APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

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.

Lic#:
GOYAL, NISHA V
036 Cred #2924474 07/21/2009
By:ACCEPT EXAM
SSN:322-76-8662

PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
PHYSICIAN	036	Acceptance of Exam	(100) prorated $300.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [X] 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.

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division 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. UNITED STATES SOCIAL SECURITY NO.
GOYAL	NISHA		MD	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: [redacted]

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: 2900 N. Lakeshor Drive Chicago IL 60657-5640

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)

7. MOTHER'S MAIDEN NAME: Sood

8. PLACE OF BIRTH CITY STATE/COUNTRY: [redacted]

9. DATE OF BIRTH (Month Day Year): [redacted]

10. AGE: [redacted] [X] Female [ ] Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: ([redacted] (Area Code) Home: [redacted] (Area Code)

Fax: ([redacted] (Area Code) Fax: (___) ___-____ (Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) [If available]: [redacted]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI): GOYAL NISHA

SS#: [redacted]

Profession: physician

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
William Fremd High School	Palatine, IL.	06 / 2000 (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)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
University of Illinois Urbana Champaign	Champaign, IL.	8/2000	12/2003	BS.
Saint James School of medicine	Kralendijk, Bonaire Netherlands Antilles	1/2004	4/2007	MD

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)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
Saint Joseph Hospital	Chicago, IL	6/2007	6/2010	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): GOYAL NISHA

SS#: [redacted]

Profession: Physician

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 IL	Licensed medical temporary physician	125.053332	6/20/07	active
State of Current Licensure where you most recently have been practicing.				
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)
USMLE Step 1	IL	6/2005	passed
USMLE Step 2 CK	IL	8/2006	passed
USMLE Step 2 CS	IL	10/2006	passed
USMLE Step 3	IL	1/2009	passed

(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 been convicted of a felony?		X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		X
4. 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
5. 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
6. 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

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. [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ]

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

c) CHART IV - Find your School of Graduation and enter school code: [ ][ ][ ][ ][ ]

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

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☒
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☒

PART IX: 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] 6/20/9

Signature of Applicant — Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and 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.

NAME (Last, First, MI): GOYAL NISHA

SS#: [redacted]

Profession: physician

Saint Joseph Hospital
2900 North Lake Shore Drive
Chicago, Illinois 60657
773.665.3000

Resurrection Health Care

June 20, 2009

To whom it may concern:

Please allow Pat Hardy from the Academic Affairs Department of Saint Joseph Hospital to follow up on the status of my application for my Illinois permanent medical license. If you have any concerns, please feel free to contact me at [redacted] Thank you.

Sincerely,

[redacted]

Nisha Goyal, M.D.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE
GOYAL NISHA

3. ADDRESS STREET CITY STATE ZIP CODE
[redacted]

4. DATE OF BIRTH
[redacted]
Month Day Year

5. SOCIAL SECURITY NUMBER
[redacted]

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☒ Permanent Physician License	036
☐ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION
Saint Joseph Hospital

ADDRESS STREET, CITY, STATE, ZIP CODE
2900 N. Lakeshore Dr. Chicago IL 60657

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 20 / 2007 (Month / Day / Year)
To 06 / 19 / 2010 (Month / Day / Year)

HOURS WORKED PER WEEK
70

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
2 years so far, Will have been 3 yrs

JOB TITLE
Resident physician

DESCRIPTION OF DUTIES PERFORMED
patient care
inpatient
outpatient/clinic

B. NAME OF BUSINESS / INSTITUTION

ADDRESS STREET, CITY, STATE, ZIP CODE

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 (Year/Month)

JOB TITLE

DESCRIPTION OF DUTIES PERFORMED

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

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	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
NISHA GOYAL	[redacted] Month Day Year	[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.	
6. MAIDEN OR GIVEN SURNAME: [redacted]	PHYSICIAN (Profession Name)	036 (Profession Code)
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable): 125-053332	8. ISSUANCE DATE: 6-20-07	

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed 24 months of postgraduate clinical training in ST. JOSEPH HOSPITAL FAMILY MEDICINE
(Name of Specialty Program)

from 6-20-07 (MM/DD/YYYY) to 6-21-09 (MM/DD/YYYY) at the following hospital:

Hospital: ST. JOSEPH HOSPITAL

Number and Street: 2900 N LAKE SHORE DR

City, State and Zip Code: CHICAGO IL 60657

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

- [x] the ACGME
- [ ] the AOA
- [ ] the CFPC, RCPSC or FMLAC (Canadian Programs)
- [ ] not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: LOIS T. GARCIA MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 6-21-09

University/Hospital SEAL

Telephone No: [redacted]

(If no seal, attach letter on letterhead stating no seal exists.)

US·MLE
United States
Medical
Licensing
Examination
TM

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date : 07/27/2009

Recipient:

Illinois Department of Financial and Professional Regulation
ATTN: Sandy Dunn, Manager of Med Licensure
320 W Washington Street
3rd Floor
Springfield, IL 62786

Examinee: Goyal, Nisha
Alt Name(s): Goyal, Nisha V

Examinee ID#: [redacted]
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/27/2005	Pass	[redacted]				

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	08/31/2006	Pass	[redacted]				

Clinical Skills (CS)*

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	10/20/2006	Pass	[redacted]				

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
CONNECTICUT	01/15/2009	Pass	[redacted]				

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

RECEIVED ELECTRONICALLY

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 7/28/2009

Initials: DR

License No: 036 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

NISHA V GOYAL MD

[redacted]

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Additional $200.00 fee is required. The fee for physician application if $300.00. Please make check payable to IDFPR.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 7/23/2009

Initials: CW

License No: 036 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

NISHA V GOYAL MD

[redacted]

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

USMLE pass/fail history must be received directly from the Federation of State Medical Boards.

Additional $ 200.00 fee is required, the fee for the application for a physician is $ 300.00, please make check payable to the IDFPR.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.

Place Label Here or Name

DO NOT WRITE IN BOX

Profession Code

License # or SSN #

FILE ROUTE CARD

DO NOT WRITE ON FILE FOLDER

IL486-1327 10/04 (RS)

01000001616

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure unr ; information is VOLUNTARY. Ho ; processed.

GOYAL, NISHA V
125 Cred #2294102 05/10/2007
By:NON-EXAM

The ation for Lice

1. [redacted] AND/OR

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.
5. 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.

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

RECEIVED
CASH SECTION
MAY 07 2007
IDFPR
Div. of Professional Regulation

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Licensure	1 2 5	Nonexamination	$ 100.00

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.

PART II: Applicant Identifying Information - You must notify the Department of Financial and Professional Regulation - Division 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. UNITED STATES SOCIAL SECURITY NO.
GOYAL	NISHA	V	M.D.	[redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
N/A

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)
N/A

7. MOTHER'S MAIDEN NAME [redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY [redacted]

9. DATE OF BIRTH [redacted] Month Day Year

10. AGE [redacted] ☑ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: (____) ___-____ (Area Code)
Home: [redacted] (Area Code)
Fax: (____) ___-____ (Area Code)
Fax: [redacted] (Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) [If available]
[redacted]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI): GOYAL, NISHA, V

SS#: [redacted]

Profession: temp Physician licensure

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
Fremd High School	Palatine, IL	06 / 2000 (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)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
University of Illinois at Urbana-Champaign	Urbana-Champaign, IL	8/2000	12/2003	(Bachelor of Sciences) B.S.
Saint James School of Medicine	Bonaire, Netherlands Antilles	1/2004	3/2007	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)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): GOYAL, NISHA, V

SS#: [redacted]

Profession: temp. physician license

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				
State of Current Licensure where you most recently have been practicing.				
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)
USMLE Step 1	IL	6/05	passed
USMLE Step 2 CK	IL	8/06	passed
USMLE Step 2 CS	IL	10/06	passed

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

NAME (Last, First, MI): GOYAL, NISHA V

SS#: [redacted]

Profession: temp physician licensure

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 been convicted of a felony?		X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		X
4. 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
5. 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
6. 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

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. ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐

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

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

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

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? *(NOTE: If you are not subject to a child support order, answer "no.")* Yes ☐ No ☒

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☒

PART IX: 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] 4/12/07

Signature of Applicant — Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and 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.

