3 0 0 0 0 0 4 3 2 2 2

PAGE ONE

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.

B. The licensure and application fee are NOT refundable.

C. Disclosure of Social Security number is not mandatory. It is used only to ensure identification, accuracy and to expedite processing of your application.

D. If the name shown on your supporting documents is different from that shown on your application, you must submit proof of legal name change - copy of marriage license, divorce decree, affidavit or court order.

PART I: Application Category Information

A. SEE **REFERENCE SHEET, CHART I,** PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician	0 3 6	Endorsement	$ 300

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

☒ This is the first time I have made application for this profession in Illinois.

☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

☐ Other: _____

☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

02802 76

PART II: Applicant Identifying Information - You must notify the Department of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. SOCIAL SECURITY NUMBER
Jackson, Darwin Clinton	MD	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

[redacted]

5. [redacted]

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE D ABOVE) n/a

7. PLACE OF BIRTH CITY STATE/COUNTRY	8. DATE OF BIRTH	9. AGE
[redacted]		

10. [redacted]

Area Code Area Code

IL488-1018 9/94 (LT)

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 (12)

Graduated High School? ☒ Yes ☐ No

Received OR G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
John F. Kennedy HS	Cleveland, Ohio	6 / 68 (Month / Year)

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 (8)

Graduated? ☒ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	TO (Month/Year)	TYPE OF DEGREE EARNED
Ohio State Univ.	Columbus, Ohio	9/68	3/72	B.S.
Washington Univ Med Sch	St Louis, Mo	6/72	6/76	M.D.

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	TO (Month/Year)	Did You Complete Training?
Barnes Hospital	St Louis, Mo	7/76	7/80	☒ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure: Missouri	Physician	R 8089	9-8-77	active
State of Current Licensure where you most recently have been practicing: Missouri	"	"	"	"
Other States of Licensure				

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state, for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
National Bd. of Med. Examiners III	Mo.	9/76	Passed
NBME (part II)	"	9/75	"
" (part I)	"	9/74	"

(If additional space is needed, attach a separate sheet.)

PART VI: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		X
2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		X
3. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		X
4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		X
5. Are you a U.S. citizen OR a lawfully admitted alien of the United States?	X	

PART VII: Examination Coding Information *(This part is for Examination Applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes.

TEST CODES

b) CHART III - Select the examination site you desire and enter Test Center Code.

TEST CENTER CODE

c) CHART IV - Find your School of Graduation and enter school code.

SCHOOL CODE

d) Record the number of times you have taken this exam in Illinois or any other state.

EXAM ATTEMPTS

e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated? ☐ Yes ☐ No

PART VIII: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted]

Signature of Applicant

1-25-95

Date

My signature above authorizes the Department of Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

PRINTED BY THE AUTHORITY OF
THE STATE OF ILLINOIS
02-94/60,025/REQ.# X34469
PRINTED ON RECYCLED PAPER

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

0 9 6 7 1 9 2 2 4

Diplomate Name: Darwin Clinton Jackson, MD

Date of Birth: [redacted]

Certification Date: 07/01/1977

Certificate #: 167538

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME PART I	Jun 1974	[redacted]		PASS	[redacted]						

					Med	Surg	Ob/Gyn	PM/PH	Ped	Psych
NBME PART II	Sep 1975			PASS	[redacted]					
NBME PART III	Mar 1977			PASS						

DATE: 06/21/1995

SEE OTHER SIDE FOR SCORE INFORMATION

JUN 27 1995

IL0915

This [illegible] may include scores for Step 1, Step 2, [illegible] Medical Licensing Examination (USMLE). The USMLE is established by the Federation [illegible] NBME [illegible] NBME was a logic [illegible] consisting of three Step [illegible] Examination [illegible] and the NBME Parts I, II and III. The NBME [illegible] Part I [illegible] plus Part II or Step 2 plus Part III or Step 3 [illegible] the examination requirements [illegible] NBME Parts [illegible] USMLE Steps [illegible] NBME. Scores for physicians who pass Steps [illegible] and [illegible] USMLE.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

The most recent [illegible] and subject [illegible] are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subject scores on a Part. Scores are on a three-digit scale with a mean of 500 and a standard deviation of 100 (increments of 5).

NBME Part I and Part II Examinations June 1991 and Thereafter

[illegible] three-digit scale with a mean of 500 and a standard deviation of 25 (increments of 1).

USMLE Step 1, Step 2 and Step 3

The complete [illegible] are reported. A total test score is reported [illegible] with a mean of [illegible] and a standard deviation of [illegible] (increments of 1).

All NBME Part III Examinations

The most recent [illegible] are reported. This score is on a three-digit scale with a mean of 500 and a standard deviation of [illegible] (increments of [illegible]).

Two-Digit Scores

For all examinations [illegible] scale score or a two-digit score [illegible]. The scale score ranges from 1 to 72 and the minimum passing [illegible] 70. Scale scores are reported in increments of [illegible].

EXPLANATION OF COMMENTS

[illegible] USMLE [illegible] Step 3 [illegible] 1991 [illegible]

If you wish to obtain further information about individual examinees who have [illegible] under Comments, please write the NBME [illegible] Licensing Examination Service [illegible]

Indeterminable — Results that cannot be combined or interpreted as a valid reflection of the examinee's knowledge in [illegible] required for the examination. Decisions to classify results as indeterminable may be made on the basis of factors that include, but are not limited to, irregularity or performance [illegible] between the examinee's scores on the same Steps. **No score is reported.**

Incomplete — The examinee did not sit for one or all of the scheduled test blocks. **No score is reported.**

Irregular Behavior — The USMLE Committee has frequently [illegible] information that the examinee engaged in irregular behavior. Irregularities include those as described in the [illegible] *USMLE Bulletin of Information*. If determined, the [illegible] of the irregular behavior. The examinee's score may be withheld or invalidated, and the examinee's [illegible] may be requested by writing to the USMLE Secretariat [illegible]

Score Not Available — Score is not available pending further review and analysis.

