood of Indiana & Kentucky
Address 200 S. Meridian, #400
Indianapolis IN 46225
Phone Number 317-637-4343
Fax Number 317-637-4309

Affix Seal Here
(If no seal, so indicate)
No Seal

Print Form

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AUG 12 2013
K.B.M.L.

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application (with the exception of training as that is verified via the FCVS). If you have more than 20 affiliations in the past 5 years, you will only be required to verify the last 20 affiliations. Your signature below is your authority to release any and all information in your files, favorable or otherwise regarding yourself.

Name: John W. Stutsman (M.D./~~D.O.~~) _____
(Please print) (Signature)

Name and Address of Facility: Wishard Medical Center / Eskenazi Health

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To Reference Source: Please complete this form, sign, and return directly to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith.

1. Position and Department of the above applicant? Active Staff / OB/GYN
2. Affiliation Dates: From 7/15/03 To present
3. Were any limitations imposed on this physician? No If **"Yes"**, please explain briefly and attach certified copies of any documentation pertaining to such action.
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? No If **"Yes"**, please explain briefly and attach certified copies of any documentation pertaining to such action.
5. Was the above physician terminated from employment? No If yes, please explain in detail.

Derogatory Information, if any: _____

Comments, if any: _____

Affix Seal Here
(If no Seal, so indicate)

Signature, Date, Title _____
Printed Name Elizabeth Ferries Rowe M.D.
Facility Wishard Health Services
Address 1001 W. 10th St. OPW U3200
INDPLS IN 46202
Phone Number 317-630-6414
Fax Number 317-630-2416

Print Form

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

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Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application (with the exception of training as that is verified via the FCVS). If you have more than 20 affiliations in the past 5 years, you will only be required to verify the last 20 affiliations. Your signature below is your authority to release any and all information in your files, favorable or otherwise regarding yourself.

Name: John W. Stutsman (Please print) M.D./D.O. _____ (Signature)

Name and Address of Facility: Indiana University ~~School of Medicine~~ Medical Center / IU Health

To Reference Source: Please complete this form, sign, and return directly to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith.

1. Position and Department of the above applicant? Medical Staff Member - OB/GYN
2. Affiliation Dates: From 10/22/2003 To Present
3. Were any limitations imposed on this physician? NO If **"Yes"**, please explain briefly and attach certified copies of any documentation pertaining to such action.
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? NO If **"Yes"**, please explain briefly and attach certified copies of any documentation pertaining to such action.
5. Was the above physician terminated from employment? NO If yes, please explain in detail.

Derogatory Information, if any: _____

Comments, if any: _____

Signature, Date, Title Jay Buland, Director Med Staff 7/30/2013
Printed Name JAY BULAND
Facility IU Health Academic Health Center
Address 340 W 10th St, Suite 3100
Indpls, In ~~46202~~ 46202
Phone Number 317-962-8301
Fax Number 317-968-1060

(Insert seal/certificate) Affix Seal Here

INDIANA UNIVERSITY HEALTH, INC. • 1997 • HEALTH • INDIANAPOLIS, INDIANA

Print Form

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

CME Form

Name John W. Stutsman, M.D.
(Please Print or Type)

Record of Category I Continuing Medical Education Credits
(Last 3 years only)

DO NOT PROVIDE DOCUMENTATION

Please note: If you have been in training or are still in training this form still needs to be submitted. Please write "In training" on the form and submit.

Dates:	Name of Activity/Course	# of Credit Hours
Dec. 2012	ABOG MOC Part II	25
Dec. 2011	ABOG MOC Part II	25
Dec. 2010	ABOG MOC Part II	25
2/28/13	9th Annual PPFA Med Directors	12.5
2/2012	8th " " " "	12.0
2/2011	7th " " " "	12.0
9/2012	SFP - NA Forum on Family Planning	16.0

I attest that the above is valid.

Signature

7/29/13
Date

Print Form

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Kentucky Board of Medical Licensure
310 Whittington Pkwy., Suite 1B
Louisville, KY 40222

Reference Form

This form is to be completed by a physician fully licensed in the state which the form is notarized. The recommending physician must have known the applicant for at least six months. Relatives may not serve as recommending physicians nor may physicians who are currently in the process of applying for a KY license. Recommending physicians are strongly urged to include additional comments. The recommending physician must have this form notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return to the Kentucky Board of Medical Licensure at the address above.

