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RECEIVED
STATE
FEB - 8 1988
DEPARTMENT OF PROFESSIONAL REGULATION

PAGE ONE

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter III of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

APPLICATION FOR LICENSURE / EXAMINATION

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

1. Four page APPLICATION FOR LICENSURE/ 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 you may be required to submit with your application.
5. SCANTRON FORM, must be completed and submitted with your application.

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

1. Type or print legibly with black ink only.
2. The licensure fee and application fee are NOT refundable.
3. Disclosure of Social Security number is not mandatory. It is used only to ensure identification, accuracy and to expedite processing of your application.
4. If the name shown on your supporting documents is different from that shown on your application, you must submit proof of legal name change—marriage license, divorce decree, affidavit or court order.
5. Any document in a foreign language must be accompanied by an original, notarized English translation. The translator must not be related to you by blood or marriage; must be fluent in both English and the foreign language; and must certify to these requirements as well as the accuracy of the translation.

PART I: Application Category Information. (See REFERENCE SHEET, CHART I, prior to completing PART I.)

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
PHYSICIAN/SURGEON	0 3 6	Acceptance of Exam: FLEX	$ 300.00

PART II: Applicant Identifying Information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE	3. SOCIAL SECURITY NUMBER
LICHTENBERG,	EDWARD	STEVE	PHYSICIAN/SURGEON	[redacted]

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

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

6. MAIDEN OR GIVEN SURNAME
N/A

7. PLACE OF BIRTH CITY STATE/COUNTRY	8. DATE OF BIRTH	9. AGE
[redacted]	[redacted]	42

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Area Code [redacted]

IL486-1019 2/87 (L.T.A)

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School — Circle number of years completed)

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

Graduated High School? [X] Yes [ ] No

Received G.E.D.? [ ] Yes [X] No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
WALNUT HILLS HIGH SCHOOL	CINCINNATI, OHIO	06 / 63 (Month / Year)

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

1 2 3 4 5 6 7 8

Graduated? [X] 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
CORNELL UNIVERSITY	ITHACA, NEW YORK	9/63	6/67	BA

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 PENNSYLVANIA	PHILADELPHIA, PENNSYLVANIA	9/67	6/71	MD DEGREE [X] Yes [ ] No
ST. LUKES HOSPITAL	SAN FRANCISCO, CALIFORNIA	7/71	6/72	INTERNSHIP [X] Yes [ ] No
UNIVERSITY OF CALIFORNIA, BERKELEY	BERKELEY, CALIFORNIA	7/72	6/73	MPH DEGREE [X] Yes [ ] No
UNVERSITY OF CALIFORNIA, SAN FRANCISCO	SAN FRANCISCO, CALIFORNIA	7/79	6/82	RESIDENCY/OB-GYN [X] Yes [ ] No
				[ ] Yes [ ] No

LEB - 8 1989

PART VI: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you ever 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. Also include, where applicable, certified copies of order evidencing discharge from penalties imposed, or if such copies are not obtainable, a notarized statement explaining their unavailability.*		X
2. Do you have any physical or mental impairment or disability that could interfere with your ability to practice your profession? *If yes, attach a detailed explanation.*		X
3. Are you now addicted to or do you excessively use alcohol, narcotics, barbiturates or habit-forming drugs? *If yes, attach a detailed explanation.*		X
4. Have you ever suffered from, been diagnosed as having, or been treated for any disease or condition which is generally regarded by the medical community as chronic, including (1) physical disease or condition; (2) mental or emotional disease or condition; and (3) alcohol or other substance abuse? *If yes, attach a detailed statement, including a statement whether or not you are currently under treatment and a signed statement regarding the disease or condition from your treating physician.*		X
5. Have you ever been denied a license, permit, or privilege of taking an examination by any licensing authority? *If yes, attach a detailed explanation.*		X
6. Have you ever had a license or permit encumbered in any way (revoked, suspended, surrendered, censured, restricted, limited, placed on probation)? *If yes, attach a detailed explanation.*		X
7. 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
8. Have you ever been declared incompetent by any court by reason of mental or physical defect or disease? *If yes, attach a detailed explanation.*		X
9. Are you a U. S. citizen **OR** a lawfully admitted alien of the United States?	X	
10. Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated?	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 other state.