Testing Accommodations — Testing accommodations are approved [illegible] the examinee's testing accommodations were [illegible] the administration of the examination.

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WORK HISTORY

0 9 3 7 1 2 2 2 4

SUPPORTING DOCUMENT

WH

APPLICANT: *Complete Work History. If you have never been employed you may stop at box 8. You are authorized to photocopy this form if additional space is required.*

1. NAME LAST FIRST MIDDLE: Jackson, Darwin Clinton
2. DATE OF BIRTH: [redacted]
3. SOCIAL SECURITY NUMBER: [redacted]
4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted]
5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
   Profession Name: Physician
   Profession Code: 0 3 6
6. MAIDEN OR GIVEN SURNAME: n/a
7. CHECK HERE IF YOU HAVE **NEVER** BEEN EMPLOYED ☐
8. DATE FORM COMPLETED: 1-25-95

9. RECORD WORK HISTORY CHRONOLOGICALLY - *Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.*

A. NAME OF BUSINESS/INSTITUTION: Ob-Gyn Specialties

ADDRESS STREET, CITY, STATE, ZIP CODE: 201 Dunn Rd, Suite A, Florissant, Mo. 63031-7928

SUPERVISOR NAME: n/a

DATE OF EMPLOYMENT/ATTENDANCE
From 0 8 / 0 1 / 8 4 (Month Day Year)
To Present (Month Day Year)

HOURS WORKED PER WEEK: 40 +

TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Yr./Mo.): 10 yrs

JOB TITLE: Physician / Owner

DESCRIPTION OF DUTIES PERFORMED: Private practice in Ob-Gyn including surgery, office visits, & managing the practice

B. NAME OF BUSINESS/INSTITUTION: Jonathan Reed, MD

ADDRESS STREET, CITY, STATE, ZIP CODE: 100 N. Euclid, Suite 400, St Louis, Mo 63108

SUPERVISOR NAME: Jonathan Reed, MD

DATE OF EMPLOYMENT/ATTENDANCE
From 0 7 / 0 1 / 8 0 (Month Day Year)
To 0 7 / 3 1 / 8 4 (Month Day Year)

HOURS WORKED PER WEEK: 40 +

TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Yr./Mo.): 4 yrs

JOB TITLE: Physician

DESCRIPTION OF DUTIES PERFORMED: Private practice in Ob-Gyn

IL486-1071 6/93 (LT-A)

COMPLETE THE REVERSE SIDE OF THIS FORM

C. NAME OF BUSINESS/INSTITUTION		JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME		
DATE OF EMPLOYMENT/ATTENDANCE From __ __ / __ __ / __ __ Month Day Year To __ __ / __ __ / __ __ Month Day Year	HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Yr./Mo.)		

D. NAME OF BUSINESS/INSTITUTION		JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME		
DATE OF EMPLOYMENT/ATTENDANCE From __ __ / __ __ / __ __ Month Day Year To __ __ / __ __ / __ __ Month Day Year	HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Yr./Mo.)		

E. NAME OF BUSINESS/INSTITUTION		JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME		
DATE OF EMPLOYMENT/ATTENDANCE From __ __ / __ __ / __ __ Month Day Year To __ __ / __ __ / __ __ Month Day Year	HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Yr./Mo.)		

Universitas Washingtoniana

SANCTI LUDOVICI

IN CIVITATE MISSOURIENSI.

Omnibus ad quos hae Literae pervenerint, Salutem in Domino sempiternam:

Nos Praeses et Socii Universitatis Washingtonianae ex commendatione Cancellarii honorandi Professorumque eruditorum in Comitiis sollemnibus,

Darwin Clinton Jackson

alumnum pro meritis ad gradum

Medicinae Doctoris

admisimus eique dedimus et concessimus insignia et jura omnia ad hunc honorem spectantia.

In cujus rei Testimonium *literis hisce Universitatis sigillo munitis, teste Secretario, die Maii* XXI *Anno Domini* MCMLXXVI *et Reipublicae Americanae* CC.

Nos pro auctoritate nobis commissa nomina subscripsimus.

William H. Danforth
Cancellarius

M. K. King
Decanus

Charles Allen Thomas
Praeses Provisorius

Mel M. Huntsinger
Secretarius

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATION BY LICENSING AGENCY/BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: *Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. You are authorized to photocopy this form as necessary.*

1. NAME (LAST, FIRST, MIDDLE): Jackson, Darwin Clinton

2. DATE OF BIRTH: [redacted]

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted]

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application

Physician — Profession Name

0 3 6 — Profession Code

6. MAIDEN OR GIVEN SURNAME: n/a

7. APPLICANT TELEPHONE NUMBER (Daytime): Area Code [redacted]

7a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable): Physician and Surgeon

7b. LICENSE NUMBER (If applicable): K8089

7c. ISSUANCE DATE OF LICENSE (If applicable): 9-8-77

I hereby authorize State Bd of registration for healing arts (Name of Licensing Agency/Board) to furnish to the Illinois Department of Professional Regulation or its designated testing service, the information requested below.

