A 3 0 0 1 1 0 - 2 2 2 7

PAGE ONE

RECEIVED
STATE OF ILLINOIS

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 AND/OR EXAMINATION

1 0 9 1 3 2 7 0 0 9 8

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 fee 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 - marriage license, divorce decree, affidavit or court order.

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 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 EXAMINATION	$ 300.00

PART II: Applicant Identifying Information

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

4. PERMANENT MAILING ADDRESS STREET	CITY	STATE/COUNTRY	ZIP CODE	COUNTY
[redacted]	CHICAGO	IL	60607	Cook

5. BUSINESS ADDRESS STREET	CITY	STATE/COUNTRY	ZIP CODE	COUNTY
Cook County Hosp. EMERGENCY MEDICINE 1835 W. Harrison	CHICAGO	IL	60612	Cook

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

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

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work (3 1 2) 6 3 3 - 6 0 0 0 (Area Code) Home [redacted] (Area Code)

PART III: Education Information

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 OR Received G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION Month / Year
	Newark, NJ	06/77

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
Amherst College	Amherst, MA	9/77	6/82	BA
Univ. of Medicine & Dentistry - New Jersey Medical School	Newark, NJ	9/84	5/88	MD 03306
Rutgers University	Newark, NJ	9/82	9/84	—

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?
MacNeal Hospital	Berwyn, IL	6/88	6/89	☑ Yes ☐ No
Cook County Hospital	Chicago, IL	7/89	Present	☐ 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). A 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 ILLINOIS	FLEXIBLE	125-022116	6/27/88	(temporary) LAPSED
State of Current Licensure where you most recently have been practicing. ILLINOIS	EMERGENCY MEDICINE	125-022116	7/01/89	(temporary) ACTIVE
Other States of Licensure				
n/A				

(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)
N/B	IL	3/89	P

(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 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, (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	

n/a **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. n/A — TEST CODES

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

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

d) Record the number of times you have taken this exam in Illinois or any other state. — EXAM ATTEMPTS: 0 | 1

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

PART VIII: Certifying Statement

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

[redacted]
Signature of Applicant

7 | 17 | 90
Date

PRINTED BY THE AUTHORITY OF
THE STATE OF ILLINOIS
11-89/61595/REO-02846

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

WH

APPLICANT: *Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment, old volunteer work, etc. If never employed, complete items 1 through 6 as instructed and print N/A in the first box titled "Description of Duties Performed." You are authorized to photocopy this form if additional space is required.*

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
FAINES,	LARRY		[redacted]	[redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted] CHICAGO, IL 60607

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	7. DATE FORM COMPLETED
n/a	7/16/90

8. RECORD WORK HISTORY CHRONOLOGICALLY – BEGIN WITH PRESENT EMPLOYMENT.

A. NAME OF BUSINESS/INSTITUTION: Cook County Hospital
ADDRESS STREET, CITY, STATE, ZIP CODE: 1835 W. Harrison, Chicago, IL 60612
SUPERVISOR NAME: Constance S. Greene, M.D.
DATES OF EMPLOYMENT/ATTENDANCE: From 07/01/89 To
TOTAL TIME WORKED (Yr./Mo.): 1yr. 1mo.
HOURS WORKED PER WEEK: 60+
TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time
JOB TITLE: Resident Physician - Emergency Med.
DESCRIPTION OF DUTIES PERFORMED: Currently serving as a PGY-III Resident in a four year EMERGENCY MEDICINE (incl. Transition yr.) Training Program.

B. NAME OF BUSINESS/INSTITUTION: MacNeal Hospital
ADDRESS STREET, CITY, STATE, ZIP CODE: 3249 S. Oak Park Avenue, Berwyn, IL 60402
SUPERVISOR NAME: Elizabeth B. Frye, MD
DATES OF EMPLOYMENT/ATTENDANCE: From 06/27/88 To 06/30/89
TOTAL TIME WORKED (Yr./Mo.): 12 mo
HOURS WORKED PER WEEK: 70+
TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time
JOB TITLE: Resident Physician - Transitional
DESCRIPTION OF DUTIES PERFORMED: Completed PGY-I Transitional Year as part of Residency Training.

