



# 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 27 1999

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.

- FEE:** Submit the ten dollar (\$10) fee made payable to the Health Professions Bureau. Fees are non-refundable and non-transferable.
- PROOF OF GRADUATION:** You must submit proof of graduation by submitting one of the following documents:
  - 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.
  - 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)
  - DEGREE** A notarized copy of your medical / osteopathic degree. Include official translation if not in english. (SEE NOTARIZED COPY NOTE)
- PHOTOGRAPH** Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.
- HOSPITAL / INSTITUTION CERTIFICATION** The Hospital / Institution Certification must be completed by the Hospital / Institution 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 \$ 10-	Date fee paid (month, day, year) 6-9-99	Receipt number 674-286-110-38
Permit number 11009606	Permit issuance date (month, day, year) 6-21-99 6-23-99	



### APPLICANT INFORMATION

Name of applicant (last, first, middle) Zia, Tian	Social Security number [REDACTED]
Address (number and street or Rural Route number) 1023 Newcastle	
City, state, ZIP code Westchester IL 60154	
Telephone number (daytime) [REDACTED]	Date of birth (month, day, year) [REDACTED]
Place of birth China	

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

City, State, ZIP code  
Indianapolis, IN 46202-5714

### DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY:

Name of school Chicago College of Osteopathic Medicine	Location Downers Grove, IL	Date of graduation (month, day, year) 6/7/98
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### 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 [Signature]	Date (month, day, year) 5/25/99
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**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.

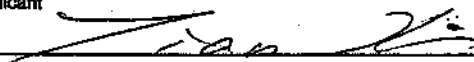
**AFFIRMATION**

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

Date signed (month, day, year)

5/25/99

Signature of applicant



**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 Tian Xia, D.O. has been granted  
 an appointment to serve at Indiana University School of Medicine 713 in  
 the Department of Physical Medicine & Rehabilitation  
 located at (address) Indianapolis, IN  
 this appointment is for the month and year beginning July 1, 1999 and ending June 30, 2000

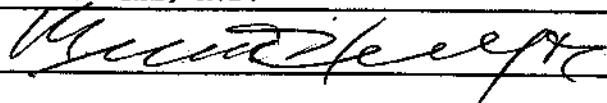
Name of Hospital Chairman/Department Head

Meredith T. Hull, M.D.

Title

Assistant Dean, School of Medicine

Signature



Date of signature (month, day, year)

May 17, 1999

Telephone number

(317) 274-7108

I hereby certify this to be a true and correct copy of the original.

*Sue Hardwidge*  
Sue Hardwidge, Registrar  
5/25/99

# Chicago College of Osteopathic Medicine



*On the recommendation of the Faculty,  
the Board of Trustees of Midwestern University  
has conferred upon*

**Tian Xia**

*the Degree of*

**Doctor of Osteopathic Medicine**

*and has granted this Diploma as evidence that the requirements  
prescribed by the College have been fulfilled for this Degree.*

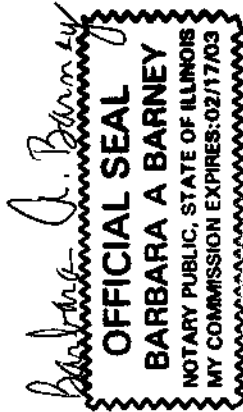
*Given at the City of Chicago in the State of Illinois on the 7th day of June, 1998.*

*M. Christensen*  
Chairman of the Board of Trustees

*Frank J. ...*  
Secretary of the Board of Trustees

*LaMoen, H. Coeppinger, Ph.D.*  
President  
Midwestern University

*L. ...*  
Dean



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Health Professions Bureau



# STATE OF INDIANA

FRANK O'BANNON, Governor

## HEALTH PROFESSIONS BUREAU

402 West Washington Street Room 041  
Indianapolis, Indiana 46204  
Telephone: (317) 232-2960  
Fax: (317) 233-4236  
<http://www.ai.org/hpb>

### MEDICAL LICENSING BOARD OF INDIANA

#### TEMPORARY MEDICAL PERMIT

Equal Opportunity Employer

This is to certify that **Tian Xia T.M.P.** has presented satisfactory evidence to the Medical Licensing Board of Indiana that he-she is enrolled in a Board approved graduate medical education or training program and is hereby issued this Temporary Medical Permit.

This permit is limited to the practice of medicine or osteopathic medicine in the specific graduate medical education or training program at **Indiana University Medical Center** and shall be valid for a period not to exceed one (1) year from the date issued unless reissued by the Medical Licensing Board.

This permit shall not be used for the purpose of accepting, receiving or otherwise being employed or engaging in any employment as a Physician unless the same is an approved adjunct of the specified institution's program.



PERMIT NUMBER: 11009606

ISSUANCE DATE: July 01, 1999

EXPIRATION DATE: June 30, 2000