Signature [redacted] Date 1-25-95

RECEIVED STATE OF ILLINOIS APR 3 1995 DEPARTMENT OF PROFESSIONAL REGULATION

DO NOT RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: *The Illinois Department of Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.*

PART I. - CERTIFICATION OF EXAMINATION STATUS

A. The applicant ☐ has written ☐ is scheduled to write the following examination:

_____ Name of Examination _____ Date of Examination

B. The applicant has or will have written the above-named examination _____ number of times.

PART II. - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE: Darwin C. Jackson, M.D.

B. LICENSE NUMBER: MDR8089

C. ISSUANCE DATE OF LICENSE: 9-8-77

D. EXPIRATION DATE OF LICENSE: 1/31/95

E. LICENSURE METHOD

- ☒ Examination (Administered in Your State)
  - ☐ National (Name) _____
  - ☐ State Constructed _____
  - ☐ Other (Name) _____
- ☐ Endorsement of License (State) _____
- ☐ Acceptance of Examination Results (Administered in Another State) _____
- ☐ Reciprocity with (State) _____
- ☐ Waiver/Grandfather
- ☐ Credentials
- ☐ Other (Describe) _____

F. CURRENT LICENSURE STATUS

- ☐ Active
- ☒ Inactive exp 1/31/95
- ☐ Lapsed
- ☐ Other (Explain) _____

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination	Score
Written	
Practical	
Other (Describe)	
Received no Grade Below	
Examination Period ___days ___ hours	

ILA86-0850 7/94 (LT)

Complete the Reverse side of this Form

PART III. - CERTIFICATION OF EXAMINATION SCORES

A. National or other Profession Specific Examination
(Record all available information)

Date of Examination _____

Scaled Score		Raw Score	
Standard Deviation		Corrected Score	
National Mean		Percent Score	

2.

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV. - FORMAL ACTIONS

A. Is there now or has there ever been any formal action commenced against the applicant? ☐ Yes ☒ No

B. Has there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? **(If yes, attach a certified copy of disciplinary action.)** ☐ Yes ☒ No

PART V. - RECIPROCAL REGISTRATION

This state ☒ does ☐ does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

Susie Wekenborg
Print Name

Licensure Technician
Title

[redacted]
Signature

SEAL

Missouri Bd of Healing Arts
Agency/Board Street Address

3-29-95
Date

3605 Mo. Blvd., Jefferson City, MO 65102
City, State, ZIP Code

Area Code [redacted]
Telephone Number

IL486-0850 7/94 (LT)

RETURN TO: Department of Professional Regulation
320 West Washington, L&T1
Springfield, Illinois 62786

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CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

0 9 4 7 1 8 2 2 4

APPLICANT: *Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.*

1. NAME LAST FIRST MIDDLE: Jackson, Darwin Clinton

2. DATE OF BIRTH: [redacted]

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted]

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

Physician — Profession Name

236 — Profession Code

6. [redacted] MAIDEN SURNAME: n/a

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)

8. ISSUANCE DATE

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 62791

This is to certify that the above-named applicant satisfactorily completed 48 months of postgraduate clinical training in Washington University/Barnes Hospital Program in Obstetrics and Gynecology
(Name of Accredited Postgraduate Clinical Training Program)

from 7/1/76 to 6/30/80 at the following hospital:

Hospital: Barnes Hospital

Number and Street: 4911 Barnes Hospital Plaza

City, State and Zip Code: St. Louis, Missouri 63110

RECEIVED STATE OF ILLINOIS APR 6 1995 PROFESSIONAL REGULATION

I further certify that at the time of such training the program was accredited by:

- [x] the Accreditation Council for Graduate Medical Education;
- [ ] the Accreditation Council on Canadian Graduate Medical Education; or
- [ ] the American Osteopathic Association

Name of Postgraduate Clinical Training Program Director: JAMES R. SCHREIBER, M.D.

Signature of Postgraduate Clinical Training Program Director: [signature]

Date of this Certification: 3/30/95

SEAL

Telephone No: (314) 362-7139

IL486-1535 4/94 (MD)

APR 18 1995

WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

St. Louis, Missouri 63110

OFFICIAL TRANSCRIPT

NAME: Jackson, Darwin Clinton DATE

ENTERED THIS MEDICAL SCHOOL [redacted]

SOCIAL SECURITY NUMBER

PRESENT STATUS:

PRESENTLY ENROLLED

WITHDREW

WAS GRADUATED, M. D. DEGREE CONFERRED ON May 21, 1976

MEDICAL REGISTRATION

YEAR	SESSION
First	9/5/72 to 5/25/73
Second	9/4/73 to 5/30/74
Third	6/10/74 to 5/24/75
Fourth	6/9/75 to 5/20/76 (36 weeks of attendance required during this period)

INTERPRETATION OF GRADING SYSTEM

"Honors" is given for a truly outstanding performance; "High Pass" for very good work; and "Pass" for the remaining passing grades.

H = Honors, HP = High Pass; P = Pass; F = Fail
I = Incomplete W = Withdrawal
DF = Deferred NG = Non Graded

Jackson, Darwin Clinton

ELECTIVE YEAR

Type	Department	Course Title	Duration	Mark
A	Int. Med.	Topics in Laboratory Medicine 1973-74	6 weeks	[redacted]
A	Int. Med.	Electrocardiography	6 weeks	
B	Int. Med.	Cardiology, Barnes Hospital	6 weeks	
B	Int. Med.	Honors Medicine, Barnes Hospital	6 weeks	
B	Radiology	Radiology, Mallinckrodt	6 weeks	
B	Int. Med.	Clinical Infectious Diseases	6 weeks	
B	Pediatrics	Combined Pediatric and Adult Metabolism	6 weeks	
B	Anatomy	Advanced Dissection	6 weeks	

"A" electives are "seminar" courses scheduled two to four hours a week for 12 or 18 weeks. Each student must complete at least two of these to be graduated. "B" electives include advanced clerkships in any of the clinical departments, research in any department, and other special full-time courses.