C. NAME OF BUSINESS/INSTITUTION:
ADDRESS STREET, CITY, STATE, ZIP CODE:
SUPERVISOR NAME:
DATES OF EMPLOYMENT/ATTENDANCE: From / To
TOTAL TIME WORKED (Yr./Mo.):
HOURS WORKED PER WEEK:
TYPE OF EMPLOYMENT: [ ] Full-time [ ] Part-time
JOB TITLE:
DESCRIPTION OF DUTIES PERFORMED:

Complete the Reverse Side of this Form

D NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From / / Month Day Year

To / / Month Day Year

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

E NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From / / Month Day Year

To / / Month Day Year

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

F NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From / / Month Day Year

To / / Month Day Year

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

G NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From / / Month Day Year

To / / Month Day Year

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

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

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.

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
FAINES,	LARRY		[redacted]	[redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE
[redacted]
CHICAGO, IL 60607

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. MAIDEN OR GIVEN SURNAME
n/a

7. DATES OF TRAINING
FROM __ / __ / __ (Month / Day / Year) TO __ / __ / __ (Month / Day / Year)

8. ILLINOIS TEMPORARY CERTIFICATE OF REGISTRATION

NUMBER (If Applicable)	ISSUANCE DATE (If Applicable)
125-022116	07/01/89

9. SPECIFIC NAME OF TRAINING RECEIVED
EMERGENCY MEDICINE

10. SUPERVISOR/INSTRUCTOR NAME

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

A. SUPERVISOR/INSTRUCTOR NAME	B. INSTITUTION/BUSINESS NAME
Russell M. Petrak, M.D.	MacNeal Hospital
C. SUPERVISOR/INSTRUCTOR JOB TITLE/PROFESSION NAME	D. INSTITUTION/BUSINESS STREET ADDRESS
Academic Director Internal Medicine	3249 S. Oak Park Avenue
E. SUPERVISOR/INSTRUCTOR LICENSE OR CERTIFICATE NUMBER	F. INSTITUTION/BUSINESS CITY, STATE, ZIP CODE
036-063-551	Berwyn, Illinois 60402
G. SUPERVISOR/INSTRUCTOR STATE OF LICENSURE OR CERTIFYING ASSOCIATION NAME Illinois OK	H. INSTITUTION/BUSINESS TELEPHONE NUMBER AREA CODE (708) 795-3400
I. APPLICANT'S TRAINING DATES FROM 06 / 27 / 88 TO 06 / 30 / 89 (Month / Day / Year)	J. TRAINING CLOCK HOURS APPLICANT COMPLETED
K. SPECIALIZATION NAME IN WHICH APPLICANT TRAINED Transitional	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.

Complete the Reverse Side of this Form

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

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

[redacted]

Russell M. Petrak, M.D.
Print Name of School Official

Academic Director Internal Medicine
Title

5-24-90
Date

INSTITUTION SEAL OR NOTARY SEAL

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

Subscribed and sworn before me this _____ day of _____, 19____

Date of Expiration

Signature of Notary Public

RETURN THIS FORM TO APPLICANT

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

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 FIRST MIDDLE: FAINES, LARRY

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

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted] CHICAGO, IL 60607

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. MAIDEN OR GIVEN SURNAME: N/A

7. DATES OF TRAINING: FROM 07 (Month) 01 (Day) 89 (Year) TO 06 (Month) 30 (Day) 90 (Year)

8. ILLINOIS TEMPORARY CERTIFICATE OF REGISTRATION
NUMBER (If Applicable): 125-022116
ISSUANCE DATE (If Applicable): 07/01/89