Do not complete unless a color photo of applicant is attached to the bottom of this form.
Black and white photos are not accepted.

I, Debra Kirkpatrick (recommending physician, print name legibly), a licensed and practicing physician in the state of IN (state of practice)
affirm that John Stutsman (applicant, print name legibly) has been known to me personally for 10 years
and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for Kentucky licensure:

I rate his/her medical knowledge and technique as: Excellent

His/her relationship with patients is: Excellent

I rate his/her ability to work well with peers and medical staff as: Excellent

His/her command of the English language is: Excellent

Additional comments: _____

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the state of Kentucky.

Printed Name and Signature of Recommending Physician (name stamps will not be accepted)
Debra C Kirkpatrick; Debra C Kirkpatrick MD IN 32215
State of Licensure and License Number

Address of Recommending Physician	550 N. UNIVERSITY BLVD, UH 2440	INDIANAPOLIS IN 46202	317-944-1661
*Print Legibly	Street Address	City, State, Zip	Phone (include area code)

Subscribed and sworn to before me this 30TH day of July, 2013.

Pamela S. Baker
Notary Public Signature

Date Commission Expires 6-5-19

PAMELA S. BAKER
Notary Public, State of Indiana
Marion County
Commission # 626919
My Commission Expires
June 05, 2019

Signature of Applicant _____ Date Photo Taken 7/25/13

Printed Name of Applicant John W. Stutsman, MD

Print Form

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Kentucky Board of Medical Licensure
310 Whittington Pkwy., Suite 1B
Louisville, KY 40222

Reference Form

This form is to be completed by a physician fully licensed in the state which the form is notarized. The recommending physician must have known the applicant for at least six months. Relatives may not serve as recommending physicians nor may physicians who are currently in the process of applying for a KY license. Recommending physicians are strongly urged to include additional comments. The recommending physician must have this form notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included. Please complete the form and return to the Kentucky Board of Medical Licensure at the address above.

Do not complete unless a color photo of applicant is attached to the bottom of this form.
Black and white photos are not accepted.

I, Brownsyne Tucker Edwards, a licensed and practicing physician in the state of Indiana
(recommending physician, print name legibly) (state of practice)
affirm that John Stutsman has been known to me personally for 2 years
(applicant, print name legibly)
and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for Kentucky licensure:

I rate his/her medical knowledge and technique as: excellent

His/her relationship with patients is: excellent

I rate his/her ability to work well with peers and medical staff as: excellent

His/her command of the English language is: excellent

Additional comments: _____

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the state of Kentucky. Brownsyne Tucker Edwards

Printed Name and Signature of Recommending Physician (name stamps will not be accepted)
IN 01069643A
State of Licensure and License Number

Address of Recommending Physician	550 N. University Blvd	Indianapolis, IN 46202	3179441166
*Print Legibly	Street Address	City, State, Zip	Phone (include area code)

Subscribed and sworn to before me this 30th day of July, 2013.

Pamela S. Baker
Notary Public Signature

Date Commission Expires 6-5-19

STATE OF INDIANA NOTARY SEAL
PAMELA S. BAKER
Notary Public, State of Indiana
Marion County
Commission # 626919
My Commission Expires
June 05, 2019

Signature of Applicant _____ Date Photo Taken 7/25/13

Printed Name of Applicant John W. Stutsman, MD

Certificate of Completion

CME Resource certifies that
John W. Stutsman TP495
has participated in the enduring material titled
#94750 HIV/AIDS: Epidemic
Update for Kentucky
on May 4, 2014
and is awarded 2
AMA PRA Category 1 Credit(s) ™.

Freda S. O'Brien
Freda S. O'Brien
Director of Academic Affairs

Erin K. Meinyer
Erin K. Meinyer
Executive Director

CME Resource is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Florida CE Broker Provider #50-2405, Board of Medicine.

This 2 contact hour/credit activity, approved by the Kentucky Cabinet for Health and Family Services, has been assigned Series 0116-0990-S. This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

POST OFFICE BOX 997571 • SACRAMENTO, CALIFORNIA 95899-7571
1482 STONE POINT DRIVE • SUITE 120 • ROSEVILLE, CALIFORNIA
PHONE: 800/232-4238 • FAX: 916/783-6067 • WWW.NETCE.COM

Print Form

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Kentucky HIV/AIDS Education
Affidavit of Reasonable Cause

I, John W. Stutsman, MD, request that the Board (KBML) defer my
(Full Name)
HIV/AIDS education requirement for initial professional licensure (KRS 214.615) for the following reason,

Please explain in detail: As I continue with my full-time busy practice, I will complete an on-line course within the required 6 months time line.