Clinical Year: TITLE OF COURSE OR SUBJECT	Mark Assigned
Surgery (Clerkship and Lectures)	[redacted]
Psychiatry (Clerkship and Lectures)	
Neurology (Clerkship and Lectures)	
Medicine (Clerkship, Lectures, & Clinical Pathological Conferences)	
Obstetrics & Gynecology (Clerkship and Lectures)	
Pediatrics (Clerkship and Lectures)	
Otolaryngology (Clerkship and Lectures)	
Ophthalmology (Clerkship and Lectures)	

Total Registrants	H	HP	P	NG	F	I	W	Au	Df
[redacted]									

WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

AT WASHINGTON UNIVERSITY MEDICAL CENTER

OFFICE OF THE DEAN
ACADEMIC ADMINISTRATION

ASSISTANT DEAN
REGISTRAR
SECRETARY TO THE EXECUTIVE FACULTY

Box 8021
660 South Euclid Avenue
St. Louis, Missouri 63110
(314) 362-6848

To Whom It May Concern

THIS TRANSCRIPT IS ISSUED TO Illinois Dept of Professional Regulation

(Page _____ of 2 pages).

Unless the face of the transcript is stamped otherwise, the student is in good standing.

MAR 2 4 [illegible]

Official with [illegible]
Dr. John L. Schultz, Registrar
Washington University
School of Medicine - St. Louis

TRANSCRIPT NOMENCLATURE

Each Washington University School of Medicine course enrollment entry is preceded by the year designation YR followed by the last two digits of the academic year in which the course was taken or begun (e.g., YR78: the academic year 1978-79). After the year designation, the following is indicated respectively: Department number; Department name, Course number, Units of credit associated with the course; Grade; and Course title. The symbol "AS" (Advanced Standing) to the left of an entry indicates credit granted by Washington University School of Medicine on the basis either of transfer from another institution or by examination. The Washington University School of Medicine equivalent course is indicated followed by the units of credit granted. The source of the credit appears at the end of the entry.

CREDIT

As reported to the Liaison Committee on Medical Education, representing the Council on Medical Education of the American Medical Association and the Executive Council of the Association of American Medical Colleges, credit hours for courses are expressed in terms of clock hours—the scheduled hours per year of actual lecture and laboratory contact between faculty and students. These clock hours are not to be interpreted as semester or quarter hours. A full time student in the medical curriculum at Washington University School of Medicine attends an average of 38.5 clock hours per week.

GRADING SYSTEM

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Member Washington University Medical Center

WASHINGTON UNIVERSITY

SCHOOL OF MEDICINE

COMMITTEE ON ADMISSIONS

OFFICE OF ACADEMIC RECORDS AND ADMISSIONS

[illegible] SOUTH KINGSHIGHWAY AVENUE

ST. LOUIS, MISSOURI [illegible]

Jackson — LAST NAME

Darwin — FIRST

Clinton — MIDDLE

SOCIAL SECURITY NUMBER [redacted]

First Academic Year: 1972-73	Mark Assigned	Total Registrants	H	HP	P	NG	F	I	W	Au	Df
TITLE OF COURSE OR SUBJECT											
Gross Anatomy	[redacted]										
Biochemistry											
Microbiology											
Social Aspects of Medicine									1		
Microscopic Anatomy											
Neural Sciences											
Physiology											
Biostatistics									2		
Genetics											
Topics in Clinical Medicine											

Second Academic Year: 1973-74	Mark Assigned	Total Registrants	H	HP	P	NG	F	I	W	Au	Df
TITLE OF COURSE OR SUBJECT											
Pathology	[redacted]										
Pathophysiology (including Laboratory Medicine and Epidemiology)											
Pharmacology											
Clinical Diagnosis											
Physical Diagnosis											
Radiology Lectures											
Psychiatry Lectures											
Surgery Lectures											
Pediatrics Lectures											
Obstetrics and Gynecology Lectures											
Ophthalmology Lectures											
Otolaryngology Lectures											

WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

AT WASHINGTON UNIVERSITY MEDICAL CENTER

OFFICE OF THE DEAN
ACADEMIC ADMINISTRATION

ASSISTANT DEAN
REGISTRAR
SECRETARY TO THE EXECUTIVE FACULTY

Box 8021
660 South Euclid Avenue
St. Louis, Missouri 63110
(314) 362-6848

THIS TRANSCRIPT IS ISSUED TO Illinois Dept of Professional Regulation

(Page 2 of 2 pages)

Unless the face of the transcript is stamped otherwise, the student is in good standing

APR 1 - 1998

MAR 9 1998

Office with Professional
Licensure Responsibility
Washington University
School of Medicine - St. Louis

TRANSCRIPT NOMENCLATURE

Each Washington University School of Medicine course enrollment entry is preceded by the year designation YR followed by the last two digits of the academic year in which the course was taken or begun (e.g., YR78: the academic year 1978-79). After the year designation, the following is indicated respectively: Department number; Department name; Course number; Units of credit associated with the course; Grade; and Course title. The symbol "AS" (Advanced Standing) to the left of an entry indicates credit granted by Washington University School of Medicine on the basis either of transfer from another institution or by examination. The Washington University School of Medicine equivalent course is indicated followed by the units of credit granted. The source of the credit appears at the end of the entry.