9. SPECIFIC NAME OF TRAINING RECEIVED: EMERGENCY MEDICINE

10. SUPERVISOR/INSTRUCTOR NAME: Constance Greene, MD

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

A. SUPERVISOR/INSTRUCTOR NAME (DR): Constance S. Greene

B. INSTITUTION/BUSINESS NAME: Cook County Hospital

C. SUPERVISOR/INSTRUCTOR JOB TITLE/PROFESSION NAME: Residency Director | Medicine

D. INSTITUTION/BUSINESS STREET ADDRESS: 1900 W Polk Street

E. SUPERVISOR/INSTRUCTOR LICENSE OR CERTIFICATE NUMBER: 036-059850

F. INSTITUTION/BUSINESS CITY, STATE, ZIP CODE: Chicago IL 60612

G. SUPERVISOR/INSTRUCTOR STATE OF LICENSURE OR CERTIFYING ASSOCIATION NAME: ILLINOIS

H. INSTITUTION/BUSINESS TELEPHONE NUMBER: AREA CODE (312) 633-3226

I. APPLICANT'S TRAINING DATES: FROM 07 (Month) 01 (Day) 89 (Year) TO 06 (Month) 30 (Day) 90 (Year)

J. TRAINING CLOCK HOURS APPLICANT COMPLETED: 2,920

K. SPECIALIZATION NAME IN WHICH APPLICANT TRAINED: Emergency Medicine

L. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE? [ ] Yes [X] No not until 1992

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

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

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

Cook County Hospital
Print Name of School Official

[redacted]
Signature of School Official

Associate Medical Director
Title

7/27/90
Date

INSTITUTION SEAL OR NOTARY SEAL

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

Subscribed and sworn before me this _____ day of _____, 19____.

_____
Date of Expiration

_____
Signature of Notary Public

RETURN THIS FORM TO APPLICANT

MAY 9 1989

PAGE ONE

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.

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.

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. All documents in a foreign language that are required to be submitted with an application or for any other purpose in connection with licensure must be accompanied by an original, notarized translation that has been performed by a person, other than the applicant, who is fluent in both English and the language of the document(s). The translator shall certify to the above requirements as well as to the accuracy of the translation.

PART I: Application Category Information. (See REFERENCE SHEET, CHART 1, prior to completing PART I.

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
LARRY FAINES M.D	— — —		$

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE	3. SOCIAL SECURITY NUMBER
FAINES	LARRY		MR.	[redacted]

4. PERMANENT MAILING ADDRESS STREET	CITY	STATE/COUNTRY	ZIP CODE	COUNTY
[redacted]	CHICAGO	IL/US	60607	

5. BUSINESS ADDRESS STREET	CITY	STATE/COUNTRY	ZIP CODE	COUNTY
MACNEAL HOSP. 3249 S OAK PARK AVE.		IL/US	60402	

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

7. PLACE OF BIRTH CITY	STATE/COUNTRY	8. DATE OF BIRTH Month Day Year	9. AGE
[redacted]		[redacted]	29

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (312) 795-9100 Area Code

Home [redacted] Area Code

L486-1018 10/88 (LT-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? [✓] Yes [ ] No

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

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
WEST SIDE HIGH SCHOOL	NEWARK, NJ	0 6 / 7 7 (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
AMHERST COLLEGE	AMHERST, MASS	9/77	5/82	BA
SETON HALL UNIV.	SO. ORANGE, NJ	1/80	1/81	—

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?
MACNEAL HOSPITAL	BERWYN, IL	6/88	6/89	[✓] 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, 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 (contact other state regarding possible fee). A certification of licensure from Illinois is not required. 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				
ILLINOIS	LARRY FAINES M.D.	125-022116	6/27/88	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 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)
NBME PART I	NJ	6/86	PASSED
NBME PART II	IL	9/87	PASSED
NBME PART III	IL	3/89	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 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.*		✓
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.*		✓
3. Are you now addicted to or do you excessively use alcohol, narcotics, barbiturates or habit-forming drugs? *If yes, attach a detailed explanation.*		✓
4. Have you ever suffered from, been diagnosed as having, or been treated for any disease or condition that could interfere with your ability to practice your profession, including, but not limited to: 1) physical disease or conditions; 2) mental or emotional disease or condition; 3) alcohol or substance abuse? *If yes, attach a detailed explanation.*		✓
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.*		✓
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.*		✓
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.*		✓
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.*		✓
9. Are you a U. S. citizen OR a lawfully admitted alien of the United States?	✓	

