APPLICATION FOR A TEMPORARY POSTGRADUATE TRAINING PERMIT

State Form 56058 (R / 9-17)
Approved by State Board of Accounts, 2017

RECEIVED
MAY 10 2018
Indiana Professional Licensing Agency

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 $100.00, payable to the Indiana Professional Licensing Agency, in accordance with
2. Completed application and fees should be mailed to the address listed in the upper r
3. All fees are non-refundable and non-transferable.
4. Please refer to the instructions on our website, www.pla.in.gov, for the licensing requi

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandato
** This information is being requested for workforce statistical purposes only: disclosure is voluntary.

PERMIT FEE	100.00
DATE FEE PAID (*month, day, year*)	4-9-18
RECEIPT NUMBER	6368437
PERMIT NUMBER ISSUED	110199794
DATE PERMIT ISSUED (*month, day, year*)	6-4-18

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*): Spurgeon, Sarah Elizabeth
Social Security number *: [redacted]
Credentials (*check one*): ☒ MD ☐ DO
National Practitioner Identifier number: 1154810471
ECFMG certificate number: 0-974-121-6
Date of birth (*month, day, year*): [redacted]
Place of birth (*city and state or country*): Dayton, OH
Address of applicant (*number and street or rural route*): 777 Normedge Dr.
City, state, and ZIP code: Vandalia, OH 45377
Telephone number (*daytime*): [redacted]
E-mail address (*required*): [redacted]
Gender **: ☐ Male ☒ Female
Ethnicity: Caucasian
Race **: White
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

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*)
Ross University School of Medicine	Commonwealth of Dominica, West Indies	3/31/18

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 / AOA / RC accredited at the time of enrollment.

NAME OF PROGRAM	LOCATION	FROM (*month, year*)	TO (*month, year*)	ACGME / AOA / RC ACCREDITED?
Community Hospital East FMR	Indianapolis, IN	7/2018	6/2021	☒ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

EXAMINATION HISTORY

EXAMINATION	DATE FIRST TAKEN (*month/year*)	MOST RECENT DATE TAKEN (*month/year*)	RESULTS: PASSED	RESULTS: FAILED	NUMBER OF ATTEMPTS
COMLEX-USA Level 1					
COMLEX-USA Level 2, CE					
COMLEX-USA Level 2, PE					
COMLEX-USA Level 3					
USMLE Step I	10/15	10/15	✓		1
USMLE Step II, CS	4/17	4/17	✓		1
USMLE Step II, CK	7/17		✓		1
USMLE Step III					

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 *(month, day, year)*	CURRENT STATUS

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

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.	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 surrendered your DEA registration at any time or had any limitations placed on your DEA registration?	☐ Yes ☑ No
10.	Have you ever been excluded from being a Medicare or Medicaid provider?	☐ Yes ☑ No
11.	Have you ever been terminated or disciplined by your employer while practicing as a physician or resigned in lieu of discipline?	☐ 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

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)*
	3/28/18

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.

RECEIVED
APR 09 2018
Indiana Professional Licensing Agency

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)*
	05/15/2018

HOSPITAL / INSTITUTION CERTIFICATION FOR A TEMPORARY POSTGRADUATE TRAINING PERMIT

(To be completed by the Hospital / Institution Chairman / Department Head and notarized.)

This is to certify that Sarah Spurgeon has been granted

an appointment to serve at Community Hospital East Family Medicine Residency in

the Department of Family Medicine

located at *(address)* 10122 E. 10th St., Suite 100 Indianapolis, IN 46229.

This appointment is for the month and year beginning 07/01/2018 and ending 06/30/2021.

Name of Hospital Chairman / Department Head	Title	
Maurice Henein, MD	Program Director	
Signature	Date of signature *(month, day, year)*	Telephone number
	05/15/2018	(317) 355-3210

TRAINING LOCATIONS

(To be completed by the Hospital / Institution Chairman / Department Head and notarized.)

List all training locations under this permit.