CREDIT

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STATE OF ILLINOIS
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Member Washington University Medical Center

Resident

JACKSON, DARWIN CLINTON
Name

Permanent Student Number

CLEVELAND, CUYAHOGA COUNTY, OHIO [redacted] LOUISVILLE, KENTUCKY
Address — Place of Birth

DARWIN C. JACKSON — CLEVELAND, OHIO [redacted]
Parent, Guardian, or Spouse — Address

THE OHIO STATE UNIVERSITY
COLUMBUS, OHIO
OFFICE OF THE REGISTRAR

ARTS AND SCIENCES

Entered SEPT.25,1968
Graduated March 1972
Degree B.S. (cum laude)

Admission Information

CLEVELAND, OHIO, JOHN F. KENNEDY HIGH SCHOOL, JUNE 1968.

Title of Course	Department	Course Number	Cr. Hrs.	Grade	Pts.
AUTUMN QUARTER 1968					
GENERAL CHEMISTRY	CHEM	121	[redacted]		
COMPOSITION & RDG	ENGLISH	101			
COMPOSITION & RDG	ENGLISH	102			
COMPOSITION & RDG	ENGLISH	103			
ALGEBRA & TRIG	MATH	150			
CALC & ANALYT GEOM	MATH	151†			
GENERAL PSYCHOLOGY	PSYCH	100			
ORIENTATION	ARTS SRV	001			
REQUIRED	PHYS ED	101			
2.947	19	56	30	2.947	
WINTER QUARTER 1969					
GENERAL CHEMISTRY	CHEM	122			
W CIV 1815-PRESENT	HISTORY	102			
CALC & ANALYT GEOM	MATH	152			
HYGIENE	HLTH EDU	101			
REQUIRED	PHYS ED	102			
3.000	36	108	47	3.058	
SPRING QUARTER 1969					
GENERAL BIOLOGY	BIOLOGY	100			
GENERAL CHEMISTRY	CHEM	123			
INTRO W EUROP LIT	COMP LIT	103†			
TYPES	PHILOS	100			
REQUIRED	PHYS ED	103			
3.226	53	171	64	3.705	
AUTUMN QUARTER 1969					
INTRO SHAKESPEARE	ENGLISH	220			
INTERMEDIATE	FRENCH	103			
MECHANICS & HEAT	PHYSICS	111			
GENERAL PSYCHOLOGY	PSYCH	101			
3.301	73	241	84	3.500	

Title of Course	Department	Course Number	Cr. Hrs.	Grade	Pts.
WINTER QUARTER 1970					
INTERMEDIATE	FRENCH	104	[redacted]		
HONORS PROSEM U S	HISTORY	H599.01†			
ELEC MAGNETSM & LT	PHYSICS	112			
GENERAL ZOOLOGY	ZOOLOGY	101			
3.363	88	296	102	3.666	
SPRING QUARTER 1970					
MODERN PHYSICS	PHYSICS	113			
VRITES MOD MARRIGE	SOCIOL	530			
INTRO TO THEATRE	THEATRE	165			
COMP VERT ANATOMY	ZOOLOGY	234			
3.396	101	343	120	3.615	
AUTUMN QUARTER 1970					
INTRO OF ECOLOGY	BIOLOGY	313			
ORGANIC CHEMISTRY	CHEM	241			
ORGANIC CHEM LAB	CHEM	243			
FUNDAMENTALS	SOCIOL	201			
3.384	117	356	136	3.338	
WINTER QUARTER 1971					
PERSONAL FINANCE	BUS ADM	220			
ORGANIC CHEMISTRY	CHEM	242			
ORGANIC CHEM LAB	CHEM	244			
PRINS OF HEREDITY	GENETICS	314			
3.450	131	452	150	4.000	
SPRING QUARTER 1971					
THE ECONOMIC SYSTM	ECON	201			
INFORMATIVE WRITNG	ENGLISH	301			
GROUP STUDIES	PHARMACY	694			
VERTEBRATE EMBRYOL	ZOOLOGY	430			
3.523	151	532	170	4.000	

APR 19 1999

(OVER)

THE OHIO STATE UNIVERSITY

TRANSCRIPT KEY

RELEASE OF INFORMATION

This transcript cannot be released to another person, agency or organization except to officials internal to your own organization or agency who have been determined by you to have a legitimate interest and need. Release to other parties requires written consent of the student or former student, as the case may be. These instructions are in accordance with the Family Educational Rights and Privacy Act of 1974 as Amended.

TRANSCRIPT AUTHENTICITY

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- Transcripts for most students last enrolled since Autumn Quarter 1985 will be laser printed from our automated records system in printed format. A transcript will be official when it bears the facsimile signature of the university registrar and the university seal in black ink. If the transcript was issued to the student, the message "Issued to Student" will appear under the Registrar's signature. The transcript form will print in red and will incorporate a background design of the university seal.
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ACCREDITATION

The Ohio State University (Columbus, Lima, Mansfield, Marion, Newark and the Agricultural Technical Institute, Wooster, Ohio) is accredited by the North Central Association of Colleges and Secondary Schools as a degree-granting institution at the associate, baccalaureate, masters, professional and doctoral levels.

