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

State Form 17598 (R10 / 3-07)
Approved by State Board of Accounts, 2007

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

* 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.

** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

**FOR OFFICE USE ONLY**

| Permit fee | Date fee paid (month, day, year) | Receipt number |
|---|---|---|
| 100.00 | 5-2-11 | 3459879 |

| Permit number | Permit issuance date (month, day, year) |
|---|---|
| 11015991A | 5-20-11 |

Applying for: ☒ Postgraduate training ☐ Teaching ☐ Fellowship

**APPLICANT INFORMATION**

| Name of applicant (last, first, middle) | Social Security number * |
|---|---|
| QASBA, NEENA TICKU | |

Address of practice (number and street or rural route)
550 N. University Blvd.

City, state, and ZIP code
Indianapolis, IN 46205

| Telephone number (daytime) | Date of birth (month, day, year) | Ethnicity ** | Race ** | Gender ** |
|---|---|---|---|---|
| | 2/8/1984 | South Asian | South Asian | ☐ Male ☒ Female |

Please indicate what address you want your permit sent to (number and street or rural route) (if different than above)
550 N. University Blvd, Rm 2440

City, state, and ZIP code
Indianapolis, IN 46205

Email address

National Practitioner Identifier number
1417248253

**DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY**

| Name of school | Location | Date of graduation (month, day, year) |
|---|---|---|
| University of Connecticut | Farmington, CT | 5/15/2011 |

**APPLICATION AFFIRMATION**

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

| Signature of applicant | Date (month, day, year) |
|---|---|
| | 4/23/11 |

**PRE-MEDICAL / OSTEOPATHIC EDUCATION**

| NAME OF SCHOOL | LOCATION | DATES ATTENDED (month, day, year) |
|---|---|---|
| Johns Hopkins University | Baltimore, MD | 8/1/02 - 5/25/06 |
| | | |

**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) |
|---|---|---|
| University of Connecticut | Farmington, CT | 5/15/2011 |
| | | |

**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 SCHOOL | LOCATION | FROM (month, year) | TO (month, year) | ACGME ACCREDITED? |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |



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Indiana Professional Licensing Agency

| LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL | |
|---|---|
| GENERAL LOCATION | DATE (*month, day, year*) |
| Farmington, CT | 7/2007 – 6/1/11 |
| | |
| | |
| | |

| LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL | | |
|---|---|---|
| NAME AND ADDRESS OF EMPLOYER | RESPONSIBILITIES | DATE (*month, day, year*) |
| | | |
| | | |
| | | |
| | | |

| LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION | | | | |
|---|---|---|---|---|
| STATE | TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT | NUMBER | DATE ISSUED | CURRENT STATUS |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s), case information, detailed description of the case / events and settlement amount, including court documents, if applicable. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following, is grounds for permanent revocation of a license or permit issued pursuant to this application.

| | |
|---|---|
| 1. Has disciplinary action ever been taken regarding any 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 osteopathic medicine or any regulated health occupation in any state (*including Indiana*) or country, or surrendered your license? | ☐ Yes ☒ No |
| 3. Are you now being, or have you ever been treated for drug or alcohol abuse? | ☐ Yes ☒ No |
| 4. Have you ever been the subject of an investigation by a regulatory agency concerning your license? | ☐ Yes ☒ No |
| 5. Have you ever been arrested, convicted of, pled guilty or nolo contendere to, or are formal charges pending:<br>A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substance or drug addiction?<br>B. Any offense, misdemeanor or felony in any state? (*Except for minor traffic laws resulting in fines.*) | ☐ Yes ☒ No<br>☐ 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 surrendered your DEA registration at any time or had any limitations placed on your DEA registration? | ☐ 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 [signature] Date signed (*month, day, year*) 4/23/11

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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 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 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 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 disclosures.

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

## AFFIRMATION

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

| Date signed *(month, day, year)* | Signature of applicant |
|---|---|
| 4/23/11 | |

## 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 Neena Qasba has been granted

an appointment to serve at Indiana University School of Medicine in

the Department of Obstetrics and Gynecology

located at *(address)* Indianapolis, IN 46202

this appointment is for the month and year beginning July 1, 2011 and ending June 30, 2012

| Name of Hospital Chairman/Department Head | Title | |
|---|---|---|
| Peter Nalin, MD | Associate Dean for Graduate Medical Education | |
| Signature | Date of signature *(month, day, year)* | Telephone number |
| | March 31, 2011 | ( 317 ) 274-5261 |

# University of Connecticut

Be it known that

## Neena Ticku Qasba

having satisfied the requirements for the Degree of

## Doctor of Medicine

in

## The School of Medicine

has been admitted to that degree with all the related honors, privileges, and obligations. In recognition we present the seal of the University and the signatures as authorized by the Board of Trustees.



Given at Farmington, in the State of Connecticut, on the Fifteenth day of May, Two Thousand and Eleven.

Dean, School of Medicine

President of the University

President of the Board of Trustees

## Person Info

**Name:** Neena Ticku Qasba

## Address Info

**Street Address:** 550 N
University Blvd.
Room 2440

**Fax:**

**City:** Indianapolis

**State:** IN

**Zipcode:** 46205

**Country:** United States

**County:** Marion

**Email:**

**Phone:**

## Survey Response Summary
## Question Response Summary

| Question | Answer |
|---|---|
| 1) Has any health profession license, certificate, registration or permit you hold or have held been denied, surrendered, disciplined or are formal charges pending in any state (including Indiana)? | N |
| 2) Have you been disciplined or terminated by your residency program or been suspended, or subject to any restriction, probation, or have you resigned in lieu of discipline or termination? | N |
| 3) Have you had a malpractice judgment against you or settled a malpractice action? | N |
| 4) Since you last renewed, and except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been convicted of, pled guilty to, or pled nolo contender to any offense, misdemeanor, or felony in any state? | N |
| 5) Have you been excluded from being a Medicare or Medicaid provider? | N |