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

State Form 29495 (R10 / 11-01)
Approved by State Board of Accounts, 2001

Health Professions Bureau
402 W. Washington St., Room 041
Indianapolis, IN 46204
Telephone number: (317) 232-2960

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

| | |
|---|---|
| Application fee | 250.00 |
| Date fee paid (month, day, year) | 2/3/04 |
| Receipt number | 1025542 |
| Application number | |
| License number | 01058843A |
| License issuance date (month, day, year) | 03/19/04 |

| | |
|---|---|
| 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, maiden) | Check one: | Social Security number* |
|---|---|---|
| Goyal, Vijay, L., Sood | ☒ MD ☐ DO | [redacted] |

Address (number and street or Rural Route)
1640 N. Arlington Heights Road, Suite 100

City, state, ZIP code
Arlington Heights, IL 60004

| Telephone number (daytime) | Birthdate (mo., day, yr.) | Birthplace |
|---|---|---|
| [redacted] | 08/24/55 | Nepal |

E-mail address [redacted]

## TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit?
☐ Yes ☒ No

## DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

| Name of School | Location | Date of Graduation (Month, Day, Year) |
|---|---|---|
| Jawaharlal Institute of postgraduate Medical Education & Research | Pondicherry, India | 02/03/1980 |

RECEIVED
FEB 02
Health Professions Bu

## EXAMINATION

Check appropriate box(es) indicating which examination or combination of examinations you have taken.
*(Please review instruction sheet for address and telephone numbers on how scores may be obtained.)*

| | |
|---|---|
| ☒ FLEX EXAMINATION | ☐ STATE BOARD EXAMINATION |
| ☐ Component I ☐ Component II ☐ Other | Examination taken in which state? |
| ☐ NATIONAL BOARD OF MEDICAL EXAMINERS | ☐ LMCC EXAMINATION |
| ☐ Part I ☐ Part II ☐ Part III | |
| ☐ USMLE EXAMINATION | ☐ NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS |
| ☐ Step I ☐ Step II ☐ Step III | ☐ Part I ☐ Part II ☐ Part III |

| PRE-MEDICAL / OSTEOPATHIC EDUCATION | | |
|---|---|---|
| NAME OF SCHOOL | LOCATION | DATES ATTENDED |
| Government College | Simla, India | 07/1971 - 16/1973 |
| | | |

| MEDICAL / OSTEOPATHIC EDUCATION | | |
|---|---|---|
| NAME OF SCHOOL | LOCATION | DATES ATTENDED |
| Jawaharlal Institute of Postgraduate Medical Education and Research | Pondicherry, India | 07/1973 - 02/1980 |
| | | |

| POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA (*Include ALL internships, residencies and / or fellowships*) | | | |
|---|---|---|---|
| NAME OF PROGRAM | LOCATION | FROM (*month, year*) | TO (*month, year*) |
| 3-year residency in Pediatrics | Cook County Hospital, Chicago, Illinois | 07/1980 | 06/1983 |
| | | | |
| | | | |
| | | | |

| *LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL* | |
|---|---|
| GENERAL LOCATION | DATE |
| Hoffman Estates, Illinois | 1980-1986 |
| Inverness, Illinois | 1986 - Present |
| | |
| | |

| *LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL* | | |
|---|---|---|
| NAME AND ADDRESS OF EMPLOYER | RESPONSIBILITIES | DATE |
| Cook County Hospital 1825 W. Harrison, Chicago, IL | Resident Physician | 07/1980-06/1983 |
| Self-employed | Practicing Physician | 1983-present |
| | | |
| | | |

| *LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION* | | | | |
|---|---|---|---|---|
| STATE | TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT | NUMBER | DATE ISSUED | CURRENT STATUS |
| IL | Physician & Surgeon | 036-062651 | 07/27/81 | Active |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

| | |
|---|---|
| 1. Has disciplinary action ever been taken regarding any 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? | ☐ Yes ☒ No |
| 3. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem? | ☐ Yes ☒ No |
| 4. Have you ever been charged with drug addiction? | ☐ Yes ☒ No |
| 5. Have you ever been convicted of, plead guilty or *nolo contendere* to:<br>A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?<br>B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines.*) | ☐ Yes ☒ No<br>☐ Yes ☒ No |
| 6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? | ☐ Yes ☒ No |
| 7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? | ☐ Yes ☒ No |
| 8. Have you ever had a malpractice judgment against you or settled any malpractice action? | ☐ Yes ☒ No |

## 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*) |
|---|---|
| [signature] | 1/26/2004 |

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for 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 Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and 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 affirm that I have read the above statements and agree to same.

| Date signed (*month, day, year*) | Signature of applicant |
|---|---|
| 01/26/2004 | [signature] |

RECEIVED
FEB 02 2004
Health Professions Bureau

725

*Government of India*

JAWAHARLAL INSTITUTE
OF POSTGRADUATE MEDICAL EDUCATION AND RESEARCH
DHANVANTARI NAGAR – PONDICHERRY-605006
*(Directorate General of Health Services)*

## CHARACTER CERTIFICATE

This is to certify that ~~Thiru/Selvi~~ VIJAY LAXMI SOOD

has been a student of this Institute from 25 JULY 1973 to 3 FEB 1980

~~His/Her~~ character and conduct during the period were Good

Date 14th Feb. 1980 (Seal)

Principal
DIRECTOR,
JAWAHARLAL INSTITUTE OF
POSTGRADUATE MEDICAL EDUCATION
AND RESEARCH,
PONDICHERRY-605006.