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

June 5, 2007

NISHA V GOYAL MD
DEPT OF GME

Your application for temporary licensure in Illinois has been approved, and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 06/20/2007. Assuming you remain in the training program listed below, this license will be valid until 06/19/2010.

PROGRAM: Family Medicine
TRAINING FACILITY: ST JOSEPH HOSPITAL

Utilization of this license is limited to the training program listed above. It may not be used for any clinical medical practice which occurs outside of the residency program; i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferred from one program/institution to another.

Applications for temporary licensure transfers must be filed with the Department at least 60 days prior to commencement of the new program. You are not eligible to begin a new training program until your current temporary license has been returned to the Department and a license has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of the temporary license. Any violation of the Act may result in disciplinary action by this Department.

If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department's Springfield address indicated below.

Sandra Dunn, Manager
Medical Unit

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

NOTE: An applicant shall not commence specialty/residency training before he or the hospital/institution receives written notice of the approval of his application from the Department of Financial and Professional Regulation.

APPLICANT: Complete the applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the remainder of the form.

1. NAME — LAST: GOYAL; FIRST: NISHA; MIDDLE: V

2. DATE OF BIRTH (Month Day Year): [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.

6. MAIDEN OR GIVEN SURNAME:

Profession Name: temporary Physician licensure — Profession Code: 125

ADMINISTRATOR: Complete the remainder of this form and return it to the applicant.

A. HOSPITAL/INSTITUTION NAME: ST. JOSEPH HOSPITAL

B. BEGINNING DATE (Month Day Year): 06 / 20 / 2007

C. ENDING DATE (Month Day Year): 06 / 19 / 2010

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: 2900 N. LAKESHORE CHICAGO IL 60657

E. SPECIALTY / RESIDENCY NAME: FAMILY PRACTICE

F. BUSINESS TELEPHONE NUMBER: Area Code (773) 665-3411

G. YEAR OF POSTGRADUATE TRAINING: PGY-1

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Financial and Professional Regulation, the applicant is found to be eligible for licensure.

[redacted]

Signature of Program Director

LOUIS A GARCIA M.D

Print Name of Program Director

PROGRAM DIRECTOR

Title

4/23/07

Date

SEAL

IL486-0272 08/04 (MD)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF AFFILIATION

SUPPORTING DOCUMENT

AF-MED

APPLICANT: Complete the applicant section of this form, then forward it to the appropriate official for completion of A or B.

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
GOYAL	NISHA	V	[redacted] Month Day Year	[redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

6. MAIDEN OR GIVEN SURNAME

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

temporary physician licensure (Profession Name) — 125 (Profession Code)

DEAN OR ADMINISTRATOR OF CLINICAL TEACHING FACILITY
Read A and B below, then complete either A or B and return form to the applicant.

A. MEDICAL COLLEGE: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was **owned or operated** by the medical college from which he graduated, sign the certification below.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility **owned or operated** by the medical college from which he graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

SEAL OF COLLEGE

Signature of Dean of Medical College

Name of Medical College

Type Name of Dean of Medical College

Street Address

Date

City State Zip Code

B. CLINICAL TEACHING FACILITY: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was **formally affiliated or contracted** with the medical college from which he graduated, sign the certification below. Further, you must **submit a copy of the affiliation agreement** between the hospital and the medical college which conferred the degree and a **copy of an evaluation form** for each core clerkship rotation, which was completed by the supervising physician of that rotation.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility **formally affiliated or contracted** with the medical college from which the applicant graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

SEAL OF INSTITUTION

[redacted]
Signature of Administrator of Clinical Teaching Facility

Jackson Park Hospital
Name of Clinical Teaching Facility

Danny Rollins
Type Name of Administrator of Clinical Teaching Facility

7531 S. Stony Island Ave.
Street Address

04/12/07
Date

Chicago IL 60649
City State Zip Code

COPY

Saint James School of Medicine
Clinical Rotation Evaluation Form

Name of Rotation: INTERNAL MEDICINE
Student Name: NISHA GOYAL
Dates of Rotation: Start: 07/25/05 Finish: 10/14/05 No. of Wks 12

Preceptor's Name: J. MADHANI, MD. / Q. JAMAL, MD.
Name of Hospital/Rotation site: JACKSON PARK HOSPITAL
Address of Rotation site: 7531 STONY ISLAND AVENUE
City/State/Zip: CHICAGO, ILLINOIS 60649
Contact phone: [redacted]
Email:

Student's Evaluation Scores

- **Knowledge Level**
- **Diagnosis**
- **Therapeutics**
- **Patient Interaction**
- **Data Collection**

[redacted]

- **Chart Work**
- **Treatment/ Implementation**
- **Rapport**
- **Responsibility**
- **Interest**

[redacted]

*NOTE: 10=Outstanding, 9=Advanced, 8=Proficient, 7=Needs Remediation, < 7=Poor/Failing

Comments for Dean's letter:

Nisha is very hardworking and diligent student. I am sure she will do well in any field she shooses. I wish her all the best.

*Please return this form by mail to: **St James School of Medicine, 4433 W. Touhy Ave, Ste 368, Chicago, IL 60712. Ph: 800-542-1553 Fax: 847-677-8169.**

Thank you.

Preceptor's Signature: [redacted] **Date** 12/07/05

Saint James School of Medicine

Plaza Juliana - 4 Kralendijk, Bonaire Netherlands Antilles

Tel: +11-599-717-2150 Fax: +11-599-717-2151

Affiliation Agreement

Agreement made this: Date 1/1/04 *by and between Saint James School of Medicine, hereinafter called SJSM and* Jackson Park Hosp *hereinafter called Training Site, situated in* Chicago IL.

WITNESSETH

That whereas, it is the desire of the parties to have an ongoing contractual arrangement between them of the development of teaching program in healthcare; and

Whereas, SJSM by association with the TRAINING SITE will gain additional clinical facilities for teaching purposes, and such affiliation will provide didactic resources to its students and enlarge the experience of its faculty; and

Whereas, it is the desire of the TRAINING SITE and SJSM to have teaching programs that are mutually coordinated and mutually beneficial; and

Whereas, the parties wish to operate in a close affiliation and maintain high standards in healthcare and education as outlined by the various accrediting bodies;

NOW THEREFORE, in consideration of the premises, it is agreed by and between the parties that they hereby become affiliated upon the terms and conditions hereinafter specified to with:

1. *The agreement shall be for the period of ~~August 2003~~* January/04 January 07 *to ~~August~~ August 2005 and may be cancelled by either party upon 90 days notice of intention to do so, delivered in writing to the other party.*

2. *Nothing in this agreement shall be construed to limit authority of SJSM over the education of its students, establishment of its curricula, and all other operations and function of the school, which remain the sole responsibility of SJSM.*

3. *The designated student of SJSM shall participate in regular clinical practice and procedures and shall be responsibly involved in [patient care, subject to limitations provided by law and restrictions imposed by director of Medical Education and/or the attending physician.* or mentor .