NAME OF FACILITY	ADDRESS *(number and street, city, state, and ZIP code)*
Community Group Family Medicine Residency	10122 E. 10th St., Suite 100 Indianapolis, IN 46229
Jane Pauley Community Health Center	2040 N. Shadeland Ave., Suite 300 Indianapolis, IN 46219

NOTARY CERTIFICATE

STATE OF Indiana

COUNTY OF Marion } SS:

I, Sarah Spurgeon, having been duly sworn on oath, say that I am the above-named, that I have personally prepared the foregoing affidavit, and that the same is true to the best of my knowledge and belief.

Signature of Chairman / Department Head	Signature of Notary Public	
	Jeana Craft	
Printed or typed name of Chairman / Department Head	Printed or typed name of Notary Public	
Maurice Henein, MD	Jeana Craft	
Date subscribed and sworn to Notary Public *(month, day, year)*	County of residence	Date commission expires *(month, day, year)*
05/15/2018	Marion	08/29/2020

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)*
[signature]	3/28/18

HOSPITAL / INSTITUTION CERTIFICATION FOR A TEMPORARY POSTGRADUATE TRAINING PERMIT

(To be completed by the Hospital / Institution Chairman / Department Head and notarized.)

This is to certify that Sarah Spurgeon has been granted an appointment to serve at Community Hospital East Family Medicine Residency the Department of Family Medicine located at *(address)* 10122 E. 10th St. Suite 100 Indianapolis, IN 46229

This appointment is for the month and year beginning 7/1/18 and ending 6/30/2021.

Name of Hospital Chairman / Department Head	Title	
Maurice Renein MD	Program Director	
Signature	**Date of signature *(month, day, year)***	**Telephone number**
[signature]	3/28/18	(317) 355-3210

TRAINING LOCATIONS

(To be completed by the Hospital / Institution Chairman / Department Head and notarized.)

List all training locations under this permit.

NAME OF FACILITY	ADDRESS *(number and street, city, state, and ZIP code)*
Community Hospital East FMR	10122 E 10th St. Suite 100 Indianapolis, IN 46229
Jane Pauley CHC	2040 N. Shadeland Ave. Ste. 300 Indianapolis IN 46219

NOTARY CERTIFICATE

STATE OF Indiana

COUNTY OF Marion } SS:

I, Sarah Spurgeon, having been duly sworn on oath, say that I am the above-named, that I have personally prepared the foregoing affidavit, and that the same is true to the best of my knowledge and belief.

Signature of Chairman / Department Head	Signature of Notary Public	
[signature]	Jeana Craft	
Printed or typed name of Chairman / Department Head	**Printed or typed name of Notary Public**	
Maurice Renein MD	Jeana Craft	
Date subscribed and sworn to Notary Public *(month, day, year)*	**County of residence**	**Date commission expires *(month, day, year)***
8/30/2012	Marion	8/29/2020

on this 15th day of May 2018, I certify that this document is a true, exact, complete, and unaltered photocopy of the original.

Jeana Craft / Jeana Craft, Notary Public

Commission expires 8/29/2020 State of Indiana, County of Marion

Community Health Network

Family Medicine Center
10122 E. 10th Street, Suite 100
Indianapolis, IN 46229
O 317.355.5717
eCommunity.com

April 2, 2018

Indiana Professional Licensing Agency
402 West Washington Street, Room #W072
Indianapolis, IN 46204

Dear Board Members,

This letter is to accompany the medical permit application of **Sarah Spurgeon.** She will begin her residency training with Community Hospital East Family Medicine Residency Program on **July 1, 2018.** Her anticipated date of completion for the residency program is **June 30, 2021**.

She is set to graduate medical school in May. Her medical school diploma will be sent at that time.

If you have any questions or need further information, please do not hesitate to contact me at 317-355-3210.

Sincerely,

Maurice Henein, MD
Program Director
East Family Medicine Residency Program
Community Health Network, Indianapolis
mhenein@ecommunity.com

On this 15th day of May 2018, I certify that this document is a true, complete, exact, and unaltered photocopy of the original.
Jana Craft / Jana Craft Commission expires 8/29/2020
County of Marion / State of Indiana

Educational Commission for Foreign Medical Graduates

The ECFMG® certifies that

Sarah Elizabeth Spurgeon

has successfully passed the required examinations, satisfied all the requirements of the Commission, and has been awarded this Certificate.