Note: The explanation is required in order for your Affidavit of Reasonable Cause to be accepted. Additionally, location is not a valid reason for deferment as there are several courses available online.

I understand that the deferment is valid for six (6) months from the date of the issuance of my temporary permit to practice medicine and is not renewable. I further understand that within this six months I must send to the Board (KBML), a copy of a certificate showing completion of a Kentucky Cabinet for Health Services approved HIV/AIDS course for a full and unrestricted license to be issued.

Signature: _____ Date: 07I29/2013

Printed Name: John W. Stutsman, MD

Social Security Number: 307-62-0857

→ This form must be sent to the Board (KBML) in order for you to receive a six-month extension. Please retain a copy of this affidavit for your records. Either this affidavit or the completed course must be in the Boards office in order to meet the Board Deadlines. A list of approved courses may be obtained from the following website or you by calling (502) 564-6539.

http://chfs.ky.gov/dph/epi/HIVAIDS/ProfessionalEducation.htm

AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Name and Mailing Address:

JOHN WM STUTSMAN MD
[redacted]

Primary Office Address:

WISHARD MEMORIAL HOSPITAL
F5
1001 W 10TH ST
INDIANAPOLIS IN 46202-2879
Phone: 1-317-274-8609

Birthdate: [redacted]

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY

Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

IN UNIV SCH OF MED, INDIANAPOLIS IN 46202

Degree Awarded: Yes

Degree Year: 1991

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association ("AMA") and the Requesting Organization that the physician profiles being requested are provided to the Requesting Organization with the understanding that: (1) the information on the physician profiles will be treated with complete confidentiality; (2) such information is granted solely to the Requesting Organization and is granted as a non-exclusive limited license, consistent with and limited to the sole and specific purpose of verifying physicians' credentials; (3) no physician profile information will be released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency; (4) no physician profile obtained or any information contained therein will be used as a vehicle to create, maintain or enhance another database; and (5) that upon breach of any of the foregoing covenants this license to use and possess physician profiles shall be automatically and immediately terminated and no further physician profiles shall be provided by AMA.

AMA endeavors to maintain its physician profiles with information that is accurate, complete and current; however, because AMA compiles data from numerous and varied sources, and therefore may experience reporting and processing errors or delays, no representations or warranties as to the accuracy or completeness of the data or as to the uninterrupted access can be or are made.

AMA makes no representations or warranties of any nature, with respect to the physician profiles obtained including without limitation, the implied warranties of merchantability and fitness for any particular purpose, nor assumes any responsibility or legal liability for Requesting Organization's use or the results of its use of such profiles. In consideration of the receipt of each physician profile provided by AMA, the Requesting Organization hereby releases AMA and their respective agents and servants from any and all liability whatsoever for inaccurate or incomplete information in any physician profile obtained.

AMA
AMERICAN
MEDICAL
ASSOCIATION

AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as 'In progress' or 'Current' with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: MARICOPA MED CTR
Sponsoring State: ARIZONA
Specialty: OBSTETRICS & GYNECOLOGY
Dates: 06/1994 - 06/1998 (VERIFIED)

Sponsoring Institution: UCSF-FRESNO MED EDUC PROG
Sponsoring State: CALIFORNIA
Specialty: FLEXIBLE OR TRANSITIONAL
Dates: 06/1991 - 06/1992 (VERIFIED)

Note: **If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.**

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1992

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
TENNESSEE	MD	06/08/1998	02/28/2007	INACTIVE	UNLIMITED	05/18/2007
INDIANA	MD	09/30/1993	10/31/2013	ACTIVE	UNLIMITED	07/01/2013

AMA Physician Profile (continued)

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AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Current and/or Historical NPI Information:

NPI Number	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1588693956	06/30/2006	NOT RPTD	NOT RPTD	NOT RPTD	07/13/2013

ECFMG Certification:

Applicant Number:

Note: **The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.**

Federal Drug Enforcement Administration:

** Only the last three characters of active DEA number(s) are displayed.*

DEA Number *	Schedule	Expiration Date	Last Reported
[redacted]	22N 33N 4 5	02/29/2016	07/01/2013