4. *Students of the training site will be covered by medical malpractice coverage provided by SJSM. SJSM shall maintain malpractice insurance in accordance with the coverage of the board of insurance and risk management.*

5. *All students of SJSM will act exclusively under the direction and supervision of the director of medical education or his designee. Students and faculty will conduct themselves in accordance with established standards and regulations of the training site and SJSM.*

6. - BASE TUITION FOR STUDENT WILL BE 1,250" PER MONTH. ~~SUBJECT TO AGREEMENT~~. PAYABLE TO TRAINING SITE.

AFFILIATION AGREEMENT:

Accepted By
Saint James School of Medicine:

Date.....

BY: [redacted] *Designation*... President.....

Print Name DR. KALLOL GUHA

Accepted By

MEDICAL EDUCATION COORDINATOR IN ILLINOIS
ALBERT TORRES M.D.
1-847-967-9853
9400 N. NARRAGANSETT
MORTON GROVE IL 60053

Name of the Hospital JACKSON PARK HOSPITAL

Date 07/16/03

BY [redacted] *Designation*... PRESIDENT/CEO

Print Name... MERRITT J. HASBROUCH

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**CERTIFICATION OF AFFILIATION**	SUPPORTING DOCUMENT **AF-MED**

APPLICANT: Complete the applicant section of this form, then forward it to the appropriate official for completion of A or B.

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
GOYAL	NISHA	V	[redacted]	[redacted]

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

6. MAIDEN OR GIVEN SURNAME

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

temporary physician licensure (Profession Name) — 125 (Profession Code)

DEAN OR ADMINISTRATOR OF CLINICAL TEACHING FACILITY
Read A and B below, then complete either A or B and return form to the applicant.

A. MEDICAL COLLEGE: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was **owned or operated** by the medical college from which he graduated, sign the certification below.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility **owned or operated** by the medical college from which he graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

SEAL OF COLLEGE

Signature of Dean of Medical College

Name of Medical College

Type Name of Dean of Medical College

Street Address

Date

City State Zip Code

B. CLINICAL TEACHING FACILITY: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was **formally affiliated or contracted** with the medical college from which he graduated, sign the certification below. Further, you must **submit a copy of the affiliation agreement** between the hospital and the medical college which conferred the degree and a **copy of an evaluation form** for each core clerkship rotation, which was completed by the supervising physician of that rotation.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility **formally affiliated or contracted** with the medical college from which the applicant graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

SEAL OF INSTITUTION

[redacted]
Signature of Administrator of Clinical Teaching Facility

Mercy Hospital & Medical Center
Name of Clinical Teaching Facility

STEVEN R. POTTS DO FACP
Type Name of Administrator of Clinical Teaching Facility

2525 South Michigan Ave.
Street Address

4-13-07
Date

Chicago IL 60616
City State Zip Code

Honors

Saint James School of Medicine
Clinical Rotation Evaluation Form

Name of Rotation: Obstetrics and Gynecology

Student Name: Nisha Goyal

Dates of Rotation: Start: 12/26/05 Finish: 2/3/06 No. of Wks 6

Preceptor's Name: [redacted]

Name of Hospital/Rotation site: Mercy Hospital and Medical Center

Address of Rotation site: 2525 South Michigan Avenue

City/State/Zip: Chicago, Illinois 60616-2477

Contact phone: [redacted]

Email: [redacted]

Student's Evaluation Scores

▪ **Knowledge Level**	[redacted]	▪ **Chart Work**	[redacted]
▪ **Diagnosis:**		▪ **Treatment/ Implementation**	
▪ **Therapeutics**		▪ **Rapport**	
▪ **Patient Interaction**		▪ **Responsibility**	
▪ **Data Collection**		▪ **Interest**	

*NOTE: 9-10=Excellent, 8-9=Good, 7-8=Fair, < 7=Poor/Failing

Comments for Dean's letter:

Dr N. Goyal was one of the finest most motivated students we have had the pleasure to have rotate at Mercy. Her enthusiasm and initiative were second to none. She was extremely helpful to the residents and definitely acted at the capacity of an intern. Her talk on [redacted] was phenomenal. Impressive to use her work and recent publication as an aide to her lecture!

*Please return this form by mail or fax to : **St James School of Medicine, 4433 W. Touhy Ave, Ste 368, Chicago, IL 60712. Fax: 847-677-8169, Ph: 800-542-1553.**

Thank you.

Preceptor's Signature: [redacted] **Date** 3/30/6

CLINICAL AFFILIATION AGREEMENT

THIS CLINICAL AFFILIATION AGREEMENT (hereinafter referred to as the "Agreement") is entered into this 06 day of December, 2004, (hereinafter referred to as the "Effective Date"), by and between MERCY HOSPITAL AND MEDICAL CENTER, an Illinois not-for-profit corporation (hereinafter referred to as the "Medical Center") and SAINT JAMES SCHOOL OF MEDICINE, Bonaire, Netherlands-Antilles (hereinafter referred to as the "School").

RECITALS:

WHEREAS, a program of education and training for students in Internal Medicine requires facilities, equipment, and services appropriate for the School's students to obtain the necessary experience; and

WHEREAS, the Medical Center operates a hospital with a Department of Medicine; and

WHEREAS, the parties wish to affiliate so that the School's students may participate in a program of education and training (hereinafter referred to as the "Program") at the Medical Center.

NOW THEREFORE, in consideration of the mutual terms and covenants herein exchanged, the parties hereby agree as follows:

1. Affiliation. The Medical Center shall affiliate with the School and accept placement of certain students duly enrolled in the School's Program, which students may be reasonably acceptable to the Medical Center to perform such duties at the Medical Center as are deemed appropriate by the parties pursuant to the terms and conditions set forth in this Agreement. The guidelines for the affiliation relationship between the parties are set forth on Exhibit A attached hereto and made a part hereof; however, to the extent there is an inconsistency between the terms of this Agreement and Exhibit A, this Agreement shall govern. The School agrees to pay Medical Center an honorarium of $200.00 per student for each week students of the School participate in the Program. The honorarium shall be paid prior to placement of each student at the Medical Center. In addition, the School agrees to pay Medical Center four hundred dollars ($400.00) per week for clerical support of the program.

2. Responsibilities of the School.

2.01. Education Program. The School shall plan and determine the adequacy of the educational experience of students in theoretical background, basic skills, professional ethics, attitude and behavior, and shall assign to the Medical Center only those students who have satisfactorily completed the prerequisite didactic portions of the School's curriculum.

2.02. Health Insurance Coverage. The School shall provide the Medical Center with proof of health insurance for each student placed at the Medical Center pursuant to the Program.

2.03. Liability Insurance Coverage. During the term of this Agreement, the School, at its sole cost and expense, shall cover each student and its faculty members participating in Program instruction at the Medical Center for professional and personal liability with such insurance companies in such amounts and forms as are acceptable to the Medical Center, and shall assure the Medical Center of coverage amounts that meet the Medical Center's reasonable approval. Prior to

any student placement, the School shall deliver to the Medical Center a certificate of insurance indicating general and professional liability coverage and amounts. Such coverage cannot be cancelled without ten (10) days prior written notice to the Medical Center.