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

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

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

TEST CODES [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ]

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

TEST CENTER CODE [ ][ ][ ][ ]

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

SCHOOL CODE [ ][ ][ ]

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

EXAM ATTEMPTS [ ][ ]

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

PART VIII: Certifying Statement

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

[redacted]
Signature of Applicant

4-23-89
Date

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 **WH**

APPLICANT: *Complete Work History [illegible]. If never employed, complete items 1 through 6 as instructed and write N/A in the first box under "Description of Duties Performed." You are authorized to photocopy this form if additional space is required.*

1. NAME LAST FIRST MIDDLE FAINES LARRY	2. DATE OF BIRTH [redacted] Month Day Year
3. SOCIAL SECURITY NUMBER	[redacted]
4. ADDRESS STREET, CITY, STATE, ZIP CODE [redacted] CHICAGO, IL 60607	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. LARRY FAINES M.D. Profession Name ___ Profession Code
6. MAIDEN OR GIVEN SURNAME	7. DATE FORM COMPLETED

8. RECORD WORK HISTORY CHRONOLOGICALLY – BEGIN WITH PRESENT EMPLOYMENT.

A. NAME OF BUSINESS/INSTITUTION MACNEAL HOSPITAL	JOB TITLE TRANSITIONAL INTERN
ADDRESS STREET, CITY, STATE, ZIP CODE 3249 S. OAK PARK AVE. BERWYN IL, 60402	DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME DR FYRE, PROGAM DIRECTOR	
DATES OF EMPLOYMENT/ ATTENDANCE From ___ / ___ / ___ (Month Day Year) To ___ / ___ / ___ (Month Day Year)	TOTAL TIME WORKED (Yr./Mo.) HOURS WORKED PER WEEK TYPE OF EMPLOYMENT [ ] Full-time [ ] Part-time

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

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

Complete the Reverse Side of this Form →

D. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ __ / __ __ / __ __
Month Day Year

To __ __ / __ __ / __ __
Month Day Year

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

E. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ __ / __ __ / __ __
Month Day Year

To __ __ / __ __ / __ __
Month Day Year

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

F. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ __ / __ __ / __ __
Month Day Year

To __ __ / __ __ / __ __
Month Day Year

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

G NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ __ / __ __ / __ __
Month Day Year

To __ __ / __ __ / __ __
Month Day Year

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

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

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY / RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA - MED

0 0 3 6 7 1 0 0 2 5 Y

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 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 FIRST MIDDLE: FAINES LARRY

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
LARRY FAINES M.D. — Profession Name: 125 — Profession Code

6. MAIDEN OR GIVEN SURNAME:

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

A. HOSPITAL/INSTITUTION NAME: COOK COUNTY HOSPITAL

B. BEGINNING DATE: 07 / 01 / 89 (Month / Day / Year)

C. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE:
1835 WEST HARRIOSN STREET
CHICAGO, IL 60612

D. ENDING DATE: 06 / 30 / 91 (Month / Day / Year)

E. BUSINESS TELEPHONE NUMBER: Area Code (312) 633 - 6705

F. SPECIALTY / RESIDENCY NAME: EMERGENCY MEDICINE

G. YEAR OF POSTGRADUATE TRAINING: FIRST

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 Professional Regulation, the applicant is found to be eligible for licensure.

[redacted]
Signature of Program Director

Robert Simon MD
Print Name of Program Director

Chairman
Title

4-25-89
Date

SEAL

IL486-0272 1 89 (MD)

1 0 0 0 0 3 2 1 5 1

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. SCAN FORM, must be completed and submitted with your application.

