BEFORE THE MEDICAL LICENSING BOARD
OF INDIANA
CAUSE NO.: 95 MLB 0012

STATE OF INDIANA,)
)
Petitioner,)
)
v.)
)
DAVID M. DUNCAN, M.D.,)
License No. 01035275,)
)
Respondent.)

FILED

APR 03 1995

HEALTH PROFESSIONS
BUREAU

ORDER

Comes now the Medical Licensing Board of Indiana, (hereinafter "Board"), and hereby ORDERS David M. Duncan, M.D., (hereinafter "Respondent"), to submit to a complete psychiatric examination to be performed by:

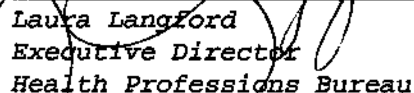
Rodney Deaton, M.D.
Gallahue Mental Health Center
6934 Hillsdale Court Bldg. #4
Indianapolis, Indiana 46250

This examination shall be performed at the expense of the Respondent. Respondent shall provide a written release to the examining physician and shall cause a report of the examination, including all examination notes, evaluations, tests, and prognoses, to be submitted directly to the Board and to the Office of the Attorney General within (30) days of the receipt by Respondent of this Order.

Respondent shall make full disclosure of the basis of this order and provide a copy of this order and the emergency suspension order to the examining physician.

So ORDERED this 3rd day of April, 1995.

MEDICAL LICENSING BOARD OF INDIANA

BY: 
Laura Langford
Executive Director
Health Professions Bureau

cc: *David M. Duncan, M.D.*
9462 West 1025 South
Fortville, IN 46040
CERTIFIED MAIL #Z025 765 566
RETURN RECEIPT REQUESTED

David M. Duncan, M.D.
Building 4
1700 E. 38th Street
VA Medical Center
Marion, IN 46953
CERTIFIED MAIL #Z025 765 567
RETURN RECEIPT REQUESTED

Amy Huffman Oliver
Office of the Attorney General
Indiana Government Center South
402 West Washington Street, Fifty Floor
Indianapolis, IN 46204-2770

Is your **RETURN ADDRESS** completed on the reverse side?

SENDER:
- Complete items 1 and/or 2 for additional services.
- Complete items 3, and 4a & b.
- Print your name and address on the reverse of this form so that we can return this card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit.
- Write "Return Receipt Requested" on the mailpiece below the article number.
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I also wish to receive the following services (for an extra fee):

1. ☐ Addressee's Address
2. ☐ Restricted Delivery

Consult postmaster for fee.

3. Article Addressed to:

David M. Duncan, M.D.
9462 West 1025 South
Fortville, IN 46040

4a. Article Number
Z 025 765 566

4b. Service Type
☐ Registered ☐ Insured
☒ Certified ☐ COD
☐ Express Mail ☐ Return Receipt for Merchandise

7. Date of Delivery

5. Signature (Addressee)
Kim B Duncan

6. Signature (Agent)
tlh Health Professions

8. Addressee's Address (Only if requested and fee is paid)

PS Form **3811**, December 1991 ☆U.S. GPO: 1993—352-714 **DOMESTIC RETURN RECEIPT**

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Receipt for Certified Mail

UNITED STATES POSTAL SERVICE

No Insurance Coverage Provided
Do not use for International Mail
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Sent to David M. Duncan, M.D.	
Street and No.	
P.O., State and ZIP Code	
Postage	$ .32
Certified Fee	1.10
Special Delivery Fee	
Restricted Delivery Fee	
Return Receipt Showing to Whom & Date Delivered	1.10
Return Receipt Showing to Whom, Date, and Addressee's Address	
TOTAL Postage & Fees	

, March 1993

Z 025 765 567

Receipt for Certified Mail

UNITED STATES POSTAL SERVICE

No Insurance Coverage Provided
Do not use for International Mail
(See Reverse)

Sent to David M. Duncan, M.D.	
Street and No.	
P.O., State and ZIP Code	
Postage	$ .32
Certified Fee	1.10
Special Delivery Fee	
Restricted Delivery Fee	
Return Receipt Showing to Whom & Date Delivered	1.10
Return Receipt Showing to Whom, Date, and Addressee's Address	
TOTAL Postage & Fees	$ 2.52
Postmark or Date	

800, March 1993

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☐ Registered ☐ Insured
☒ Certified ☐ COD
☐ Express Mail ☐ Return Receipt for Merchandise

7. Date of Delivery
APR 6 1995

5. Signature (Addressee)

6. Signature (Agent)
K JN

8. Addressee's Address (Only if requested and fee is paid)

PS Form **3811**, December 1991 ☆U.S. GPO: 1993—352-714 **DOMESTIC RETURN RECEIPT**

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