CALENDAR

- The quarter system replaced the semester system in Autumn Quarter 1922 university wide.
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GOOD STANDING/PROBATION/DISMISSAL

To remain in good standing a student must maintain a 2.0 point hour ratio. Probation is formal notice that a judgement on the dismissal of a student will be made the subsequent quarter based on satisfactory progress that quarter. Students may be placed on probation by accumulating a deficiency of 15 or more credit points below that required for a 2.0 point hour ratio or by special action of the college when preparation, progress or the success with their Academic Program is determined to be unsatisfactory. When students do not make satisfactory progress in meeting the conditions placed by the college or school probation, they are dismissed. Dismissed students are ineligible to reenroll until reinstated by any college or school.

COURSE NUMBERING SYSTEM

(Established September 1967 - Revised January 1975)

000-099 Non-Credit Courses (except certain seminars and colloquia) for orientation, remedial, or other noncollege level experiences. Credit is added to Graduation Requirements.

100-199 Basic Courses providing Undergraduate Credit, but not to be counted on a major or field of specialization in any department. Beginning Courses. Required or Elective Courses that may be prerequisite to other courses.

200-299 Basic Courses providing Undergraduate Credit and may be counted on a major or field of specialization.

300-499 Intermediate Courses providing Undergraduate Credit or Basic Professional Credit that may be counted on a major or field of specialization.

500-599 Intermediate Courses providing Undergraduate or Professional Credit that may be counted on a major or field of specialization and may provide Graduate Credit only in other departments.

600-699 Courses providing Undergraduate or Professional Credit that may be counted on a major or field of specialization, and may provide Graduate Credit (in all departments).

700-799 Advanced Courses providing Undergraduate, Graduate, or Professional Credit.

800-999 Courses providing Graduate Credit and are open to undergraduates only with the consent of the Vice Provost for Research and Dean of the Graduate School.

OFFICIAL MARKING AND GRADING SYSTEM

A	Excellent	4.0 Pts.	EM	Examination Credit	0 Pts.
A-	Excellent	3.7 Pts.	K	Transferred Credit	0 Pts.
B+	Above Average	3.3 Pts.	I	Incomplete	0 Pts.
B	Above Average	3.0 Pts.	P	Progress	0 Pts.
B-	Above Average	2.7 Pts.	PA	Pass	0 Pts.
C+	Average	2.3 Pts.	NP	Non-Pass	0 Pts.
C	Average	2.0 Pts.	R	Registered to Audit	0 Pts.
C-	Average	1.7 Pts.	S	Satisfactory	0 Pts.
D+	Poor	1.3 Pts.	U	Unsatisfactory	0 Pts.
D	Poor	1.0 Pts.	W	Withdrew	0 Pts.
E	Failure	0 Pts.			

Plus and minus values were added to the grading system Winter Quarter 1978. # notation denotes a course involved in the substitution of marks rule - see recalculation of averages per Faculty Rule.

PAST GRADE NOTATIONS NO LONGER IN EFFECT

E Abs	Failed Absent	0 Pts.	(Summer 1922-Summer 1955)
F	Failed Absent	0 Pts.	(Summer 1955-Autumn 1958)
H	Honors (Medicine Only)	0 Pts.	(Autumn 1963-Summer 1973)
INC	Incomplete	0 Pts.	(Summer 1922-Summer 1955)
N	None Required	0 Pts.	(Summer 1955-Autumn 1958)
R	Final mark reported at end of sequence	0 Pts.	(Summer 1956-Autumn 1958)
T	Temporarily excused	0 Pts.	(Summer 1955-Summer 1973)
U	Audit	0 Pts.	(Summer 1955-Autumn 1958)
WF	Withdrew failing	0 Pts.	(Summer 1970-Summer 1973)
WP	Withdrew passing	0 Pts.	(Summer 1970-Summer 1973)
X	Permanently excused	0 Pts.	(Summer 1955-Summer 1973)

Office of the University Registrar
Transcript Division
320 Lincoln Tower
1800 Cannon Drive
Columbus, Ohio 43210-1233
Telephone: 614-292-8500

UNIVERSITY CLASS RANKING SYSTEM

(effective Summer Quarter 1975)

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RANK	EARNED HOURS
Freshman	0 through 44
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TECHNICAL CREDIT: A "T" prefix indicates a technical course which is part of a two year technical program. Some credit may be transferred to a baccalaureate degree (effective September 1972).

RECALCULATION OF AVERAGES PER FACULTY RULE

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CUMULATIVE INFORMATION RECALCULATED PER FACULTY RULE 3335-7-261: An undergraduate who re-enrolls in the University after an absence of five or more years may petition to have his/her point hour ratio recalculated. If the petition is approved, the student resumes his academic program with no cumulative point hour ratio. All courses taken will remain on the permanent record but only courses with marks of "A", "A-", "B+", "B", "B-", "C+", "C", "C-", "EM", "K", "PA", OR "S" will be allowed toward degree requirements and count in the total hours earned (effective June 1979). A graduate student who re-enrolls in the Graduate School after an absence of five or more years may petition that previous graduate credit not be counted toward the total earned hours and graduate cumulative point hour ratio. No previous credit hours count in the student's total earned hours, averages, or apply toward graduation requirements; and no previous grades are computed in the student's graduate cumulative point hour ratio. All previous courses taken and grades earned in the Graduate School remain on the student's official permanent record (effective September 1981).