OFFICE OF THE DIRECTOR
JIPMER
PONDICHERRY-6

RECEIVED
FEB 02 2004
Health Professions Bureau

Signed: _____ Date: 1/21/2004.

Subscribed to and sworn before me this 21 day of January, 2004.

Notary Public

OFFICIAL SEAL
CATHERINE RAMIREZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11-5-2005

Folio No. 336

# UNIVERSITY OF MADRAS

University Centenary Building,
Chepauk, Madras-600 005.

Dated 25 JAN 1980

C.P.No. 27

Register No. 1960

Disposal No. YE. 1775

RECEIVED
FEB 02 2004
Health Professions Bureau

## PROVISIONAL CERTIFICATE-M.B. & B.S.

This is to certify that Vijay Laxmi Sood

has qualified for the Degree of Bachelor of Medicine and Surgery She having passed in the Second Class the Final M.B. & B.S. Degree Examination held in December 1978 and having satisfactorily completed the period of Compulsory Rotatory Internship in January 1980.

C. Umapathy
Assistant Registrar.

UNIVERSITY 82 OF MADRAS

Signed: Vijay Sood

Date: 1/21/2004

Subscribed to and sworn before me this 21 day of January, 2004.

Notary Public

OFFICIAL SEAL
CATHERINE RAMIREZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11-5-2005

Cook County Hospital
1835 W. Harrison St., Chicago, Illinois 60612 Telephone 312/633 6000

June 30, 1983

TO WHOM IT MAY CONCERN:

This is to certify that Dr. Vijay L. Goyal completed a 3-year residency in Pediatrics at Cook County Hospital, July 1, 1980 through June 30, 1983.

Very sincerely yours,

Robert A. Miller

Robert A. Miller, M.D.
Chairman,
Department of Pediatrics

RAM:GD

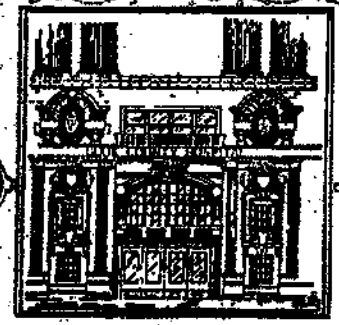
Signed: _____ Date: 1/21/2004

Subscribed to and sworn before me this 21 day of January, 2004.

_____
Notary Public

OFFICIAL SEAL
CATHERINE RAMIREZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11-6-2005

# Cook County Hospital

CHICAGO,  ILLINOIS.

This certifies that

## Vijay L. Goyal, M.D.

has satisfactorily completed

## Residency in Pediatrics

from July 1, 1980 to June 30, 1983

*In Testimony Whereof the undersigned have affixed their signatures at Chicago, Illinois*

RECEIVED
FEB 0 9 2004
Health Professions Bureau

Lowina Hayes Brown M.D.
Medical Director

Fred E. Sheinfeld M.D.
President of Staff

COOK COUNTY HOSPITAL
ORGANIZED
1865
CHICAGO, ILL.

Conrad Tarshe, M.D.
Department of Medical Education

Robert A. Miller M.D.
Department Chairman

Subscribed to and sworn before me this 21 day of January, 2004

Notary Public

OFFICIAL SEAL
CATHERINE RAMIREZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11-5-2006

Signed:

Date: 1/21/04

# EDUCATIONAL COMMISSION
# for
# FOREIGN MEDICAL GRADUATES

CERTIFIES THAT

## VIJAY LAXMI GOYAL

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,

SUCCESSFULLY PASSED ITS EXAMINATIONS

AND HAS BEEN AWARDED THIS CERTIFICATE.