2.04. Indemnification. The School shall assume responsibility and liability for damage to, or loss of property and injuries in the Medical Center caused by or contributed to by employees, faculty or students of the School, arising out of, or occurring in connection with the performance of this Agreement, unless such damage or loss is a result of the Medical Center's negligence, or of that of its officers, employees or agents. The School shall, during the term of this Agreement, indemnify, defend, and hold the Medical Center, and its employees, agents, directors, officers, and affiliated corporations and their respective officers, directors and employees harmless from any and all legal liability, injury or damage, including reasonable attorney's fees, costs and expenses for injuries to persons, employees or students, public liabilities, and property damage arising solely out of the acts or omissions of the School or its officers, agents, employees, students, or the operation of the clinical experience program while on the Medical Center premises pursuant to this Agreement. Where possible, the School shall name the Medical Center on its insurance policy as an additional insured for providing coverage under the provisions of this Section. The School's policy shall specify coverage with regard to the Medical Center under this Agreement as primary and non-contributing. This indemnification provision shall survive the termination of this Agreement for acts that arose while this Agreement was in effect.

2.05. Liaison. The School shall designate an individual to coordinate and act as the liaison with the Medical Center. The assignments to be undertaken by the students participating in the Program shall be mutually arranged by the School and the Medical Center. A continuous exchange of information shall be maintained by the School and the Medical Center, either by on-site visits or by other appropriate means of oral or written communication.

2.06. Rules and Regulations. The School shall notify each student prior to entering the Program at the Medical Center that he or she shall follow all administrative policies, standards and practices of the Medical Center. To the extent the Medical Center's rules and regulations do not contradict the School's rules and regulations, students shall also be requested to adhere to the School's rules and regulations.

2.07. Student Admission, Discharge, Placement, and Credits. Subject to the provisions of Paragraph 3.07 of this Agreement, the School shall be responsible for the admission and discharge of all students involved in the Program, as well as the awarding of course credit and degrees to students who have completed all School requirements and Medical Center requirements.

2.08. Student Responsibilities. The School shall be responsible for informing students of the following additional responsibilities.

(a) Personal conduct, academic achievement, and skill achievement in all educational situations, whether in the School's classrooms or in the Medical Center.

(b) Maintenance of work standards set by the Medical Center's clinical supervisor, which includes wearing the uniform and identifying insignia of the School at all times while in the Medical Center, unless otherwise instructed by the supervisor at the Medical Center.

(c) Required attendance at work experiences, classes, seminars, recruitment, and individual conferences with instructors.

(d) Meeting those health standards required by the School and the Medical Center.

(e) Necessity of conforming to all policies and procedures of the Medical Center before publishing any material relating to the Program experience.

(f) Obtaining prior written approval of the School and Medical Center before publishing any material relating to the Program experience.

2.09. Accreditation. The School will at all times relevant, maintain appropriate state accreditation, and advise the Medical Center of any change in the approval or accreditation status of the School or its Program.

2.10. Medical Center Orientation. The School shall be responsible for orientation and in-service of Medical Center personnel regarding the aims and objectives of the Program; providing those staff of the Medical Center's Department of Medicine who are involved with the Program with opportunities to participate in the development of specific educational objectives for each student experience provided within the Medical Center; providing opportunities for such staff of the Medical Center to participate in joint planning and evaluation of student experiences related to the Program; and providing opportunities for such staff of the Medical Center to participate in the development of the students' schedules (including the scheduling of make-up sessions).

2.11 Background Check. The parties further agree to place students in accordance with the provisions of the Health Care Worker Background Check Act ("Act"). Although not required by the Act with respect to students, School nevertheless agrees to initiate a UCIA criminal history record check of each student and to provide the Medical Center with a copy of the results of each record check prior to the initial placement of any student. The parties agree that any student whose UCIA criminal history record check indicates a conviction for committing or attempting to commit one or more of the offenses enumerated in Section 25 of the Act shall be immediately removed from assignment to the education program at the Medical Center. The parties agree that the Medical Center shall not be responsible for any expenses related to UCIA record checks or results of such record checks.

2.12. Student Activities Schedule. The School, in collaboration with the Medical Center, will prepare a schedule of student activities which will include the proposed clinical areas and patient service facilities to be used by the student and the type and extent of patient care in which the student schedules participation during the Program, and shall supply student schedules which shall include all courses and clinical experiences to the appropriate supervisory personnel of the Medical Center.

2.13. Site Visit/Conferences. The School will give advance written notice to the Medical Center of site visits by any accrediting agency involved with the Program.

3. Responsibilities of the Medical Center.

3.01. Clinical Supervision. The Medical Center shall provide clinical supervision of the students of the School. Supervision shall be provided by a Medical Center-designated coordinator, qualified in Internal Medicine, and having licensure or certification in the specialty field, if applicable. It is anticipated that this coordinator will be Steven Potts, D.O. but may be another qualified individual as determined by the Medical Center. While in the Medical Center, student shall not render patient care and/or services except for educational purposes as specified under the Program. Students shall not replace staffing at the Medical Center.

3.02. Licensing. The Medical Center shall, at all times relevant, maintain an unrestricted license to operate a hospital and/or in-patient or out-patient services in the state of Illinois.

3.03. Student Evaluations. The Medical Center shall submit prescribed written evaluations of student performances to the designated faculty of the Program.

3.04. Program Organization. The Medical Center shall organize the Program in order to advance the learning process of the School's students. As relevant, students will have access to patient records or portions of such records subject to the provisions of Paragraphs 5.03 and 5.04 of this Agreement.

3.05. Facilities. The Medical Center shall provide equipment, facilities, supplies and services for the Program as necessary to meet the objectives of the on-site Program. The Medical Center is not, however, obligated to provide equipment, facilities, and services beyond those already in place. The School agrees that such existing equipment, facilities, and services are adequate for purposes of the Medical Center carrying out its responsibilities under this Agreement.

3.06. Orientation. The Medical Center shall conduct an orientation program for the School's supervising faculty of the Program which covers such matters as relevant policies, rules, regulations, services, or any other items of conduct.

3.07. Corrective Action. The Medical Center shall notify the School in the event that the Medical Center's rules, regulations, procedures, and/or policies are violated by the School's faculty or students. The parties shall mutually agree upon the appropriate corrective action. However, the Medical Center, in its sole discretion, may take independent corrective action, including dismissal of said faculty or students from the Medical Center, where, in the sole opinion of the Medical Center, faculty or student behavior is an immediate threat to the health, safety, or well being of the Medical Center or its patients. In such event, the Medical Center shall notify the School immediately thereafter. The Medical Center shall have the right to approve or disapprove at any time of any student or faculty participating in the Program at the Medical Center who does not comply with the responsibilities and behaviors under this Agreement. While the Medical Center may make any final determination regarding a student at its site, the Medical Center shall strongly consider the recommendations of the School.

3.08. Medical Care. The Medical Center shall provide medical care to students and faculty as it does to the general public with the costs of such care being the sole responsibility of the student or faculty, unless other arrangements are made in writing by School.

3.09. Indemnification. The Medical Center shall, during the term of this Agreement, indemnify and hold harmless the School and its officers, employees, and agents from any and all claims, losses, expenses, liabilities, judgments, settlements, suits, damages or costs (including reasonable attorneys' fees) arising solely out of the acts or omissions of the Medical Center, or its officers, agents, or employees, including but not limited to injury of persons, employees, and property damage. This indemnification provision shall survive the termination of this Agreement for acts that arose while this Agreement was in effect.