Alan N Kuchma MD
Chair, Board of Trustees

William W. Pinsky MD
President and Chief Executive Officer

Certificate Number	0-974-121-6
Medical Science	
USMLE Step 1	October 23, 2015
USMLE Step 2 CK	July 10, 2017
Clinical Skills	
USMLE Step 2 CS	April 20, 2017

Date Issued April 19, 2018

STATE OF INDIANA
ONLINE RENEWAL RECORD

Renewal Submission Date:	September 20, 2021

Person Info

Name:	Sarah Elizabeth Spurgeon
License Number:	01085100A

Address Info

Street Address:	1338 North Grant Avenue
City:	Indianapolis
State:	IN
Zipcode:	46201
County:	Marion
Phone:	[redacted]
Email:	[redacted]

Question Response Summary

1.) Since you last renewed, has any health profession license, certificate, registration or permit you hold or have held been disciplined or are formal charges pending in any state or U.S. territory?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state or U.S. territory?	N
3.) 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 contendere to any offense, misdemeanor, or felony in any state or U.S. territory?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff memberships or privileges in any hospital or clinic or have staff membership or privileges been revoked, suspended, or subjected to any restriction, probation, or other type of discipline or limitations?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N
Citizenship Status:	
Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that:	
I am a United States Citizen	Y

Survey Response Summary

01.) What is your employment status?	Actively working in a position that requires a medical license
02.) What is your race? Mark one or more boxes.	White
03.) Are you of Hispanic, Latina/o, or Spanish origin?	N
04.) Where did you complete your medical degree?	Another Country (not US)
05.) Where did you complete your residency training?	Indiana
06.) Which of the following best describes the area of practice in which you spend most of your professional time? Please select only one response.	Family Medicine/General Practice
07.) Do you use telehealth to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; 'telehealth' means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including: (1) secure videoconferencing; (2) interactive audio-using store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location)?	Y
08.) What is the street address of your primary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A"	7910 E Washington St
09.) In what city is your primary practice location? If this does not apply, please indicate "N/A"	Indianapolis
10.) In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A"	IN
11.) What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"	46219
12.) Which of the following categories best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable."	Office/Clinic – Single Specialty Group
13.) Estimate the average number of hours per week spent in direct patient care at your primary practice location. If this does not apply, please select "not applicable."	33 – 36 hours per week
14.) Estimate the percentage of Indiana Medicaid patients at your primary practice location. If this does not apply, please select "not applicable."	Indiana Medicaid accounts for 21% - 30% of my practice
15.) Are you accepting new Indiana Medicaid patients at any or all of your practice locations?	Y
16.) If you selected no on the previous question, but you are enrolled as an Indiana Medicaid provider, please describe barriers to participation. If this does not apply, please indicate "N/A".	N/A

17.) Estimate the percentage of patients on a sliding fee scale at your primary practice location. If this does not apply, please select "not applicable."	I do not offer a sliding fee scale
18.) What is the street address of your secondary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
19.) In what city is your secondary practice location? If this does not apply, please indicate "N/A".	N/A
20.) In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
21.) What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate "N/A".	N/A
22.) Which of the following categories best describes the practice setting at your secondary practice location? If this does not apply, please select "not applicable."	Not applicable
23.) Estimate the average number of hours per week spent in direct patient care at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
24.) Estimate the percentage of Indiana Medicaid patients at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
25.) Estimate the percentage of patients on a sliding fee scale at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
26.) What is the street address of your tertiary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
27.) In what city is your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
28.) In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
29.) What is the 5-digit ZIP code of your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
30.) Which of the following categories best describes the practice setting at your tertiary practice location? If this does not apply, please select "not applicable."	Not applicable
31.) Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
32.) Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
33.) Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
34.) Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purpose of this services list is to gather information on key health issues in Indiana) Please check all that apply.	None of the above
35.) Please indicate the population groups to which you provide services:	Newborns,Children (ages 2-10),Adolescents (ages 10-19),Adults,Geriatrics (Ages 65+),Disabled Individuals
36.) What are your employment plans for the next 2 years?	Continue as you are