Address: Wishard Memorial Hospital, F5, 1001 W 10th St, Indianapolis, IN 46202-2879

Note: **Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.**

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying Board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate Type: GENERAL

Duration	Effective	Expiration	Reverification	Occurrence	Last Reported
TIME LIMITED	12/15/2012	12/31/2013		RE-CERT	07/05/2013
TIME LIMITED	12/31/2011	12/31/2012		RE-CERT(**)	07/05/2013
TIME LIMITED	12/31/2010	12/31/2011		RE-CERT(**)	07/05/2013
TIME LIMITED	12/31/2005	12/31/2010		RE-CERT(**)	07/05/2013

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AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Certifying Board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate Type: GENERAL

Duration	Effective	Expiration	Reverification	Occurrence	Last Reported
TIME LIMITED	12/31/2004	12/31/2010		RE-CERT(**)	07/05/2013
TIME LIMITED	12/31/2003	12/31/2010		RE-CERT(**)	07/05/2013
TIME LIMITED	12/31/2002	12/31/2010		RE-CERT(**)	07/05/2013
TIME LIMITED	12/31/2001	12/31/2010		RE-CERT(**)	07/05/2013
TIME LIMITED	11/08/2000	12/31/2010		INITIAL(**)	07/05/2013

Note: **For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.**

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association ("AMA") and the Requesting Organization that the physician profiles being requested are provided to the Requesting Organization with the understanding that: (1) the information on the physician profiles will be treated with complete confidentiality; (2) such information is granted solely to the Requesting Organization and is granted as a non-exclusive limited license, consistent with and limited to the sole and specific purpose of verifying physicians' credentials; (3) no physician profile information will be released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency; (4) no physician profile obtained or any information contained therein will be used as a vehicle to create, maintain or enhance another database; and (5) that upon breach of any of the foregoing covenants this license to use and possess physician profiles shall be automatically and immediately terminated and no further physician profiles shall be provided by AMA.

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AMA AMERICAN MEDICAL ASSOCIATION

AMA Physician Profile

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the Physician Profile is intended to assist with credentialing. Appropriate use of the data contained in the AMA Physician Masterfile by an organization meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification and Federal DEA registration.

If you note any discrepancies, please log onto our web site (http://www.ama-assn.org/go/amaprofiles) and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60654
800- 665-2882
312 464-5900 (fax)

If you have questions or need additional information, please call the AMA Profile Service customer support line at 800-665-2882.

AMA Physician Profile (continued)

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STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
tennessee.gov/health
TENNESSEE BOARD OF MEDICAL EXAMINERS
1-800-778-4123

August 6, 2013

JOHN W STUTSMAN, MD
[redacted]

TO WHOM IT MAY CONCERN:

The Tennessee Board of Medical Examiners is pleased to furnish the following information from our files:

PROFESSION:	Medical Doctor
NAME:	JOHN W STUTSMAN
RANK:	Medical Doctor
LICENSE NUMBER:	MD30636
ISSUE DATE:	06/08/1998
EXPIRATION DATE:	02/28/2007
CURRENT STATUS:	Voluntarily Retired
STATUS DATE:	03/23/2007

THE GREAT SEAL OF THE STATE OF TENNESSEE XVI AGRICULTURA COMMERCIO 1796

COMMENTS: There is no derogatory information in our files concerning this individual. The State of Tennessee only provides the above information. Any other information needed must be obtained from the licensee.

Sincerely,

Board Administrator
Tennessee Board of Medical Examiners

MD/LV1

To expedite the verification process, the above is the standard format used by the Medical Board of Tennessee.

STATE OF INDIANA

Michael R. Pence

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Official Proof of Licensure
Digitally Certified Record

Personal Information

Name:	John William Stutsman
Address:	[redacted]
Date of Birth:	

License Information

Number Issued:	01041889A
License Type:	Physician
Status:	Active
Issue date:	09/30/1993
Expiration Date:	10/31/2013
Obtained By:	Endorsement
Disciplinary Action:	None

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams.