4. Joint Responsibilities.

4.01. Scheduling. The School and the Medical Center shall from time to time agree upon the timing and the duration of a student's placement at the Medical Center.

4.02. Number of Students Placed. The School and the Medical Center shall determine the number of students eligible to participate in the Program. It is anticipated that two (2) students will be initially placed at the Medical Center. The Medical Center shall notify the School at least five (5) weeks in advance of the student's expected assignment, if the Medical Center is unable to meet the teaching obligation as agreed.

4.03. Evaluations. The School and the Medical Center shall evaluate the relevant learning experiences of students and develop materials for that purpose. The School and the Medical Center shall communicate as needed to review and evaluate the Program.

4.04. Program Costs. The School and the Medical Center shall periodically review Program costs and potential payment schedules for either party. It is specifically agreed that neither party shall be responsible for costs or expenditures incurred by the other in the conduct of clinical service, research, education, or training programs, other than those expenses defined in any separate written agreements that may be made between the School and the Medical Center. Such agreements must be signed by authorized officers or designees of the School and the Medical Center. The School shall incur no financial obligations on behalf of the Medical Center without prior written approval of the Medical Center.

4.05. Anti-Discrimination. The School and Medical Center shall accept students for placement without regard to race, sex, creed, religion, color, national origin, age, martial status, height, weight, veteran status, disabilities, or any other such factors as set forth in accordance with federal, state, and local laws and ordinances.

5. Miscellaneous.

5.01. Independent Contractor Status. In the performance of all work, duties, and obligations, the School and the Medical Center are at all times independent contractors and, except as may be stated in this Agreement, neither party shall have control of the manner in which the other party performs its work and functions. Neither party, nor their respective faculty, employees, students or agents shall be or shall claim to be the faculty, employee, student or agent of the other, except as may be stated in this Agreement. In that regard, the Medical Center shall not owe any compensation to or on behalf of the School's faculty or students of the type generally related to employment, including, but not limited to, salary, vacation, pension, insurance, workers compensation, unemployment compensation or employer's federal or state tax.

5.02. No Partnership/Third Party Rights. Nothing herein shall be deemed to create any association, partnership, joint venture or agency relationship between the School and the Medical Center. This Agreement shall not be construed under any circumstances to confer any rights or privileges on any third parties, and neither the School nor the Medical Center shall be under any obligation to any third party by reason of this Agreement or any term thereof.

5.03. Confidentiality. Each party and their respective agents, employees, students, faculty and representatives shall take reasonable precautions to maintain the confidential nature of, and to prevent the unauthorized disclosure of all confidential information, records, and data pertaining to the Medical Center's patients, the School's students, or to the operations, facilities and staff of the School and the Medical Center.

5.04. Employment Practices and Record-Keeping. Each party's respective employment, health care and record-keeping practices shall conform to all federal, state and local statutes, ordinances, and rules and regulations. Upon reasonable request, each party shall provide the other with any information or certificates which may be required to prove compliance with such statutes, ordinances, and rules and regulations, or for licensure, accreditation, and quality assurance purposes. The School acknowledges and agrees that all charts and medical records of the Medical Center patients shall be and remain the property of and in the custody of the Medical Center. Upon termination of this Agreement, the School and its faculty and students shall not retain the medical record of any Medical Center patient.

5.05 Term, Renewal and Termination.

A. Term. This Agreement's "Term" commences on the Effective Date and continues for a period of one (1) year ("Initial Term"), or otherwise as agreed by the parties, but in no event shall the term exceed a one (1) year period.

B. Renewal and Termination. This Agreement shall automatically renew after the Initial Term for successive one (1) year periods unless written Notice of Termination of this Agreement is given at least thirty (30) days prior to the expiration of the Initial Term, or at least ninety (90) days in advance at any time thereafter for any reason. Any such termination shall be effective on the last day of the Initial Term or the intended termination date as stated in the Notice. The parties may terminate this Agreement by mutual consent at any time.

5.06. Notices. Notices under this Agreement shall be given by commercially reasonable means to the party owed such notice at its place of business or as such party subsequently specifies by Notice, and shall be effective upon receipt. Notices of breach and/or termination must be given in writing and delivered personally or via a means of receipted delivery. Unless and until changed, the places of business of the parties are as set forth as follows:

Mercy Hospital and Medical Center
2525 South Michigan Ave.
Chicago, IL 60616-2477
Attention: President/CEO

Saint James School of Medicine
c/o HRDS
4433 W. Touhy Avenue, Suite 215
Chicago, IL 60712

5.07. Headings. Section headings are for convenience only and shall not influence the construction of this Agreement.

5.08. Non-Assignability. This Agreement shall not be assignable by either party without the express written consent of the other party, and any unauthorized assignment shall be deemed a ground for termination.

5.09. Severance. If any provision of this Agreement is deemed invalid, illegal, or unenforceable, in whole or in part, it may be modified to the extent necessary so as to most closely carry out the parties' expressed intent. If modification is not possible, the offensive provision, or portion thereof, shall be deemed severed, and the remainder of this Agreement shall be enforced.

5.10. Entire Agreement/Amendment. Each party acknowledges that it has read and understands this Agreement, and agrees to be bound by its terms. Each party further agrees that this Agreement is the complete and exclusive statement of agreement between the parties that supersedes and merges all prior proposals, understandings, and agreements, oral and written, between the parties relating to the same subject matter for services rendered on or after the Effective Date. This Agreement may not be modified or altered except by written instrument duly executed by all parties.

5.12. Waiver of Breach. The waiver by any party of a breach or violation of any provision of this Agreement shall not operate as, or be considered to be, a waiver of any subsequent breach of the same provision or any other provision of this Agreement.

5.13. Choice of Law/Venue. This Agreement shall be interpreted under the internal laws of the State of Illinois, and both parties consent to jurisdiction of court of the State of Illinois sitting in Cook County and to jurisdiction of the United States District Court for the Northern District of Illinois. The parties waive any venue or inconvenient forum objections to proceeding in such courts and agree to be validly served in connection with any legal proceeding by certified mail addressed as specified for Notices.

5.14. Counterparts. This Agreement may be executed in one or more originals, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument, without necessity of production of the others. Facsimile signatures shall be binding upon the parties until such time as an original and counterpart are executed.

5.15. Binding on Successors in Interest. Subject to Paragraph 5.08, the rights, duties, and obligations hereunder shall extend to, be binding upon, and inure to the benefit of the successors and assigns of each party.

5.16. Authority. Each individual signing this Agreement warrants that such execution has been duly authorized by the party for which he or she is signing. The execution and performance of this Agreement by each party has been duly authorized in accordance with all applicable laws and regulations and all necessary corporate action has been taken, and this Agreement constitutes the valid and enforceable obligation of each party in accordance with its terms.

5.17. Compliance with Applicable Laws, Regulations and Standards. Each of the parties hereto shall abide by and meet all applicable state and federal laws and regulations that pertain to them. This Agreement at all times is subject to applicable state, local and federal laws including the Social Security Act, the Federal Health Insurance Portability and Accountability Act of 1996 and its related regulations (HIPAA), and the Rules and Regulations and policies of the Department of Health and Human Services, all public health and safety provisions of state law and regulation, and accrediting standards of the Joint Commission on Accreditation of Healthcare Organizations.