Date: 3/17/2004

RECEIVED
MAR 19 2004
Health Professions Bureau

Signed: [signature]

Subscribed to and sworn before me this 17 day of MARCH 2004

[signature]
Notary Public

OFFICIAL SEAL
CATHERINE RAMIREZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11-5-2005

CERTIFICATE NUMBER 309-839-9

MEDICAL EXAMINATION JULY 25, 1979

ENGLISH EXAMINATION JULY 25, 1979

DATE ISSUED February 20, 1981

VALID THROUGH

CERTIFICATE NUMBER
0-309-839-9
ENGLISH EXAMINATION
February 4, 2004
VALID THROUGH
February 2006

ECFMG

Harold C. Penney, Jr.
PRESIDENT

Ray L. Castellino
EXECUTIVE DIRECTOR

# Illinois Department of Professional Regulation

Fernando E. Grillo
Director

Rod R. Blagojevich
Governor

## CERTIFICATION OF LICENSURE

HEALTH PROFESSIONS BUREAU
402 W WASHINGTON ROOM 041
INDIANAPOLIS, IN 46204

| | |
|---|---|
| **Licensee:** | VIJAY L GOYAL |
| **License Number:** | 036-062651 |
| **Profession:** | PHYSICIAN AND SURGEON |
| **Date of Issuance:** | 07/27/1981 |
| **Expiration Date:** | 07/31/2005 |
| **License Status:** | ACTIVE |
| **License Method:** | ENDORSEMENT - FLEX |
| **Disciplinary History:** | NONE |

RECEIVED
MAR 09 2004
Health Professions Bureau

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

DEPT. OF PROFESSIONAL REGULATION * STATE OF ILLINOIS *

Daniel E. Bluthardt
Deputy Director, Licensing & Testing

3/4/2004
Date

*Refer to the Department's Web Site at www.dpr.state.il.us to verify professional licenses via License Look-Up.*

Hindu elo arriage Register
(Rule 12).

Serial number of marriage 6 of year 1979.

| | | |
|---|---|---|
| 1. (a) Full name of Husband | Vinod Kumar Goyal. | |
| (b) Caste | Hindu. | |
| (c) Age (Date of birth) | 30 years 7.8.1948. | |
| (d) Occupation and address before marriage. | Doctor. C/o Shri Jagat Ram Goyal Delhi Gate elo alerkotla Punjab | |
| 2. (a) Full names of parents of the husband | Father: Jagaram Goyal | elo other: Padma Vati |
| (b) Caste | Hindu | Hindu. |
| (c) Their age | 56. | 48. |
| (d) Occupation and address. | Nil. Delhi Gate elo alerkotla. | Same |
| 3. (a) Full name of wife | Vijay Laxmi Sood. | |
| (b) Caste | Hindu. | |
| (c) Age (Date of birth) | 23 years. 24.8.1955. | |
| (d) Occupation and address before marriage | Doctor C II Jipmer Pondy 6. | |
| 4. (a) Full names of parents or guardian in marriage if any of the wife | Father: Dr. Gian Chand Sood | elo other: Vimala Sood. |
| (b) caste | Hindu | Hindu. |
| (c) Their age | 56. | 49. |
| (d) Occupation and address. | Doctor C II III Jipmer Pondicherry. | Same. |
| 5. Name and address of the person who Solemnized the marriage | Vedantkar Prasad Aurobindo Ashram Pondicherry. | |
| 6. Whether the marriage was solemnized under customary rights and ceremonies of either parties to the marriage as required under sub sections (1) and (2) of Section 7 of the Act. | According to the Hindu right under Section 1 and 2 of Section 7 of the Hindu elo arriage Act. | |

Signed: [signature]

Date: 1/21/2004

Subscribed to and sworn before me this 21 day of January, 2004.

[signature]

OFFICIAL SEAL
CATHERINE RAMIREZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11-8-2005

| | |
|---|---|
| 7. Place Viz the Village taluk and District Where the marriage was solemnized with full address | Mbarie Town Hall Beach Road Pondicherry. |
| 8. The Date on which the marriage Was solemnized | 12.7.1979. |
| 9. Signature of the husband | Vinod Kumar Goyal. |
| 10. Signature of the wife | Vijay Laxmi Sood. |
| 11. Signatures with their names in block letters of the witnesses and their addresses. | 1) Ashock Kumar. Ashok Kumar C/o S K Jagat Ram Modi Delhi Gate Mb alerKotla. 2) Dr. RaKesh Sood. Dr. RaKesh Sood C II 111 Jipmer Pondicherry. 3) Amita Kapoor. Amita Kapoor C/o Mbr Mb L. Kapur 314. Mbakesh Nagar. Ambala cault. |

Certified that the marriage of which particulars are given above has been registered by me under the Pondicherry Hinduellbarriage (Registration) Rul 1967 this the 13th day of July 1979.

Station ozhukarai
Date 13.7.79.

M. Dinadayalan.
Signature of the Mbarriage Registrar.

True copy.

Copy prepared by hadjamaiyal copyist

Copy compared by { Reader [illegible] Mbe
Examiner hadjamaiyal copyist.

Station ozhukarai
Date 13.7.79.

SEAL OF THE SUBREGISTRAR OF OZHUKARAI

Mbarriage Registrar.
ozhukarai.