Name JACKSON, DARWIN CLINTON

Major: Zoology

Warned by Dean for Low Scholarship

Academic Dismissal

MAY 15 1973

Reinstated

Title of Course	Department	Course Number	Cr. Hrs.	Grade	Pts.
AUTUMN QUARTER 1971					
GEN CELLULAR BIOL	BIOLOGY	640	[redacted]		
MICROBIOL REL MAN	MICRBIOL	509			
AM MINORTY RELATNS	SOCIOL	280			
3.533 165 583 184		3.642			
WINTER QUARTER 1972					
INTRO TO BIOL CHEM	BIOCHEM	511			
CRIMINOLOGY	SOCIOL	410			
ANIMAL PARASITES	ZOOLOGY	610			
3.557 174 619 198		4.000			

Title of Course	Department	Course Number	Cr. Hrs.	Grade	Pts.

0 0 9 5 7 1 9 0 2 2 4

Transcripts Issued

JUL 15 1971 SEP 16 [redacted] NOV 12 1971 MAY 19 1972 JUN 1 [redacted]

REMARKS

THE OHIO STATE UNIVERSITY

TRANSCRIPT KEY

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DARWIN CLINTON JACKSON

STUDENT ID: 295-48-1928

PRINTED: 03/31/95

0 9 5 7 1 9 2 2 4

********** NO ENTRIES BELOW THIS LINE *********

ILLINOIS DEPARTMENT OF
PROFESSIONAL REGISTRATION
P.O. BOX 7007
SPRINGFIELD, IL 62791

Hardcopy Record Copy
Attached

RECEIVED
STATE OF ILLINOIS
APR 6 1995
DEPARTMENT OF
PROFESSIONAL REGULATION

APR 19 1995

Application No. _____ Prof. Code _____ SSN/FEIN

or Label Space: 0 9 5 7 1 2 0 2 2 4

APPLICATION REVIEW FINDINGS

AMF 2

1. DATE: 05/01/95
2. EMPLOYEE: 0307
3. PERSONAL HISTORY: _____ (Y OR N)
4. STATUS: 1
5. DEFICIENCIES - ADD: _____
   CLEAR: 021, 093, 099
6. LAST CORRESPONDENCE RECEIVED DATE: __/__/__
7. LAST CORRESPONDENCE SENT DATE: 05/01/95
8. IL APPRENTICE TRAINING LICENSE NO.: _____

EDUCATION INFO:

9. School Name _____
10. School Code _____ 11. Foreign School _____ (Yes or No) 12. Date Graduated __/__/__
13. City/County School Located _____ 14. State School Located _____

RECIPROCITY INFO:

15. Original Licensure State _____ 16. Licensure Date ____/____ (Month / Year)
17. Current Licensure State _____ 18. Licensure Date ____/____ (Month / Year)
19. No. of States Licensed In _____

ACCEPTANCE OF EXAM INFO:

20. Who Gave Exam _____ 21. Examination Date __/__/__
22. Grades: 23. No. of Times Exam Taken: _____

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____

MISC. INFO:

24. Related License No.:

1. _____ D___ 2. _____ D___ 3. _____ D___ 4. _____ D___

25. License Specialty Code _____ 26. Bond Insurance Expire Date __/__/__
27. Agency Manager Name _____ 28. Telephone No. _____
29. Renewal Fee Exempt _____ 30. Experience Requirement Complete _____

LICENSE ASSIGNMENT INFO:

31. Original IL License No. _____ 32. Issuance Date __/__/__

ILA86-1323 12/92 (LT)

Application No. _____ Prof. Code _____ SSN/FEIN

or Label Space: 0 9 5 7 1 2

APPLICATION REVIEW FINDINGS

2 2 4

AMF 2

1. DATE: 4/10/95

3. PERSONAL HISTORY: _____ (Y OR N)

2. EMPLOYEE: 0317

4. STATUS: 1

5. DEFICIENCIES - ADD: 01, 03, 02, 04

6. LAST CORRESPONDENCE RECEIVED DATE: __/__/__

CLEAR: _____

7. LAST CORRESPONDENCE SENT DATE: 4/2/95

8. IL APPRENTICE TRAINING LICENSE NO.: _____

EDUCATION INFO:

9. School Name _____

10. School Code _____ 11. Foreign School _____ (Yes or No) 12. Date Graduated __/__/__

13. City/County School Located _____ 14. State School Located _____

RECIPROCITY INFO:

15. Original Licensure State _____ 16. Licensure Date ____/____ (Month / Year)

17. Current Licensure State _____ 18. Licensure Date ____/____ (Month / Year)

19. No. of States Licensed In _____

ACCEPTANCE OF EXAM INFO:

20. Who Gave Exam _____ 21. Examination Date __/__/__

22. Grades: 23. No. of Times Exam Taken: _____

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____

MISC. INFO:

24. Related License No.:

1. _____ D ___ 2. _____ D ___ 3. _____ D ___ 4. _____ D ___

25. License Specialty Code _____ 26. Bond Insurance Expire Date __/__/__

27. Agency Manager Name _____ 28. Telephone No. _____

29. Renewal Fee Exempt _____ 30. Experience Requirement Complete _____

LICENSE ASSIGNMENT INFO:

31. Original IL License No. _____ 32. Issuance Date __/__/__

IL456-1323 12/92 (LT)