STATE OF INDIANA
ONLINE RENEWAL RECORD

Renewal Submission Date:	September 20, 2021

Person Info

Name:	Sarah Elizabeth Spurgeon
License Number:	01085100B

Address Info

Street Address:	1338 North Grant Avenue
City:	Indianapolis
State:	IN
Zipcode:	46201
County:	Marion
Phone:	[redacted]
Email:	[redacted]

Question Response Summary

1.) Since you last renewed, has there been an occasion where you have not maintained effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels?	N
2.) Since you last renewed, has there been an occasion where you have not been in complete compliance with all state and local laws pertaining to controlled substances?	N
3.) Since you last renewed, have you been convicted, pled guilty, or pled nolo contendere, under any federal or state laws relating to any controlled substances that has not been expunged under IC 35-38-9?	N
4.) Since you last renewed, have you had any action, discipline, revocation, or surrender of your Drug Enforcement Registration or entered into any settlement or Memorandum of Understanding with respect to said registration?	N
5.) Since you last renewed, have you had any action, discipline, revocation, or surrender of any professional license in any jurisdiction related to controlled substances?	N

Survey Response Summary

STATE OF INDIANA
ONLINE RENEWAL RECORD

Renewal Submission Date:	June 10, 2019

Person Info

Name:	Sarah Elizabeth Spurgeon
License Number:	11019979A

Address Info

Street Address:	1338 North Grant Avenue
City:	Indianapolis
State:	IN
Zipcode:	46201
County:	Marion
Phone:	[redacted]
Email:	[redacted]

Question Response Summary

1) Since you last renewed, 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) or U.S. territory?	N
2) Since you last renewed, have you been disciplined or terminated by your residency or fellowship program or been suspended, or subject to any restriction, probation, or have you resigned in lieu of discipline or termination?	N
3) Since you last renewed, 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 or U.S. territory?	N
5) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
Citizenship Status: You should only indicate one 'Yes' response to the statement below.	
Pursuant to IC 12-32-15 and IC 12-32-1-6, I swear under the penalty of perjury that:	
I am a United States Citizen	Y
I am a Qualified Alien as defined under 8 U.S.C. 1641	N

Survey Response Summary

Where did you complete your medical degree?	Another Country (not listed)
Where did you complete your residency training?	Indiana
Which of the following best describes the area of practice in which you spend most of your professional time?	Family Medicine/General Practice
Do you use telemedicine to deliver services to patients located in Inidiana?	N
If located in Indiana, what is the county of your primary practice location? *If not located in Indiana enter 'NA'*	Marion
If located in Indiana, what is the zip code of your primary practice location? *If not located in Indiana enter '0'.*	46219
Which of the following categories best describes the practice setting at your primary practice location?	Other
Estimate the number of hours per week spent in direct patient care at your primary practice location.	41 or more hours per week
Estimate the percentage of Indiana Medicaid patients at your primary practice location.	Indiana Medicaid accounts for 31%-50% of my practice
Estimate the percentage of patients on a sliding fee scale at your primary practice location.	Sliding fee patients account for >0%-5% of my practice

STATE OF INDIANA
ONLINE RENEWAL RECORD

Renewal Submission Date:	May 28, 2020

Person Info

Name:	Sarah Elizabeth Spurgeon
License Number:	11019979A

Address Info

Street Address:	1338 North Grant Avenue
City:	Indianapolis
State:	IN
Zipcode:	46201
County:	Marion
Phone:	[redacted]
Email:	[redacted]

Question Response Summary

1) Since you last renewed, 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) or U.S. territory?	N
2) Since you last renewed, have you been disciplined or terminated by your residency or fellowship program or been suspended, or subject to any restriction, probation, or have you resigned in lieu of discipline or termination?	N
3) Since you last renewed, 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 or U.S. territory?	N
5) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
Citizenship Status: You should only indicate one 'Yes' response to the statement below.	
Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that:	
I am a United States Citizen	Y
I am a Qualified Alien as defined under 8 U.S.C. 1641	N