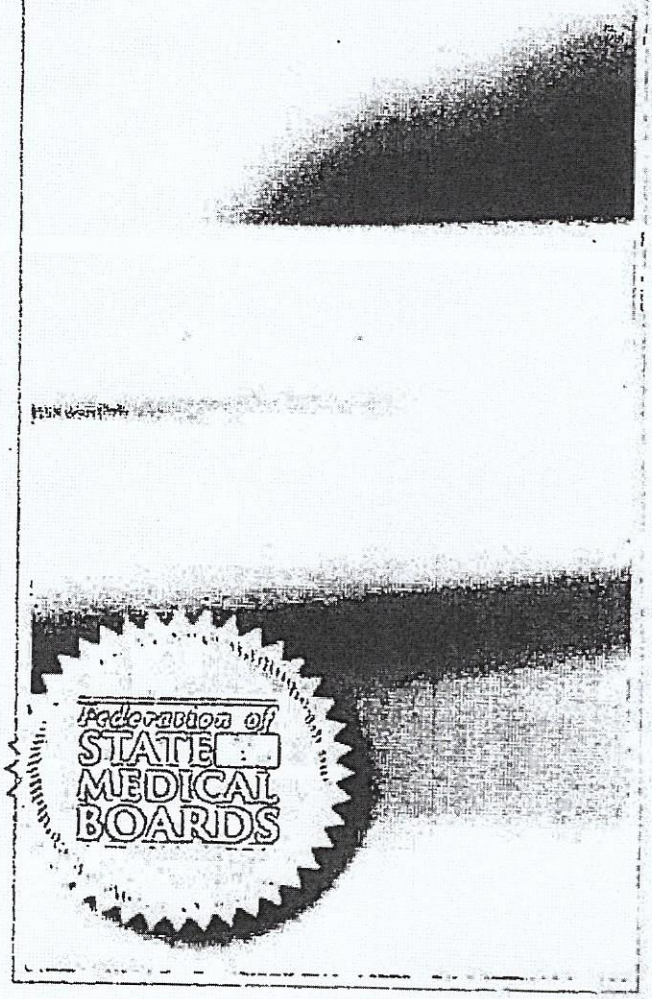
For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at www.in.gov/pta/boards.htm

Digitally Certified on: Thu Aug 08 01:44:09 PM EDT 2013

UNITED STATES POSTAL SERVICE
Electronic Postmark

FCVS

FEDERATION CREDENTIALS VERIFICATION SERVICE



Medical Professional Information Profile

This report provides credentialing information for

Name: **John William Stutsman**

Social Security Number: [redacted]

Date of Birth: [redacted]

FID#: **209220003**

Recipient: **KY - Kentucky Board of Medical Licensure**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

This FCVS Medical Professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis Report for further details on the unresolved items

Medical Professional Name: **John William Stutsman**
Date of Birth:
Social Security Number: [redacted]
FID: **209220003**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

Indiana University School of Medicine Indianapolis
1. Medical Education Form
2. Medical Education Transcript
3. Medical Education Diploma

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

University of California/University Medical Center
1. GME Form
2. GME Completion Certificate

Phoenix Hospitals/Maricopa Medical Center
1. GME Form
2. GME Completion Certificate

VI. Licensure Examination History

A. NBME Record of scores

End of report for: John William Stutsman

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Table of Contents

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

Section I

FCVS Reports

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name: **John William Stutsman**
Documentation: Certified Birth Certificate

Gender: [redacted]
Date of Birth: [redacted]
Place of Birth: [redacted]
Social Security Number: [redacted]
FID: 209220003
Physical Description: Height: 6 ft. 1 in.
Weight: 165 lbs.
Eye Color: Blue
Hair Color: Brown

Contact Information

Mailing Address: 200 S MERIDIAN ST STE 400
INDIANAPOLIS, IN 46225-1076
UNITED STATES

Permanent Address: [redacted]

Telephone Numbers: Primary: [redacted]
Secondary:
Fax:
Other:

Pre-medical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **Indiana University Bloomington**
Address: Bloomington, IN 47405
UNITED STATES
Dates of Attendance: 08/--/1983 To 05/--/1987
Degree Conferred/Issued: Bachelor of Science

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **Indiana University School of Medicine Indianapolis**
Address: 340 W 10th Street #6200
Indianapolis, IN 46202-5114
UNITED STATES

Dates of Attendance: 08/31/1987 to 03/31/1991
Date Certificate Issued: 03/31/1991
Degree Conferred/Issued: Doctor of Medicine