EXAM ATTEMPTS

PART VIII: Certifying Statement

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

[redacted]

Signature of Applicant

1/2/88

Date

0 0 8 3 1 1 3 0 1 7 0
FEB 10 88
DEPT OF PROF REG FOR DEPOSIT
PAY INDEPENDENCE BY CHECKS
DEPT OF PROF REG FOR DEPOSIT
PAY INDEPENDENCE BY CHECKS
DEPT OF PROF REG FOR DEPOSIT
PAY INDEPENDENCE BY CHECKS

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, complete the information requested below. 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. Enclosed in this application package are two Certification by Licensing Agency/Board forms for that purpose. If you have ever held a temporary, trainee or apprenticeship license or a permit or related license, it must be listed here also. 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 CALIFORNIA	PHYSICIAN/SURGEON	A024879	9/72	ACTIVE
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				
NONE				

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

PART V: Record of Examination

If you have ever written 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)
FLEX	CALIFORNIA	6/72	PASSED

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

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

CERTIFICATION BY LICENSING AGENCY/BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: *Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board.* 0 0 8 8 1 1 3 0 1 7 0

1. NAME LAST: LICHTENBERG FIRST: EDWARD MIDDLE: STEVE

2. DATE OF BIRTH: [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/SURGEON — Profession Name

0 3 6 — Profession Code

6. MAIDEN OR GIVEN SURNAME: N/A

7a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable) PHYSICIAN AND SURGEON

7b. LICENSE NUMBER (If applicable): A024879

7c. ISSUANCE DATE OF LICENSE (If applicable): 9/72, Renewed 1977 1982 1987

I hereby authorize BOARD OF MEDICAL QUALITY ASSURANCE 1430 HOWE AVENUE SACRAMENTO, CALIFORNIA 95825 (Name of Licensing Agency or Board) to furnish to the Illinois Department of Registration and Education or its designated testing service, the information requested below.

Date 12/1/87 Signature Edward Steve Lichtenberg

E. STEVE LICHTENBERG, M.D.
OB/GYN
A 024879

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

PART I. – CERTIFICATION OF EXAMINATION STATUS

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

Name of Examination _____ Date of Examination _____

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

APR 25 1988

PART II. – CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE: Physician and Surgeon

B. LICENSE NUMBER: A24879

C. ISSUANCE DATE OF LICENSE: 8-18-72

D. EXPIRATION DATE OF LICENSE: 2-28-89

E. LICENSURE METHOD

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

F. CURRENT LICENSE STATUS

[X] Active
[ ] Inactive
[ ] Lapsed
[ ] Other (Explain) _____

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination	Score
Written	
Practical	
Other (Describe)	
Received no Grade Below	

Examination Period _____ days _____ hours

IL486-0850 9/86 (LT-A)

Complete the Reverse Side of this Form →

PART III. CERTIFICATION OF EXAMINATION SCORES

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

1. Date of Examination: 6/13-15/72 — Raw Score: _____
Standard Deviation: ~~0 0 8 3~~ 1 1 3 (Corrected Score: 1 7) — Corrected Score: _____
National Mean: _____ — Percent Score: _____

2.

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE
Anat. inc. Histoloigy		[redacted]	Physiology		[redacted]
Biochemistry			Pathology		
Microbiology			Pharmacology		
Medicine			Surgery		
Ob & Gyn			Public Health & Preventive Med		

~~B. State Constructed Examination~~

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE
Pediatrics		[redacted]	Psychiatry		[redacted]
Clinical Competenct			GENERAL AVERAGE		

PART IV. FORMAL ACTIONS

A. Is there now or has there ever been any action commenced against the applicant? [ ] Yes [X] No

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

PART V. RECIPROCAL REGISTRATION

This state [X] does [ ] does not grant the same privilege of reciprocal registration to Illinois registrants.
Within the limits of California law.

