Cassing Hammond

036.090424

2008

Electronic Renewal Record

Exit | Find Another

License Number	036090424
Pin	[redacted]
Phone	
Authorization	
SSN	
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	5/1/2008
Renewal Fee	$300.00
Fee Type	3
Service Fee	$5.00
Memo	

Method | Credited:

User Responses

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

Print Record | Next Record

2011

Electronic Renewal Record

Exit | Find Another

License Number	036090424
Pin	[redacted]
Phone	
Authorization	
SSN	
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	4/17/2011
Renewal Fee	$300.00
Fee Type	R
Service Fee	$5.00
Memo	

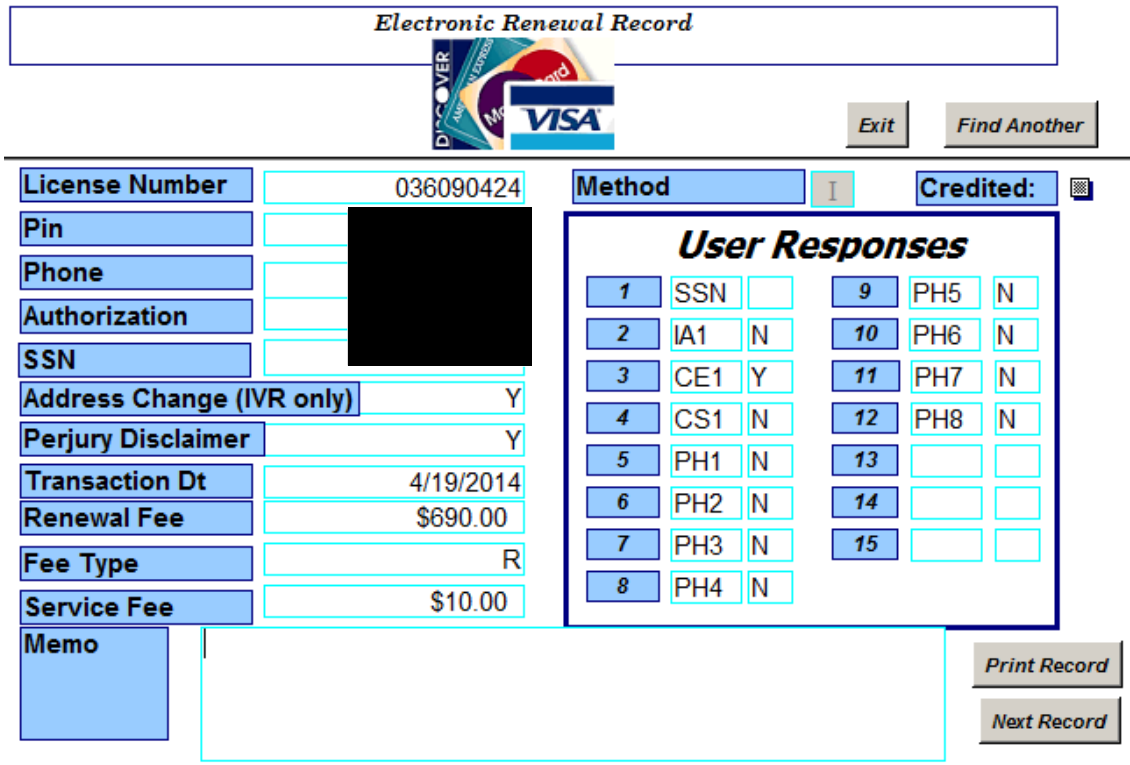
Method | Credited:

User Responses

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

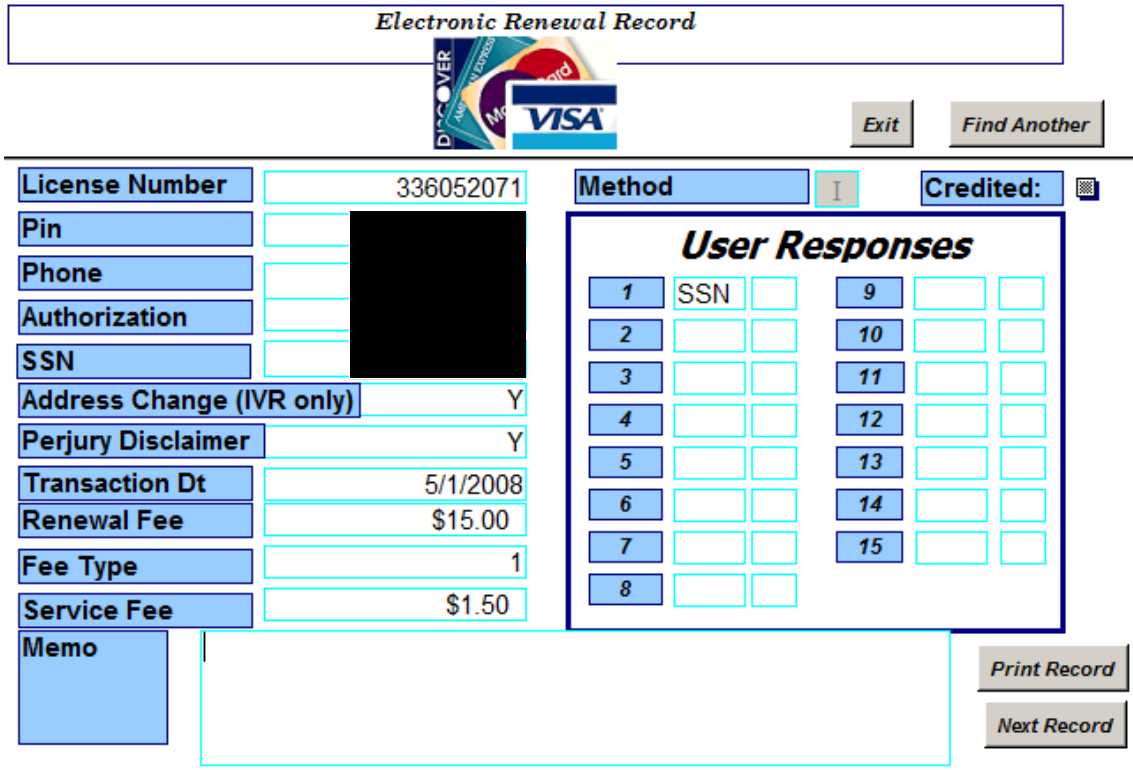
Print Record | Next Record

2014



336.052071

2008



2011

Electronic Renewal Record

Exit | Find Another

License Number	336052071
Pin	[redacted]
Phone	
Authorization	
SSN	
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	4/17/2011
Renewal Fee	$15.00
Fee Type	R
Service Fee	$1.50
Memo	

Method | Credited:

User Responses

1	SSN		9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8					

Print Record | Next Record

2014

Electronic Renewal Record

Exit | Find Another

License Number	336052071
Pin	[redacted]
Phone	
Authorization	
SSN	
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	4/19/2014
Renewal Fee	$15.00
Fee Type	R
Service Fee	$1.50
Memo	

Method | Credited:

User Responses

1	SSN		9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8					

Print Record | Next Record

3 0 0 0 0 7 1 4 1 7

PAGE ONE

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

APPLICATION FOR LICENSURE AND/OR EXAMINATION

2 1 7

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

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

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

A. Type or print legibly with black ink only.

B. The licensure and application fee are NOT refundable.

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

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

RECEIVED
FEB 14 1996
DEPARTMENT OF PROFESSIONAL REGULATION

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician	0 3 6	Endorsement	$ 300.00

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.

MD 02846 88

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

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

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

[redacted]

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

2030 Monroe Avenue Rochester, NY/USA 14618-____

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

7. PLACE OF BIRTH CITY STATE/COUNTRY	8. DATE OF BIRTH	9. AGE
[redacted]	[redacted]	30

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Wo[redacted] Home [redacted]
Area Code

IL486-1019 8/93 (LT)

PART III: Education Information

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

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

Graduated High School? ☒ Yes ☐ No

Received OR G.E.D.? ☐ Yes ☐ No

2 NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3 LAST PRELIMINARY SCHOOL LOCATION (City and State)	4 DATE OF GRADUATION
Greenwood School	Springfield, Missouri	05 / 82 (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 Missouri-Kansas City Six Year Medical School (BA/MD program)		6-82	6-88	BA and MD
(NOTE: This is a combined undergraduate and medical curriculum)				

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?
University of Rochester Dept. of ObGyn	Rochester, New York	7-88	6-92	☒ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

PART IV: Record of Licensure Information

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure New York	Physician	180304	Since 1989	Active
State of Current Licensure where you most recently have been practicing. SAME				
Other States of Licensure				
NONE				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
National Board Of Medical Examiners			
Part One		6-86	Passed
Part Two		9-87	Passed
Part Three		4-89	Passed
American Board of Obstetrics and Gyn.	Written exam	7-92	Passed
	Oral exam	12-94	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 statement for each conviction including date and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.*		X
2 Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		X
3 Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		X
4 Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		X
5 Are you a U.S. citizen **OR** a lawfully admitted alien of the United States?	X	