Survey Response Summary

01.) What is your employment status?	Actively working in a position that requires a medical degree
02.) What is your race? Mark one or more boxes.	White
03.) Are you Hispanic or Latino origin?	N
04.) Where did you complete your medical degree?	Another State (not listed)
05.) Where did you complete your residency training?	Indiana
06.) Which of the following best describes the area of practice in which you spend most of your professional time? Please select only one response.	Family Medicine/General Practice
07.) Do you use telemedicine to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; the delivery of health care services using electronic communications and information technology, including: secure videoconferencing, interactive audio-using store and forward technology, or remote patient monitoring technology between a provider in one (1) location and a patient in another location)?	Y
08.) What is the street address of your primary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A"	10122 E 10th St #100
09.) In what city is your primary practice location? If this does not apply, please indicate "N/A"	Indianapolis
10.) In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A"	IN
11.) What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"	46229
12.) Which of the following categories best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable."	Other
13.) Estimate the average number of hours per week spent in direct patient care at your primary practice location. If this does not apply, please select "not applicable."	41 or more hours per week
14.) Estimate the percentage of Indiana Medicaid patients at your primary practice location. If this does not apply, please select "not applicable."	Not applicable
15.) Are you accepting new Indiana Medicaid patients at any or all of your practice locations?	Y
16.) If you selected no on the previous question, but you are enrolled as an Indiana Medicaid provider, please describe barriers to participation. If this does not apply, please indicate "N/A".	N/A
17.) Estimate the percentage of patients on a sliding fee scale at your primary practice location. If this does not apply, please select "not applicable."	Not applicable
18.) What is the street address of your secondary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A

19.) In what city is your secondary practice location? If this does not apply, please indicate "N/A".	N/A
20.) In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
21.) What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate "N/A".	N/A
22.) Which of the following categories best describes the practice setting at your secondary practice location? If this does not apply, please select "not applicable."	Not applicable
23.) Estimate the average number of hours per week spent in direct patient care at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
24.) Estimate the percentage of Indiana Medicaid patients at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
25.) Estimate the percentage of patients on a sliding fee scale at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
26.) What is the street address of your tertiary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
27.) In what city is your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
28.) In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
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31.) Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
32.) Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
33.) Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
34.) Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.	Labor and delivery services,Pre-natal services
35.) Please indicate the population groups to which you provide services:	Newborns,Children (ages 2-10),Adolescents (ages 10-19),Adults,Geriatrics (ages 65+),Pregnant Women,Disabled Individuals,Individuals in recovery

Community
Health Network

Family Medicine Center
10122 E. 10th Street, Suite 100
Indianapolis, Indiana 46229

November 18, 2020

Indiana Professional Licensing Agency
402 West Washington Street, Room #W072
Indianapolis, IN 46204

Dear Board Members,

This letter is to accompany the application for permanent licensure for **Sarah Spurgeon, MD.** Dr. Spurgeon began her residency training with Community Health Network Family Medicine Residency Program on **July 1, 2018** and is currently a third year resident in good standing. Her anticipated date of completion for the residency program is **June 30, 2021**.

If you have any questions or need further information, please do not hesitate to contact me at 317-355-3210.

Sincerely,

Maurice Henein, MD
Program Director
East Family Medicine Residency Program
Community Health Network, Indianapolis

Ross University
School of Medicine

On the Nomination of the Faculty of the School of Medicine and by the Authority of the Board of Trustees we hereby confer upon

Sarah Elizabeth Spurgeon

the degree of

Doctor of Medicine

with all the Honors, Rights, and Privileges to that degree appertaining. In Witness Whereof the Seal of the University and the Signatures of the Chair, University Board of Trustees and Dean thereof are hereunto affixed. Given this thirty-first day of March in the year two thousand and eighteen.