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

Diane L. Ford, Program Manager
Print Name

Division of Licensing
Title

[redacted]
Signature

SEAL

Board of Medical Quality Assurance
Agency/Board Street Address

April 19, 1988
Date

1430 Howe Ave, Sac, CA 95825
City, State, Zip Code

Area Code [redacted]
Telephone Number

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Article III of the Illinois Medical Practice Act. This form is approved by the Illinois Manage[illegible]

CERTIFICATION OF TRAINING

MAR 1988

SUPPORTING DOCUMENT

TN

APPLICANT: *Complete the applicant section of this form. Forward the form to the individual who will certify your training. Return the completed form with your Application for Licensure/Examination.*

1. NAME — LAST: LICHTENBERG; FIRST: EDWARD; MIDDLE: STEVE

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/SURGEON — Profession Name

0 3 6 — Profession Code

6. MAIDEN OR GIVEN SURNAME: N/A

7. DATES OF TRAINING: FROM 7 / 1 / 79 (Month Day Year) TO 6 / 1 / 82 (Month Day Year)

8. ILLINOIS TEMPORARY CERTIFICATE OF REGISTRATION NUMBER (If Applicable):

ISSUANCE DATE (If Applicable):

9. SPECIFIC NAME OF TRAINING RECEIVED: RESIDENCY, OB-GYN

10. SUPERVISOR/INSTRUCTOR NAME: RUSSELL LAROS, MD c/o UNIV CALIF. SAN FRANCISCO SCHOOL OF MEDICINE DEPT OB-GYN ~~SAN FRANCISCO, CALIF.~~

CERTIFYING OFFICIAL: *Complete the remainder of this form. Return the completed form to the applicant.*

A. SUPERVISOR/INSTRUCTOR NAME: John L. Kitzmiller, M.D.

B. INSTITUTION/BUSINESS NAME: Univeristy of California, San Francisco Department of Ob/Gyn

C. SUPERVISOR/INSTRUCTOR JOB TITLE/PROFESSION NAME: Chief of Obstetrics

D. INSTITUTION/BUSINESS STREET ADDRESS: Box 0132, 505 Parnassuss Avenue San Francisco, CA 94143

E. SUPERVISOR/INSTRUCTOR LICENSE OR CERTIFICATE NUMBER:

F. INSTITUTION/BUSINESS CITY, STATE, ZIP CODE: San Francisco, CA 94143

G. SUPERVISOR/INSTRUCTOR STATE OF LICENSURE OR CERTIFYING ASSOCIATION NAME: UCSF, Department of Ob/Gyn

H. INSTITUTION/BUSINESS TELEPHONE NUMBER: AREA CODE (415) 4 7 6 - 5 8 9 5

I. APPLICANT'S TRAINING DATES: FROM 7 / 1 / 79 (Month Day Year) TO 6 / 1 / 82 (Month Day Year)

J. TRAINING CLOCK HOURS APPLICANT COMPLETED:

K. SPECIALIZATION NAME IN WHICH APPLICANT TRAINED: Obstetrics and Gynecology

L. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE? [X] Yes [ ] No

M. IF TRAINING WAS OBTAINED OUTSIDE OF AN INSTITUTIONAL FACILITY, INDICATE THE SETTING(S) IN WHICH TRAINING WAS OBTAINED: N/A

N. RECORD ANY ADDITIONAL COMMENTS YOU WISH TO MAKE REGARDING THE APPLICANT'S TRAINING:

I do hereby declare that the information provided is true and correct according to the official records of this institution/business.