AGREED:

MERCY HOSPITAL AND MEDICAL CENTER

[redacted]

By: Sister Sheila Lyne, RSM
Its: President/CEO

11/15/04
Date

SCHOOL:

SAINT JAMES SCHOOL OF MEDICINE, Bonaire, Netherlands-Antilles

[redacted]

By:
Its:

Nov. 22nd 04
Date

COPY

Saint James School of Medicine
Clinical Rotation Evaluation Form

Name of Rotation: PEDIATRICS
Student Name: NISHA GOYAL
Dates of Rotation: Start: 05/15/06 Finish: 06/23/06 No. of Wks 6

Preceptor's Name: S. MONTGOMERY, MD. / S. TALATHI, MD.
Name of Hospital/Rotation site: JACKSON PARK HOSPITAL
Address of Rotation site: 7531 STONY ISLAND AVENUE
City/State/Zip: CHICAGO, ILLINOIS 60649
Contact phone: [redacted]
Email:

Student's Evaluation Scores

▪ Knowledge Level	[redacted]	▪ Chart Work	[redacted]
▪ Diagnosis		▪ Treatment/ Implementation	
▪ Therapeutics		▪ Rapport	
▪ Patient Interaction		▪ Responsibility	
▪ Data Collection		▪ Interest	

*NOTE: 10=Outstanding, 9=Advanced, 8=Proficient, 7=Needs Remediation, < 7=Poor/Failing

Comments for Dean's letter:

Nisha is a focussed and disciplined student eager to learn. She completed her assignments on time and in a thorough manner. She established excellent rapport with patients, children, families, and staff members. I recommend her highly for residency program she applies.

*Please return this form by mail to: **St James School of Medicine, 4433 W. Touhy Ave, Ste 368, Chicago, IL 60712. Ph: 800-542-1553 Fax: 847-677-8169.**

Thank you.

Preceptor's Signature: [redacted] **Date** 06/23/06

Saint James School of Medicine
Clinical Rotation Evaluation Form

Name of Rotation: Psychiatry
Student Name: Nisha Goyal
Dates of Rotation: Start: 10/17/05 Finish: 11/25/05 No. of Wks 6

Preceptor's Name: Brooks W. Wilkinson, M.D.
Name of Hospital/Rotation site: Michael Reese Hospital / MERCY Hospital and MEDICAL CENTER
Address of Rotation site: 2929 S. Ellis Ave / 2525 S. Michigan Avenue
City/State/Zip: Chicago, IL 60616 / Chicago, IL 60616
Contact phone: [redacted]
Email:

Student's Evaluation Scores

- **Knowledge Level** [redacted]
- **Diagnosis**
- **Therapeutics**
- **Patient Interaction**
- **Data Collection**
- **Chart Work** [redacted]
- **Treatment/ Implementation**
- **Rapport**
- **Responsibility**
- **Interest**

*NOTE: 10=Outstanding, 9=Advanced, 8=Proficient, 7=Needs remediation, < 7: Poor/Failing

Comments for Dean's letter:

Nisha was truly an outstanding MEDICAL STUDENT during her Psychiatry Rotation! She was always prompt, responsible, and very dependable. Nisha was always ready to do extra work and demonstrated good self-reliance during her rotation. Nisha's data collection and charting were excellent. Nisha also has a very pleasant personality and was especially well-liked by patients and staff. I think she will make an exceptional physician and it was a pleasure to work with her!

*Please return this form by mail to: **St James School of Medicine, 4433 W. Touhy Ave, Ste 368, Chicago, IL 60712. Ph: 800-542-1553 Fax: 847-677-8169.**

Thank you.

Preceptor's Signature: [redacted] **Date** 12/12/05

Saint James School of Medicine
Clinical Rotation Evaluation Form

Name of Rotation: **SURGERY**
Student Name: **NISHA GOYAL**
Dates of Rotation: Start: **Feb. 21, 2006** Finish: **May 12, 2006** No. of Wks **12**

Preceptor's Name: S. Bonomo
Name of Hospital/Rotation site: Mercy hospital + medical Center
Address of Rotation site: 2525 S Michigan Ave
City/State/Zip: Chgo IL 60616
Contact phone: [redacted]
Email:

Student's Evaluation Scores

▪ **Knowledge Level**	[redacted]	▪ **Chart Work**	[redacted]
▪ **Diagnosis**		▪ **Treatment/ Implementation**	
▪ **Therapeutics**		▪ **Rapport**	
▪ **Patient Interaction**		▪ **Responsibility**	
▪ **Data Collection**		▪ **Interest**	

*NOTE: 10=Outstanding, 9=Advanced, 8=Proficient, 7=Needs Remediation, < 7=Poor/Failing

Comments for Dean's letter:
Nisha was enthusiastic + a hard worker. She sought out every opportunity to learn. She was a joy to work with.

*Please return this form by mail to: **St James School of Medicine, 4433 W. Touhy Ave, Ste 368, Chicago, IL 60712. Ph: 800-542-1553 Fax: 847-677-8169.**

Thank you.

Preceptor's Signature: [redacted] Date 6/27/06

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF EDUCATION NON-LCME ACCREDITED MEDICAL COLLEGE

SUPPORTING DOCUMENT

ED- NON

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form. You are authorized to photocopy this form as necessary.

1. NAME — LAST: GOYAL — FIRST: NISHA — MIDDLE: V

2. DATE OF BIRTH: [redacted] (Month Day Year)

3. SOCIAL SECURITY NUMBER: [redacted]

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

6. MAIDEN OR GIVEN SURNAME:

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

temporary physician licensure (Profession Name) — 1 2 5 (Profession Code)

7. NAME OF INSTITUTION ATTENDED: Saint James School of Medicine

8. DATE OF GRADUATION / COMPLETION: 0 3 / 1 6 / 2 0 0 7 (Month / Day / Year)

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below

4/12/07 (Date) — [redacted] (Signature of Applicant)

APPLICANT: DO NOT COMPLETE ANY PORTION BELOW THIS LINE.

SCHOOL OFFICIAL: Complete the bottom portion of this page and the reverse side, then return to the applicant. If this part is partially or totally completed by the applicant, the form will not be accepted.

A. NAME OF INSTITUTION: SAINT JAMES SCHOOL OF MEDICINE

C. ADDRESS OF INSTITUTION: STREET, CITY, STATE, COUNTRY/PROVIDENCE, AND ZIP CODE
4433 N. TOUHY AVE # 368
LINCOLNWOOD, IL 60712

D. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

years 1-2 : 8 months
years 3-4 : 11 months

Indicate length of academic year _____ of months

☒ Applicant completed program on 03/16/2007 (Month Day Year)

☒ Applicant graduated on 03/16/2007 (Month Day Year)

If the above dates differ, please attach a letter of explanation.

B. INDICATE DATES OF ATTENDANCE BY YEAR IN MEDICAL SCHOOL. **EACH YEAR MUST BE LISTED** SEPARATELY. DO NOT GROUP DATES OF ATTENDANCE.