Chair, University Board of Trustees

ROSS UNIVERSITY SCHOOL OF MEDICINE

William F. Owen
Dean & Chancellor

On this 18th day of November 2020, I certify that this document is a true, exact, complete, and unaltered photocopy of the original. Jeana Craft | Jeana Craft, Notary Public State of Indiana, County of Shelby Commission Expires 8/29/2028

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

State Form 29495 (R21 / 8-17)
Approved by State Board of Accounts, 2017

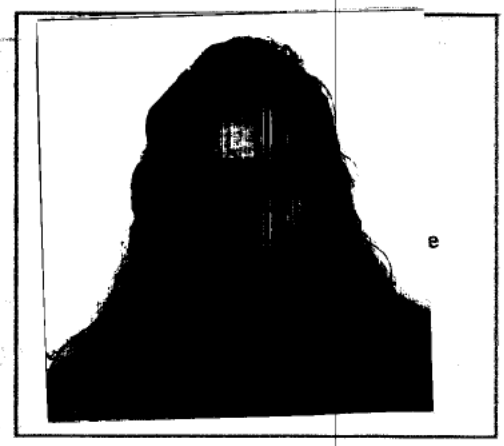
MEDICAL LICENSING BOARD OF INDIANA
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2060
E-mail: pla3@pla.IN.gov
www.pla.IN.gov

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*) 11-18-2020
Receipt number 82266061	Application number 3471346
License number	License issuance date (*month, day, year*)
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 *
Spurgeon, Sarah, E	☑ MD ☐ DO	[redacted]

Address of practice (*number and street or rural route*): 10122 E 10th St # 100

City, state, and ZIP code: Indianapolis, IN 46229

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

Mailing address (*number and street, city, state, and ZIP code*) *[if different from above]*: 1338 North Grant Avenue Indianapolis, IN 46201

E-mail address	National Provider Identifier number	ECFMG certificate number
[redacted]	1154810471	0-974-121-6

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*)
Ross University School of Medicine	Roseau, Dominica	05/19/2018
Specialties	**Board certification** (*list ABMS certification*)	
Doctor of Medicine	n/a	

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: _____

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	10/23/2015	✔		1
NBME Part III					USMLE Step II, CS	04/20/2017	✔		1
SPEX					USMLE Step II, CK	07/10/2017	✔		1
NBOME Part I					USMLE Step III	06/17/2019	✔		1

PRE-MEDICAL / OSTEOPATHIC EDUCATION

NAME OF SCHOOL	LOCATION	DATES ATTENDED (month, day, year)
University of Dayton	Dayton, Ohio	August 2005 - June 2009

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)
Ross University School of Medicine	Roseau, Dominica	January 2014 - January 2018

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA

(*Include ALL internships, residencies and / or fellowships*)

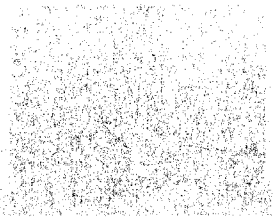
All programs must have been ACGME accredited at the time of enrollment.

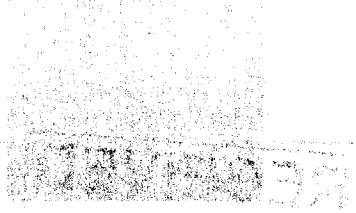
NAME OF PROGRAM	LOCATION	FROM (month, year)	TO (month, year)	ACGME / AOA / RC ACCREDITED?
Community Hospital East Family Medicine Residency	Indianapolis, Indiana	June 2018	June 2021	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL (If necessary, attach separate pages.)	
GENERAL LOCATION	DATE (month, day, year)
Vandalia, OH	January 2018 - June 2018
Indianapolis, IN	June 2018 - 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)
Community Hospital East Family Medicine Residency	Resident Physician	June 2018 - Present

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
IN	Medical Residency Permit - Temporary Permit	11019979A	06/01/2018	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 [redacted] f perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)
[redacted] MD	11/09/2020

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 [redacted] above statements and agree to same.

Signature of applicant	Date signed (*month, day, year*)
[redacted] MD	11/09/2020

RECEIVED
NOV 18 2020
Indiana Professional Licensing Agency