INSTITUTION SEAL

John L. Kitzmiller, M.D. — Print or Type Name

Chief of Obstetrics — Title

[redacted]

February 17, 1988 — Date

IL 486 1341 9/86 (LEA)

Illinois Department of Professional Regulation

Stephen F. Selcke
Director

James R. Thompson
Governor

0 0 8 3 1 1 3 0 1 7 0

Febuary 17, 1988 FEB 22 1988

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

The Ill. Dept. of Registration & Education requests a disciplinary search concerning the following individual:

Edward S. Lichtenberg, M.D.
Name

[redacted]
Address

[redacted]
City, State and Zip

[redacted]
Date of Birth

[redacted]
Social Security Number

Univ. Penn. Med. Cen., Philadelphia, Penn.
Medical School of Graduation and Branch Location

May 1971
Date of Graduation

WE HAVE NO INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN
MAR - 8 1988
BRYANT J. GALLISH, M.D.
EXECUTIVE VICE-PRESIDENT

Please mail the response to the following address:

IL Dept. of Professional Regulation
320 W. Washington, 3rd Floor - Unit IV
Springfield, IL 62786

ATTENTION: Pat Eubanks

[redacted]
Signature

MAR 11 1988

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800

State of Illinois Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/917-4500

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

CERTIFICATION OF TRAINING

SUPPORTING DOCUMENT

TN

0 0 8 3 1 1 3 0 1 7

APPLICANT: *Complete the applicant section of this form. Forward the form to the individual who will certify your training. Return the completed form with your Application for Licensure/Examination.*

1. NAME — LAST: LICHTENBERG FIRST: EDWARD MIDDLE: STEVE

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

3. SOCIAL SECURITY NUMBER: [redacted]

4. [redacted] CITY, STATE, ZIP CODE

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

PHYSICIAN/SURGEON — Profession Name

036 — Profession Code

6. [redacted]

N/A

7. DATES OF TRAINING: FROM 7 / 1 / 79 (Month Day Year) TO 6 / 1 / 82 (Month Day Year)

8. ILLINOIS TEMPORARY CERTIFICATE OF REGISTRATION

NUMBER (If Applicable):

ISSUANCE DATE (If Applicable):

9. SPECIFIC NAME OF TRAINING RECEIVED

RESIDENCY, OB-GYN

10. SUPERVISOR/INSTRUCTOR NAME

RUSSELL LAROS, MD

c/o UNIV CALIF. SAN FRANCISCO SCHOOL OF MEDICINE DEPT OB-GYN. ~~SAN FRANCISCO, CALIF~~

CERTIFYING OFFICIAL: *Complete the remainder of this form. Return the completed form to the applicant.*

A. SUPERVISOR/INSTRUCTOR NAME: John L. Kitzmiller, M.D.

B. INSTITUTION/BUSINESS NAME: Univeristy of California, San Francisco Department of Ob/Gyn

C. SUPERVISOR/INSTRUCTOR JOB TITLE/PROFESSION NAME: Chief of Obstetrics

D. INSTITUTION/BUSINESS STREET ADDRESS: Box 0132, 505 Parnassuss Avenue San Francisco, CA 94143

E. SUPERVISOR/INSTRUCTOR LICENSE OR CERTIFICATE NUMBER:

F. INSTITUTION/BUSINESS CITY, STATE, ZIP CODE: San Francisco, CA 94143

G. SUPERVISOR/INSTRUCTOR STATE OF LICENSURE OR CERTIFYING ASSOCIATION NAME: UCSF, Department of Ob/Gyn

H. INSTITUTION [redacted] AREA CODE ([redacted]

I. APPLICANT'S TRAINING DATES: FROM 7 / 1 / 79 (Month Day Year) TO 6 / 1 / 82 (Month Day Year)

J. TRAINING CLOCK HOURS APPLICANT COMPLETED:

K. SPECIALIZATION NAME IN WHICH APPLICANT TRAINED: Obstetrics and Gynecology

L. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE? [X] Yes [ ] No

M. IF TRAINING WAS OBTAINED OUTSIDE OF AN INSTITUTIONAL FACILITY, INDICATE THE SETTING (S) IN WHICH TRAINING WAS OBTAINED.