	From (Month/Day/Year)	To (Month/Day/Year)
1st year	01/04/2004	08/30/2004
2nd year	09/04/2004	04/30/2005
3rd year	05/04/2005	04/30/2006
4th year	05/04/2006	03/16/2007
5th year	___/___/_____	___/___/_____
6th year	___/___/_____	___/___/_____
7th year	___/___/_____	___/___/_____

NAME (Last, First, MI): Goyal, Nisha SS#: [redacted] Profession: TEMP. PHYSICIAN LICENSE

E. BASIC SCIENCE COURSES

Course	Date Started Month/Day/Year	Date Completed Month/Day/Year	Course	Date Started Month/Day/Year	Date Completed Month/Day/Year
Anatomy	01/04/2004	04/30/2004	Pathology	01/04/2005	04/30/2005
Physiology	05/01/2004	08/30/2004	Pharmacology and Therapeutics	09/04/2004	12/24/2004
Biochemistry	05/01/2004	08/30/2004	Preventative Medicine	01/04/2005	04/30/2005
Microbiology-Immunology	09/04/2004	12/24/2004			

F. CORE ROTATIONS (e.g. compulsory or basic training)

Core Rotations	Date Started Month/Day/Year	Date Completed Month/Day/Year	Total number of **WEEKS** spent in clinical training on this rotation	Facility Name and Address
Internal Medicine	07/25/2005	10/14/2005	12	Jackson Park Hospital Chicago, IL
Obstetrics-Gynecology	12/26/2005	02/03/2006	6	Mercy Hospital Chicago, IL
Pediatrics	05/15/2006	06/23/2005	6	Jackson Park Hospital Chicago, IL
Psychiatry	10/17/2005	11/25/2005	6	Mercy Hospital Chicago, IL
Surgery	02/21/2006	05/12/2006	12	Mercy Hospital Chicago, IL.

I certify that the information recorded herein is true and correct according to the official records of this institution.

SCHOOL SEAL

[redacted] Kallol Guha
Signature of School Official

Kallol Guha
Print Name of School Official

President and CEO
Title

04/12/07
Date

RETURN THIS FORM TO APPLICANT

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE
GOYAL NISHA V

3. ADDRESS STREET, CITY, STATE, ZIP CODE
[redacted]

4. DATE OF BIRTH
[redacted]
Month Day Year

5. SOCIAL SECURITY NUMBER
[redacted]

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☐ Permanent Physician License	036
☒ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION
American Health Center

ADDRESS STREET, CITY, STATE, ZIP CODE
1640 N. Arlington Hts Rd. Suite # 110 Arlington Hts IL 60004

DATE OF EMPLOYMENT/ATTENDANCE
From 05 / 01 / 1999 (Month / Day / Year)
To 08 / 01 / 2000 (Month / Day / Year)

HOURS WORKED PER WEEK
15

TYPE OF EMPLOYMENT
☐ Full-time ☒ Part-time

TOTAL TIME WORKED (Year/Month)
1 year 3 months

JOB TITLE
receptionist

DESCRIPTION OF DUTIES PERFORMED
answering phone
scheduling appointments

B. NAME OF BUSINESS / INSTITUTION
Gap Inc

ADDRESS STREET, CITY, STATE, ZIP CODE
Woodfield Mall Schamburg, IL

DATE OF EMPLOYMENT/ATTENDANCE
From 09 / 01 / 1998 (Month / Day / Year)
To 09 / 01 / 1999 (Month / Day / Year)

HOURS WORKED PER WEEK
10

TYPE OF EMPLOYMENT
☐ Full-time ☒ Part-time

TOTAL TIME WORKED (Year/Month)
1 year.

JOB TITLE
Sales associate / cashier

DESCRIPTION OF DUTIES PERFORMED
cashier

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 5/25/2007

Initials: DR

License No: 125 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

NISHA V GOYAL MD
ST JOSEPH HOSPITAL
DEPT OF GME
2900 N LAKE SHORE DR
CHICAGO, IL 60657

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Submit a copy of your current and valid ECFMG certificate.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.

USMLE
United States
Medical
Licensing
Examination
™

UNITED STATES MEDICAL LICENSING EXAMINATION ™

Students and graduates of medical schools outside the United States and Canada
are registered for Step 1 by the
EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES
3624 Market Street, Philadelphia, Pennsylvania 19104-2685, U.S.A.
Telephone: 215-386-5900 Internet: www.ecfmg.org

STEP 1 SCORE REPORT

Nisha V Goyal
[redacted]

DATE: July 27, 2005

USMLE ID [redacted]

TEST DATE: June 27, 2005

The USMLE is a single examination program consisting of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 1 is designed to assess whether an examinee understands and can apply important concepts of the sciences basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease, and modes of therapy. The inclusion of Step 1 in the USMLE sequence is intended to ensure mastery of not only the sciences underlying the safe and competent practice of medicine in the present, but also the scientific principles required for maintenance of competence through lifelong learning. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 1 on the test date shown above.

PASS	This result is based on the minimum passing score set by USMLE for Step 1. Individual licensing authorities may accept the USMLE recommended pass/fail result or may establish a different passing score for their own jurisdictions.
[redacted]	This score is determined by your overall performance on Step 1. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools are approximately 216 and 24, respectively, with most scores falling between 140 and 260. A score of 182 is set by USMLE to pass Step 1. The standard error of measurement (SEM)‡ for this scale is six points.
[redacted]	This score is also determined by your overall performance on the examination. A score of 75 on this scale, which is equivalent to a score of 182 on the scale described above, is set by USMLE to pass Step 1. The SEM‡ for this scale is two points.

‡Your score is influenced both by your general understanding of the basic biomedical sciences and the specific set of items selected for this Step 1 examination. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF EDUCATION

SUPPORTING DOCUMENT

ED

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.

1. NAME — LAST: Goyal — FIRST: Nisha — MIDDLE: V

2. DATE OF BIRTH (Month Day Year): [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: Temp Physician Licensure — Profession Code: 1 2 5

6. MAIDEN OR GIVEN SURNAME:

7. NAME OF INSTITUTION ATTENDED: Univeristy of Illinois Urbana-Champaign

8. DATE OF GRADUATION / COMPLETION (Month / Day / Year): 12 / 22 / 2003

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

Date: 4/13/07

Signature of Applicant: [redacted]

SCHOOL OFFICIAL: Complete the bottom portion of this page and the reverse side. RETURN THE COMPLETED FORM TO THE APPLICANT.

A. NAME OF INSTITUTION: The University of Illinois Urbana-Champaign

B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE: 901 W. Illinois Street Urbana, IL 61801

C. DEPARTMENT OF INSTITUTION: Records

D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT: Economics

E. MAJOR AREA OF STUDY OF THE APPLICANT: Economics

F. APPLICANT WAS (CHECK ONE): [x] Full-time [ ] Part-time [ ] Co-op

G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE)
- [x] 156 Semester Hours
- [ ] _____ Quarter Hours
- [ ] _____ Course Hours

H. DATES OF ATTENDANCE: From 08 / 23 / 2000 (Month Day Year) To 12 / 20 / 2003 (Month Day Year)

I. Total academic years attended (Years Months Days) _____ OR Total calendar years attended (Years Months Days) _____

J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., M.D., Ph.D.): BS

K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET (Month Day Year): 12 / 20 / 2003

L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED (Month Day Year): 12 / 22 / 2003

M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE
- [x] Applicant has graduated on 12 / 22 / 2003 (Month Day Year)
- [ ] Applicant has completed program on __ / __ / ____ (Month Day Year)
- [ ] Applicant will graduate on __ / __ / ____ (Month Day Year)
- [ ] Applicant will complete program on __ / __ / ____ (Month Day Year)

N. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

NAME (Last, First, MI):

SS#:

Profession:

I certify that the information recorded herein is true and correct according to the official records of this institution.

Melinda K. DelRossi
Print Name of School Official

[redacted]
Signature of School Official

Secretary (217) 333-9779
Title

April 13, 2007
Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this _____ day of _____, 20____.

Date of Expiration

Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.