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **University of California/University Medical Center**
Address: 445 South Cedar Avenue
Fresno, CA 93702
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Transitional
Dates of Attendance: 06/24/1991 To 06/21/1992
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Institution: **Phoenix Hospitals/Maricopa Medical Center**
Address: 2601 East Roosevelt
Phoenix, AZ 85008
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Obstetrics and Gynecology
Dates of Attendance: 06/23/1994 To 06/30/1995
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2 - 4
Program Type: Internship
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/1995 To 06/30/1998
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Licensure Examinations

NBME - National Board of Medical Examiners NBME Part I	Date: 06/1989	Passed the Exam
NBME - National Board of Medical Examiners NBME Part II	Date: 09/1990	Passed the Exam
NBME - National Board of Medical Examiners NBME Part III	Date: 03/1992	Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

A report of the results from a search of the Board Action Data Bank is enclosed.

End of report for: John William Stutsman FID: 209220003

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, Post Graduate Training program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Medical Professional Identification

Medical Professional Name: **John William Stutsman**

Date of Birth: [redacted]

Social Security Number: [redacted]

FID: **209220003**

Omissions

There are no omissions identified.

Discrepancies

There are no discrepancies identified.

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: John William Stutsman

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: John William Stutsman
Date of Birth:
Social Security Number: [redacted]
FID#: 209220003

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
08/1987	03/1991	Medical Education Record	Indiana University School of Medicine Indianapolis,340 W 10th Street #6200 Indianapolis, IN 46202-5114 UNITED STATES		
07/1991	07/1992	GME Record	University of California/University Medical Center,445 South Cedar Avenue Fresno, CA 93702 UNITED STATES		
07/1992	09/1993	Volunteer Service	Peace Corps - MALAWI,Paul D. Coverdell Peace Corps Headquarters Washington, DC 20526 UNITED STATES		
10/1993	07/1994	Employment	Planned Parenthood of Southern Indiana,200 South Meridian Street Indianapolis, IN 46225 UNITED STATES		
07/1994	07/1998	GME Record	Phoenix Hospitals/Maricopa Medical Center,2601 East Roosevelt Phoenix, AZ 85008 UNITED STATES		

End of report for: John William Stutsman

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

Section II

FSMB and Other Reports

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

ABMS Verification of Certification

Federation of STATE MEDICAL BOARDS

As of: **11/08/2013**
Medical Professional Name: **John William Stutsman**
Date of Birth: [redacted]
Year of Graduation: **(Doctor of Medicine)**
ABMSUID#: **653173**

Certification

Certification:

Board: Obstetrics and Gynecology
Specialty: Obstetrics and Gynecology
Status: ACT
Initial Certification: 11/08/2000

End of report for John William Stutsman

All certification information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

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FPDC | FEDERATION PHYSICIAN DATA CENTER

Board Action
Clearance Report

November 08, 2013

Attn:

Re: Board Action Query Dated: November 08, 2013
FSMB Batch Number: BQ2356140

The following is a report of the search results from the Board Action Data Bank as of November 08, 2013 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of November 08, 2013

Name	DOB	School	Yr/Grad	Provider ID
John William Stutsman	[redacted]	015010	1991	287816

License History

Licensing Entity
INDIANA
TENNESSEE

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

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Section III

Identity

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FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

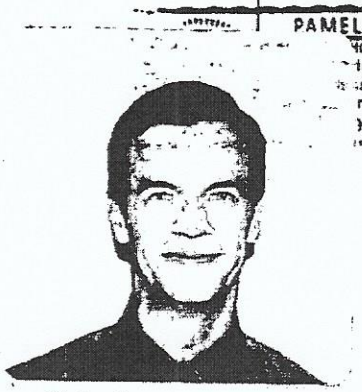
I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I, hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

While the FSMB will only use collected personal information for the purposes described on our website and in the FCVS application materials, the FSMB has no control over the entities to which an applicant authorizes the release of FCVS materials. Such entities may include state medical boards, state osteopathic boards, and other entities that may be subject to state and federal public information or open records laws, which might require the release of certain FCVS packet information to the public upon request.



Applicant's Signature (must be signed in the presence of a notary)

Stutsman
Applicant's Printed Last Name

7/22/13
Date of Signature (must correspond to date of notarization)

State of INDIANA, County of MARION,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 22ND day of JULY, 2013.

Notary Public Signature: Pamela S Baker

My Notary Commission Expires: 6-5-19

287816 287816 209220003

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