N/A

N. RECORD ANY ADDITIONAL COMMENTS YOU WISH TO MAKE REGARDING THE APPLICANT'S TRAINING

I do hereby declare that the information provided is true and correct according to the official records of this institution/business.

INSTITUTION SEAL

John L. Kitzmiller, M.D.
Print or Type Name

Chief of Obstetrics
Title

[redacted]
Signature

February 17, 1988
Date

IL486 1341 9/86 (LT-A)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

WORK HISTORY

SUPPORTING DOCUMENT

W H

APPLICANT: *Complete Work History beginning with present employment and concluding with graduation. Account for entire time period. You are authorized to photocopy this form if additional space is needed.*

1. NAME LAST FIRST MIDDLE

LICHTENBERG, EDWARD STEVE

2. [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/SURGEON — Profession Name

0 3 6 — Profession Code

6. MAIDEN OR GIVEN SURNAME

N/A

7. RECORD WORK HISTORY CHRONOLOGICALLY – BEGIN WITH PRESENT EMPLOYMENT AND CONCLUDE WITH GRADUATION.

A. NAME OF BUSINESS/INSTITUTION: FAMILY PLANNING ASSOCIATES MEDICAL GROUP

JOB TITLE: STAFF PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE: 3050 Airport Way, Long Beach, CA 90806

DESCRIPTION OF DUTIES PERFORMED: GYNECOLOGY, FAMILY PLANNING

SUPERVISOR NAME: EDWARD C. ALLRED, M.D.

DATES OF EMPLOYMENT/ATTENDANCE: From 10 / 01 / 86 (Month / Day / Year) To 12 / 01 / 87

TOTAL TIME WORKED (Yr./Mo.): 1 year/3 months

HOURS WORKED PER WEEK: 40

TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

B. NAME OF BUSINESS/INSTITUTION: CIGNA HEALTH PLANS OF CALIFORNIA

JOB TITLE: STAFF PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE: 6801 Coldwater Canyon Blvd., North Hollywood, CA 91605

DESCRIPTION OF DUTIES PERFORMED: OBSTETRICS AND GYNECOLOGY, CLINICAL

SUPERVISOR NAME: LESLIE NOVIKOFF, M.D.

DATES OF EMPLOYMENT/ATTENDANCE: From 09 / 01 / 86 (Month / Day / Year) To 03 / 01 / 87

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

HOURS WORKED PER WEEK: 40

TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

C. NAME OF BUSINESS/INSTITUTION: KAISER PERMANENTE

JOB TITLE: STAFF PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE: 6600 Bruceville Road, Sacramento, CA 95823

DESCRIPTION OF DUTIES PERFORMED: OBSTETRICS AND GYNECOLOGY, CLINICAL

SUPERVISOR NAME: Richard Scott, M.D./Gary Fox, M.D.

DATES OF EMPLOYMENT/ATTENDANCE: From 08 / 01 / 84 (Month / Day / Year) To 08 / 01 / 86

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

HOURS WORKED PER WEEK: 40

TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

IL486-1071 9/86 (LT-A)

Complete the Reverse Side of this Form →

D. NAME OF BUSINESS/INSTITUTION	JOB TITLE
OB-GYN ASSOCIATES OF DAVIS, INC	STAFF PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE
635 Anderson Road, Suite 18
Davis, California 95616

SUPERVISOR NAME
Leon Schimmel, M.D.

DATES OF EMPLOYMENT/ ATTENDANCE
From 07 / 01 / 83 (Month / Day / Year)
To 10 / 01 / 83 (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.): 3 months
HOURS WORKED PER WEEK: 40
TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

DESCRIPTION OF DUTIES PERFORMED
OBSTETRICS AND GYNECOLOGY, CLINICAL

(N.B. 10/1/83 to 8/1/84: Staff Physician
Pregnancy Consultation Center
1801 Bush Street
San Francisco, CA 94109
Supervisor: Paxton Beale)

E. NAME OF BUSINESS/INSTITUTION	JOB TITLE
FINKLELSTEIN/NOVIKOFF, INC	STAFF PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE
132 Clarendon Avenue
San Francisco, CA 94114

SUPERVISOR NAME
David Finkelstein, M.D.