33608666 61

Place Label Here or Name

Goyal, Nisha V

[redacted]

DO NOT WRITE IN BOX

Profession Code

License # or SSN #

[redacted]

FILE ROUTE CARD

DO NOT WRITE ON FILE FOLDER

IL486-1327 10/04 (RS)

(Do Not Use This Application for Renewal of an Existing License)

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

1. If you hold a non-renewed Controlled Substance License, you must reinstate that license. Do not apply for a new license.
2. Ever[illegible] [illegible]trolled sub[illegible]ense issu[illegible]ional Re[illegible] 336 Cred #2924476 07/21/2009 olled Sub[illegible] By:NON-EXAM
3. A s[illegible] SSN:[redacted] d for eac[illegible]here controlled substances are stored or located.
4. A State Controlled Substances Registration is prerequisite to a Federal Controlled Substances Registration.
5. Controlled Substances License will not be issued to a temporary license holder.

Lic#: GOYAL, NISHA V

A. Type or print legibly with black ink only.
B. The fee is $5 - Make check payable to the Department of Financial and Professional Regulation. THIS FEE IS NOT REFUNDABLE! (Separate application/fee is required for each registration.)
C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

1. PROFESSIONAL NAME	2. PROFESSIONAL CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☒336 Physician ☐316 Podiatrist ☐390 Veterinarian	Registration	$5

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
GOYAL	NISHA		MD	[redacted]

4. PERMANENT MAILING ADDRESS [redacted] CITY STATE/COUNTRY ZIP CODE COUNTY

5. NAME OF BUSINESS AND ILLINOIS LOCATION (STREET/CITY/ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED

See Attached

IL _____+____

6. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

7. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work ([redacted] Area Code) FAX ( ) _____ Area Code / Area Code

Home ([redacted] Area Code) FAX ( ) _____ Area Code / Area Code

PART III: Professional Activity

Practitioner--Check and complete one of the following:

	Professional License Number
☐Dentist	019 - _____
☒Physician	036 - _____
☐Podiatrist	016 - _____
☐Veterinarian	090 - _____

PART IV: Drug Schedule

Circle the schedules for which you are applying:

II IIN III IIIN IV V

See Attached

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

RECEIVED APR 01 2010 DEPT. MEDICAL UNIT

Disclosure of your U.S. social security number, if you have one, is ***mandatory***, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

1. PROFESSIONAL NAME	2. PROFESSIONAL CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☒336 Physician ☐316 Podiatrist ☐390 Veterinarian	Registration	$5

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
GOYAL	NISHA	✓	M.D.	[redacted]

4. PERMANENT MAILING ADDRESS [redacted] CITY [redacted]

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED

6. If you will ***not*** be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

☒ I will ***not*** be storing or dispensing controlled substances, including samples.

7. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

8. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work [redacted] Area Code **FAX** ( ) Area Code

Home [redacted] Area Code **FAX** ( ) Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:

II IIN III IIIN IV V

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 -
☒	Physician	036 - 124169
☐	Podiatrist	016 -
☐	Veterinarian	090 -

PART V: 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 been convicted of a felony?		X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.		X
4. 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
5. 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
6. 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

PART VI: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☒
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☒

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

6/20/09
Date of Application

[redacted]
Signature of Applicant

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and 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.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

NAME (Last, First, MI): Gouak, Nisha

SS#: [redacted]

Profession: physician

PART V: 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 been convicted of a felony?		X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.		X
4. 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
5. 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
6. 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

PART VI: Child Support and/or Student Loan Information (every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☒
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☒

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

3/25/10
Date of Application

[redacted]
Signature of Applicant

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and 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.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

NAME (Last, First, MI): GOMAL, NISHA V
SS#: [redacted]
Profession: Physician

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 7/23/2009

Initials: CS

License No: 336 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

NISHA V GOYAL MD
[redacted]

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

A Controlled Substance license is only issued to physicians holding a permanent license.

Need to specify the address where you intend on storing and dispensing drugs in Part II #5.

Need to indicate the drug schedules which you are applying for in Part IV.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.

336.086661

Direct Inquiries to the
Licensure Maintenance Unit

Telephone No.: 217-782-0458
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 4/6/2010

Initials: MP

License No: 036.124169

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES PLEASE MAKE THE CORRECTIONS OR ADDITIONS MARKED BELOW AND RESUBMIT

TO:

NISHA V GOYAL MD
[redacted]

RECEIVED
APR 07 2010
IDFPR - MEDICAL UNIT

RETURN THIS FORM AND APPLICATION WITH REMITTANCE IF APPLICABLE

☐	1. We are returning your application(s) on which the fee(s) has/have been accepted and validated.
●	2. We are returning your application and fee(s) in the amount of **$5.00**
☐	3. Submit the correct and required processing fee of $
☐	4. Payment must be in the form of a check or money order made payable to the Dept. of Financial and Professional Regulation.
☐	5. Remittance must be signed and currently dated.
☐	6. Application must be signed.
☐	7. The enclosed form(s) must be completed in full and returned with your application.
☐	8. Your profession, social security number, and/or a license number must be shown on the enclosed form.
☐	9. Your home address must be shown on the application.
☐	10. Your documentation of name change was unacceptable. Please comply with number 11 below.
☐	11. Submit proof of legal name change, i.e., photocopy of marriage certificate, divorce decree, court order, naturalization document or amended articles of incorporation.
☐	12. Your license must be active before your request can be processed. Comply with other indicated instructions.
☐	13. Your license expired on . A fee in the amount of $ is required to make your license active until .
☐	14. Submit your current active license and pocket card or submit a statement explaining your inability to do so.
☐	15. Submit a copy of an assumed name certificate (obtainable from your county clerk's office).
☐	16. Indicate Illinois business address in the space provided on the enclosed form.
☐	17. A recent passport size photograph must accompany your application.
☐	18. A copy of your insurance policy showing a minimum liability coverage of $1,000,000 must be submitted with your renewal.
☐	19. Your profession is now in renewal. Therefore, we are unable to process your request.
☐	20. Your license is currently non-renewed. Complete enclosed application(s) and submit with fee(s).
☐	21. Submit proof of property damage insurance showing minimum amount of $250,000 for each occurrence and liability in minimum amount of $500,000 for each occurrence of personal injury and bodily harm.
☐	22. Submit Roofing Contractor Bond in the aggregate amount of $5,000.
☐	23. Your renewal/reinstatement is being returned because you have not answered all questions and/or affixed your signature.
☐	24. We cannot process a renewal for controlled substance to an out-of-state address.
☐	25. You are required to submit proof, i.e., photocopy of hours of continuing education taken within the past months.

Other Instructions: WE SHOW YOUR APPLICATION FEE HAS ALREADY BEEN PAID, WE DO NOT REQUIRE THIS ADDITIONAL FEE

DUB

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

Disclosure of your U.S. social security number, if you have one, is ***mandatory***, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

1. PROFESSIONAL NAME	2. PROFESSIONAL CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☑336 Physician ☐316 Podiatrist ☐390 Veterinarian	Registration	$5

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
GOYAL	NISHA	V	M.D.	[redacted]

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

[redacted]

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED

6. If you will ***not*** be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

☑ I will ***not*** be storing or dispensing controlled substances, including samples.

7. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

8. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work ( ) _____ **FAX** ( ) _____
Area Code Area Code

Home ([redacted]) _____ **FAX** ( ) _____
Area Code Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:

II IIN III IIIN IV V

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 - _____
☑	Physician	036 - 124169
☐	Podiatrist	016 - _____
☐	Veterinarian	090 - _____