Profession: 036

Date: 4/10/95 Initials: RP

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

Darwin C. Jackson, M.D.
[redacted]9 5 7 1 2

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

	1. Submit the required fee of $_____ made payable to the Department of Professional Regulation. This fee is not refundable.
	2. Your application is being returned for completion of Part _____.
	3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: _____ to _____.
	4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).
	5. Submit proof that you are a lawfully admitted alien.
	6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.
	7. When your application is complete, the Medical Licensing Board will review your qualifications.
	8. Your application will be reviewed by the Medical Licensing Board on _____.
	9. Submit completed **CA-MED** form which indicates beginning and ending program dates.
	10. Submit **CA-LTD** form.
	11. Submit **ED-MED** form (certification of education).
	12. Submit **ED-NON** form completed in its entirety.
	13. Affidavits, (ED-AFF forms) must be completed in accordance with DPR policy. Copy of policy attached.
	14. **Verification of Pass/Fail Exam History**—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.
X	15. Submit official premedical/medical transcript with school seal affixed.
	16. Submit photocopy of your degree.
	17. Submit proof of Titulo or Acta.
	18. Submit proof of Social Service or Fifth pathway.
	19. Submit proof of E.C.F.M.G. certification.
	20. Submit copy of evaluation form for each of the following core rotations: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
	21. Complete **AF-MED** form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s). 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
	25. Submit a list of your work experience from _____ to _____. You must account for entire time period since graduation from medical school (Supporting Document WH).
	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
X	28. Have your Board scores forwarded directly from National Board.
	29. Submit evidence of remedial training.
X	30. Submit **TN-MED** form signed by program director, with seal of hospital.
	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on offical stationary must be attached verifying no seal exists.)
	32. Sign form(s) where indicated.
	33. Submit certification of original/current licensure (Supporting Document CT) from _____.
	34. Submit proof that you are Board-certified in a specialty.
	35. Submit restoration questionnaire (Supporting Document RS).
	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
	37. Returning original documents.

Other instructions:

IL486-1508 5/94 (LT)

Application No. _____ Prof. Code _____ SSN/FEIN or Label Space 0 9 3 1 2	APPLICATION DATA CHANGE	AMF 1

1. DATE: __/__/__
2. EMPLOYER: _____
3. APPLICATION DATE: __/__/__
4. REAPPLICATION DATE: __/__/__

5. ASSIGN S.S.N.: _____ (Yes or No)

6. LICENSURE METHOD: _____

7. DATE OF BIRTH: __/__/__

NAME:

8. Individual (Human) Last _____ First _____
   M.I. _____ Title _____

9. Business (Non-human) _____

10. **ADDRESS:**

Line 1 _____

Line 2 _____

Line 3 _____

Line 4 _____

City/Country _____ State _____ Zip _____

County _____ Foreign Address _____ (Yes or No)

FINANCIAL/BATCH:

11. Payment Date __/__/__ 12. Batch No. _____ 13. Fee Amount _____

14. Payment Type _____

15. Delete Financial _____ (Yes or No)

16. **ON CONTROL SLIP:** _____ (Yes or No)

17. Add ☐ 18. Change ☐

IL486-1322 7/89 (LT)

Application No. _____ Prof. Code _____ SSN/FEIN

or Label Space: 0 9 5 7 1 9 2 2 4

APPLICATION REVIEW FINDINGS

AMF 2

1. DATE: 07/28/95
2. EMPLOYEE: 0303
3. PERSONAL HISTORY: _____ (Y OR N)
4. STATUS: 6
5. DEFICIENCIES - ADD: _____
   CLEAR: 244
6. LAST CORRESPONDENCE RECEIVED DATE: 06/21/95
7. LAST CORRESPONDENCE SENT DATE: __/__/__
8. IL APPRENTICE TRAINING LICENSE NO.: _____

EDUCATION INFO:

9. School Name: Washington University
10. School Code _____
11. Foreign School: No (Yes or No)
12. Date Graduated: 05/21/76
13. City/County School Located: St Louis
14. State School Located: MO

RECIPROCITY INFO:

15. Original Licensure State: MO
16. Licensure Date: 09/77 (Month/Year)
17. Current Licensure State: MO
18. Licensure Date: 09/77 (Month/Year)
19. No. of States Licensed In: 1

ACCEPTANCE OF EXAM INFO:

20. Who Gave Exam _____
21. Examination Date __/__/__
22. Grades:
23. No. of Times Exam Taken: _____

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____

MISC. INFO:

24. Related License No.:

1. _____ D ___ 2. _____ D ___ 3. _____ D ___ 4. _____ D ___

25. License Specialty Code _____
26. Bond Insurance Expire Date __/__/__
27. Agency Manager Name _____
28. Telephone No. _____
29. Renewal Fee Exempt _____
30. Experience Requirement Complete _____

LICENSE ASSIGNMENT INFO:

31. Original IL License No. _____
32. Issuance Date __/__/__

IL486-1323 12/92 (LT)

Electronic Renewal Record

Exit | Find Another

License Number	[redacted]
Pin	[redacted]
Phone	([redacted]
Authorization	[redacted]
SSN	[redacted]
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	4/7/2011
Renewal Fee	$300.00
Fee Type	R
Service Fee	$5.00
Memo	

Method | Credited:

User Responses

1	SSN		9	MD2	N
2	IA1	N	10	MD3	N
3	PH1	N	11	CS1	N
4	PH2	N	12	CE1	Y
5	PH3	N	13		
6	PH4	N	14		
7	MD1	N	15		
8	MD1A	N			

Print Record

Next Record

Electronic Renewal Record

Exit | Find Another

License Number	[redacted]
Pin	[redacted]
Phone	([redacted]
Authorization	[redacted]
SSN	[redacted]
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	7/8/2008
Renewal Fee	$300.00
Fee Type	R
Service Fee	$5.00
Memo	

Method | Credited:

User Responses

1	SSN		9		
2	IA1	N	10		
3	PH1	N	11		
4	PH2	N	12		
5	PH3	N	13		
6	PH4	N	14		
7	CS1	N	15		
8	CE1	Y			

Print Record

Next Record