DATES OF EMPLOYMENT/ ATTENDANCE
From 07 / 01 / 82 (Month / Day / Year)
To 06 / 01 / 83 (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.): 11 months
HOURS WORKED PER WEEK: 40
TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

DESCRIPTION OF DUTIES PERFORMED
OBSTETRICS AND GYNECOLOGY, CLINICAL

[N.B. Residency Training 1979-1982]

F. NAME OF BUSINESS/INSTITUTION	JOB TITLE
PLANNED PARENTHOOD SAN FRANCISCO	STAFF PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE
1660 Bush Street
San Francisco, CA 94109

SUPERVISOR NAME
Mary Luke/Michael Policar, M.D.

DATES OF EMPLOYMENT/ ATTENDANCE
From 06 / 01 / 77 (Month / Day / Year)
To 07 / 01 / 79 (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.): 2 years/ 1 month
HOURS WORKED PER WEEK: 40
TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

DESCRIPTION OF DUTIES PERFORMED
FAMILY PLANNING, CLINICIAN

G. NAME OF BUSINESS/INSTITUTION	JOB TITLE
J. P. SHIVELY, M.D., INC.	STAFF PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE
1650 Valencia Street
San Francisco, CA 94110

SUPERVISOR NAME
William Waters, M.D./Jerry Furr

DATES OF EMPLOYMENT/ ATTENDANCE
From 06 / 01 / 73 (Month / Day / Year)
To 06 / 01 / 77 (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.): 4 years
HOURS WORKED PER WEEK: 40
TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

DESCRIPTION OF DUTIES PERFORMED
FAMILY PLANNING CLINICIAN
GYNECOLOGY

[N.B. MPH Degree Obtained 7/72 to 6/73]

I do hereby declare that the information contained herein is true and c[redacted]

1/6/88
Date

Signature

0 0 3 3 1 1 3 0 1 7

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

October 20, 1986

E. Steve Lichtenberg M.D., FACOG
[redacted]

Dear Doctor Lichtenberg:

It is my pleasure to congratulate you and welcome you as a Fellow of The American College of Obstetricians and Gynecologists. Your Fellowship became effective September 30, 1986 and as of that date you are privileged to use the initials FACOG after your name. A certificate of Fellowship will be prepared and mailed to you. Your certificate will be printed with your name as it appeared on your application.

All Fellows elected in 1986 will be formally inducted into Fellowship during the Convocation at the 1987 Annual Clinical Meeting of the College, April 27-30, 1987, in Las Vegas, Nevada. We strongly urge that you take part in this ceremony.

As a Fellow you will receive OBSTETRICS & GYNECOLOGY the College's official Journal: the ACOG NEWSLETTER, and a variety of other publications. These publications, which will help you keep up to date with the latest developments in our profession, are included in your dues. Enclosed please find the prorated Fellow dues statement for 1986.

Please be aware that you will soon receive a statement for 1987 dues. The statements are not mutually inclusive, and both must be paid to maintain active status in the College.

The success of your College depends on the ability to reflect the concerns of the Fellowship, and on the extraordinary voluntary effort on the part of Fellows who serve on committees and/or officers at the Section, District and National level. Your Section and District Chairman, as well as the National office welcome your comments. Be an active Fellow.

If the College may be of service to you, please write or phone.