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

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

a) CHART II - Select examination(s) you desire and enter Test Codes — TEST CODES

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

c) CHART IV - Find your School of Graduation and enter school code — SCHOOL CODE

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

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

PART VIII: Certifying Statement

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

[redacted] 2-6-95

Date

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

PRINTED BY THE AUTHORITY OF
THE STATE OF ILLINOIS
12/93/30,350/REQ. X29073
PRINTED ON RECYCLED PAPER

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

WORK HISTORY

0 9 5 1 7 2 1 7

SUPPORTING DOCUMENT

WH

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

1. NAME LAST FIRST MIDDLE: Hammond Cassing

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Physician (Profession Name) 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

8. DATE FORM COMPLETED: 2-5-95

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

A. NAME OF BUSINESS/INSTITUTION: Private Practice

ADDRESS STREET, CITY, STATE, ZIP CODE: 2030 Monroe Avenue
Rochester, NY 14618

SUPERVISOR NAME: Self

DATE OF EMPLOYMENT/ATTENDANCE: 8-94 to present
From 08 / 01 / 94 (Month / Day / Year)
To 02 / 05 / 95 (Month / Day / Year)

HOURS WORKED PER WEEK: 80-100

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

TOTAL TIME WORKED (Yr./Mo.): 6 months

JOB TITLE: Private Practice-ObGyn

DESCRIPTION OF DUTIES PERFORMED:
Since 8-94 I have operated a private ObGyn practice which remains affiliated with the extension clinic of Highland Hospital that formally employed me for the two preceding years. I continue part time employment with the hospital Duties include standard ObGyn care plus education of residents from the University of Rochester's family medicine and ObGyn programs.

B. NAME OF BUSINESS/INSTITUTION: Highland Hospital of Rochester

ADDRESS STREET, CITY, STATE, ZIP CODE: 1000 South Avenue; Rochester, NY 14620

SUPERVISOR NAME: Michael Widener, CEO; Highland Hospital

DATE OF EMPLOYMENT/ATTENDANCE:
From 07 / 20 / 92 (Month / Day / Year)
To 07 / 31 / 94 (Month / Day / Year)

HOURS WORKED PER WEEK: 80-100

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

TOTAL TIME WORKED (Yr./Mo.): 2 years

JOB TITLE: Attnding Physician/ObGyn

DESCRIPTION OF DUTIES PERFORMED:
Opening an extension clinic of Highland Hospital and gradually assuming the practice of two retiring physicians (subsequent private practice described above). Otherwise, same activities as above.

COMPLETE THE REVERSE SIDE OF THIS FORM

C. NAME OF BUSINESS/INSTITUTION
University of Rochester; Dept. of ObGyn

JOB TITLE
Resident Physician;ObGyn

ADDRESS STREET, CITY, STATE, ZIP CODE
601 Elmwood Avenue
Rochester, NY

DESCRIPTION OF DUTIES PERFORMED
Resident Physician, ObGyn

SUPERVISOR NAME
Dr. Henry Thiede, Chairman of Dept.

DATE OF EMPLOYMENT/ATTENDANCE
From 07 / 01 / 88 (Month / Day / Year)
To 06 / 30 / 92 (Month / Day / Year)

HOURS WORKED PER WEEK
80-100

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Yr./Mo.)
4 years

D. NAME OF BUSINESS/INSTITUTION
Graduation from Medical School 6-88

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE
From __ __ / __ __ / __ __ (Month / Day / Year)
To __ __ / __ __ / __ __ (Month / Day / Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Yr./Mo.)

E. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE
From __ __ / __ __ / __ __ (Month / Day / Year)
To __ __ / __ __ / __ __ (Month / Day / Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Yr./Mo.)

Illinois

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CUSTOMER SERVICE UNIT
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

[redacted] 217

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, HAMMOND CASSING
WAS ISSUED LICENSE/CERTIFICATE NUMBER 130804 FOR THE PRACTICE OF MEDICINE ON 10/10/89.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: [redacted]
SCHOOL ATTENDED: U MISSOURI COLUMBIA
DATE OF GRADUATION: 05/31/88
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

RECEIVED
STATE OF ILLINOIS
FEB 28 1995
DEPARTMENT OF

BASIS OF LICENSURE:
NAT BD CERT #353666 DATED 7/1/87

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: YES [redacted]
ADDRESS: [redacted]

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I FRANCES HARRIS, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

MAR 03 1995

SEAL

[redacted] 02/21/95
PRINCIPAL CLERK

OP026 054

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

CERTIFICATION 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 Month Day Year	3. SOCIAL SECURITY NUMBER
Hammond	Cassing		[redacted]	[redacted]

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

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

Physician (Profession Name) — 0 3 6 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

7. ILLINOIS TEMPORARY LICENSE NUMBER (if applicable):

8. ISSUANCE DATE:

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to: Illinois Department of Professional Regulation, 320 West Washington - HSS1, Springfield, Illinois 62791

NOTE: Certification of postgraduate clinical training will not be accepted if certified more than 15 days prior to date of actual completion.