Sincerely yours,

[redacted]

Warren H. Pearse, M.D., FACOG
Executive Director

WHP:blr
Enclosures

600 Maryland Avenue, SW • Washington, DC 20024-2588 • Telephone (202) 638-5577

E. STEVE LICHTENBERG, M.D.
BETSY S. AUBREY
[redacted]

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RECEIVED
STATE OF ILLINOIS
FEB 25 1988
DEPARTMENT OF
PROFESSIONAL REGULATION

February 22, 1988

Illinois Department of Registration
and Education
P. O. Box 7007
Springfield, Illinois 62791

Dear Sir:

Enclosed you will find the completed "TN" for Dr. E. Steve Lichtenberg's application for licensure that you have previously received.

If you should have any questions or need additional information, please call Dr. Lichtenberg at [redacted]

Thank you for your assistance.

Sincerely,

Cathy Monji

FEB 25 1988

Illinois Department of Professional Regulation

Stephen F. Selcke
Director

James R. Thompson
Governor

0 0 8 8 1 1 3 0 1 7 0

Febuary 17, 1988

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

The Ill. Dept. of Registration & Education requests a disciplinary search concerning the following individual:

Edward S. Lichtenberg, M.D.
Name

[redacted]
Address

[redacted]
City, State and Zip

[redacted]
Date of Birth

[redacted]
Social Security Number

Univ. Penn. Med. Cen., Philadelphia, Penn.
Medical School of Graduation and Branch Location

May 1971
Date of Graduation

Please mail the response to the following address:

IL Dept. of Professional Regulation
320 W. Washington, 3rd Floor - Unit IV
Springfield, IL 62786

ATTENTION: Pat Eubanks

[redacted]
Signature

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800

State of Illinois Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/917-4500

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STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
ATTENTION: CONTROLLED SUBSTANCES SECTION
320 West Washington, 3rd Floor
Springfield, Illinois 62786

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

Controlled Substances Registration — Every person who manufactures, distributes, prescribes or dispenses any controlled substances within the State must obtain annually a registration issued by the Department of Registration and Education in accordance with the Illinois Controlled Substances Act.

A State Controlled Substances Registration is a prerequisite to a Federal Controlled Substances Registration.

Applicant's Name E. Steve Lichtenberg, M.D.

Hospital or Business Name FAMILY PLANNING ASSOCIATES MEDICAL GROUP
Include Department, if Applicable

Business Address 5086 N. Elston
Number and Street

Chicago — City
60630 — ZIP Code
Cook — County

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 the reverse side of this application to the best of my knowledge.

[redacted]
Signature of Applicant

Fee: $ 5.00 Practitioner

$ _____ Non Practitioner

Make check or money order payable to:

Department of Registration and Education

OFFICIAL USE ONLY

State No. 36-076998-1

Receipt No. _____

OFFICIAL USE ONLY

TO EDP 6-10-88

RECEIVED
STATE OF ILLINOIS
JUN - 6 1988
DEPARTMENT OF PROFESSIONAL REGULATION

CT-20a (Revised 5/87)

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

1. Professional Activity: (Check one only)

[ ] (B) Retail Pharmacy — Pharmacy Permit No. _____

[✓] (C) Practitioner

1. Physician — Professional License No. 036-076998
2. Dentist — Professional License No. _____
3. Podiatrist — Professional License No. _____
4. Veterinarian — Professional License No. _____

[ ] (E) Hospital — Pharmacy Permit No. _____

*Hospitals with drug rooms, use Drug Enforcement Administration Number.

[ ] (F) *Teaching Institution — Drug Enforcement Adminstration No. _____

2. Drug Schedules: (Circle all applicable)

II IIN III IIIN IV V

3. Have you ever been convicted of a felony under any state or federal law relating to controlled substances?

[ ] Yes [✓] No

4. Has any previous registration held by the applicant under the Controlled Substances Act been surrendered, revoked, denied or is it pending action?

[ ] Yes [✓] No

If answer to questions 3 or 4 is yes, attach a letter explaining.

JUN 0 8 88
DEPT. OF PROF. REG. FOR DEPOSIT
PAY INDEPENDENCE BK-CHICAGO
DEPT. OF TREAS. STATE OF IL.