This is to certify that the above-named applicant has/will have satisfactorily completed 48 months of postgraduate clinical training in Obstetrics/Gynecology
(Name of Accredited Postgraduate Clinical Training Program)

from 7/1/88 to 6/30/92 at the following hospital:

Hospital: Strong Memorial Hospital

Number and Street: 601 Elmwood Avenue, Box 612

City, State and Zip Code: Rochester, NY 14642

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

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

Name of Postgraduate Clinical Training Program Director: Henry Thiede, M.D.

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: February 20, 1995

SEAL

Telephone No: [redacted]

IL486-1535 8/93 (MD)

FEB 27 1995

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

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

0 9 1 2 1 7

Diplomate Name: Cassing Hammond, MD

Date of Birth: [redacted]

Certification Date: 07/01/1989 **Certificate #:** 353666

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

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME PART I	Jun 1986	[redacted]		PASS	[redacted]						
NBME PART II	Sep 1987			PASS	Med	Surg	Ob/Gyn	PM/PH	Ped	Psych	
NBME PART III	Mar 1989			PASS	[redacted]						

DATE: 02/21/1995

SEE OTHER SIDE FOR SCORE INFORMATION

MAR 07 1995

IL0369

[redacted]

036-90424

IMPORTANT NOTICE: Completion of this form is required by 720 of the Illinois Compiled Statutes (Chap. 56 1/2, of the Ill. Rev. Stat. 1985). 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. This form has been approved by the Forms Management Center.

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

A Controlled Substances license will not be issued until your professional license has been issued.

RECEIVED
HEALTH SERVICES SECTION
MAR 27 1995
DEPARTMENT OF
PROFESSIONAL REGULATION

1. Every person who prescribes or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Professional Regulation in accordance with the Illinois Controlled Substances Act.
2. A separate controlled substance registration is required for each place of professional practice or business where controlled substances are stored or located.
3. A State Controlled Substances Registration is prerequisite to a Federal Controlled Substances Registration.

A. Type or print legibly with black ink only.

B. The fee is $5 - Make check payable to the Department of Professional Regulation. The fee is not refundable. (Separate application/fee required for each registration.)

C. Submit application and fee to:

Department of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION.
(Do not use this form to renew existing Registration)

MAR 1 3 1995

☒ First Time Applicant ☐ Additional Location (separate office where drugs are stored)

PART I: Application Category Information

1 PROFESSIONAL NAME	2 PROFESSIONAL CODE	3 LICENSURE METHOD	4 FEE
Controlled Substances	0 0 3	Registration	$5

PART II: Application Identifying Information

1 NAME LAST	FIRST	MIDDLE	2 TITLE (e.g. M.D., D.O.S., etc.)	[redacted]
Hammond	Cassing		MD	

4 LOCATION WHERE DRUGS ARE STORED
680 North Lakeshore Drive/Dept. of ObGyn

5 STREET	CITY	STATE/COUNTRY	ZIP CODE	COUNTY
680 North Lake Shore Drive	Chicago	Illinois	6 0 6 1 1 + ____	Cook

6 MAIDEN OR GIVEN SURNAME (If applicable)	7 PLACE OF BIRTH CITY STATE/COUNTRY	8 DATE OF BIRTH
(Same as above)	[redacted]	[redacted]

9 TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work ([redacted]) [redacted]
Area Code

Note: Illinois home phone pending.

Home [redacted]
Area Code

PART III: Professional Activity

1 CHECK AND COMPLETE ONE OF THE FOLLOWING

Practitioner *(Give Professional License No.)*

- ☒ Physician 036 - 090424
- ☐ Dentist 019 - _____
- ☐ Podiatrist 016 - _____
- ☐ Veterinarian 090 - _____

5-1-95
CS

Illinois license No. pending at time application is filed.

2 DRUG SCHEDULES (Circle the schedules for which you are applying)

II IIN III IIIN IV V

IL486-0500 6/93 (CS)

REVERSE SIDE MUST BE COMPLETED

PART IV: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you ever been charged or convicted of any drug related criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a statement for each conviction including dates and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.*		X
2. Do you now suffer, have you suffered from, been diagnosed as having, or been treated for any disease or condition which is generally regarded by the medical community as chronic, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; and (3) physical disease or condition that could interfere with your ability to practice your profession? *If yes, attach a detailed statement, including a statement whether or not you are currently under treatment.*		X
3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		X
4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		X
5. Has any previous registration held by the applicant under the Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? *If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.*		X

PART V: 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.

Cassing Hammond, MD
Print Name of Applicant

[redacted]
Signature of Applicant

3-6-95
Date of Application

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

IL486-0500 6/93 (CS)

Application must be completed in its entirety.

If not completed, it will be returned to the address noted on front of application.