RECEIVED APR 27 1988 PROFESSIONAL REGULATION

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
Temporary Licensure	1 2 5	nonexamination	$100.**

PART II: Applicant Identifying Information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE	3. SOCIAL SECURITY NUMBER
FAINES	LARRY		MR.	[redacted]

4. PERMANENT MAILING ADDRESS STREET	CITY	STATE/COUNTRY	ZIP CODE	COUNTY
[redacted]	JERSEY CITY	NJ/HUDSON	07302	US

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

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

7. PLACE OF BIRTH CITY	STATE/COUNTRY	8. DATE OF BIRTH Month Day Year	9. AGE
[redacted]		[redacted]	28

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

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

IL486-1019 10/87 (LT-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? [✓] Yes [ ] No

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

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
WEST SIDE HIGH SCHOOL	NEWARK, NEW JERSEY	0 6 / 7 7 (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
RUTGERS UNIVERSITY	NEWARK/NJ/ESSEX	9/82	1/84	—
AMHERST COLLEGE	AMHERST/MASS.	9/77	5/82	BA
SETON HALL UNIVERSITY	SO ORANGE/NJ	1/79	4/80	—
[redacted]				
Void 5 1 kood				
[redacted]				

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

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.*		✓
2. Do you have any physical or mental impairment or disability, or 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 physical disease or condition, that could interfere with your ability to practice your profession? *If yes, attach a detailed explanation.*		✓
3. Are you now addicted to or do you excessively use alcohol, narcotics, barbiturates or habit-forming drugs? *If yes, attach a detailed explanation.*		✓
4. Have you ever suffered from, been diagnosed as having, or been treated for any (1) mental or emotional disease or condition; or (2) alcohol or 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.*		✓
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.*		✓
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.*		✓
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.*		✓
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.*		✓
9. Are you a U. S. citizen OR a lawfully admitted alien of the United States?	✓	
10. Do you authorize the Department to release your Licensure Examination scores to the education program from which you graduated?	✓	

DEPT. OF PROF. REG. FOR DENTAL
APR 29 88
DEPT. OF PROF. REG. FOR DENTAL

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

N/A

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

PART VIII: Certifying Statement

Under penalties of perjury, I declare that I have examined 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

4/15/88
Date

DEPT. OF PROF. REG. FOR DENTAL
APR 29 88

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				
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 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)

(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 OF EDUCATION

0089|8901|29

SUPPORTING DOCUMENT

ED - MED

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 FIRST MIDDLE: FAINES, LARRY

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

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted] NEWARK, NJ 07103

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
TEMPORARY LICENSUEE Profession Name — 125 Profession Code

6. MAIDEN OR GIVEN SURNAME

7. NAME OF INSTITUTION ATTENDED: UMDNJ - NJMS

8. DATE OF GRADUATION/COMPLETION: 05/25/88 Month Day Year

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

4/15/88 Date — [redacted] Signature of Applicant

SCHOOL OFFICIAL: Complete the items printed on this page and the reverse side, then return to the applicant.

A. NAME OF INSTITUTION: UMDNJ-New Jersey Medical School

B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE: 185 S. Orange Ave, Newark, N.J. 07103-2757

C. INDICATE YEAR BY YEAR THE DATES OF ATTENDANCE IN COLLEGE - (Both pre-medical and medical education must be included.)

From	To
8/27/84	6/3/85
8/26/85	5/19/86
7/7/86	6/19/87
7/6/87	5/20/88
/ /	/ /
/ /	/ /

D. Total academic years attended: 4 Years / Months / Days
OR
Total calendar years attended: Years / Months / Days

E. TYPE OF DEGREE OR CERTIFICATE ~~XXXXXXX~~ expected to receive.
Doctor of Medicine

F. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS ~~XXXXXXX~~ will be met.
5/20/88 Month Day Year

G. DATE THAT DEGREE OR CERTIFICATE ~~XXXXXXXXXXX~~ will be conferred.
5/25/88 Month Day Year

H. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

[ ] Applicant has graduated on / / Month Day Year

[X] Applicant will graduate on 5/25/88 Month Day Year

[ ] Applicant has completed program on / / Month Day Year

[X] Applicant will complete program on 5/20/88 Month Day Year

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

Complete the Reverse Side of this Form →

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

WHEN THIS FORM IS CERTIFIED PRIOR TO THE ACTUAL GRADUATION OF THE APPLICANT, THE SCHOOL OFFICIAL IS RESPONSIBLE FOR NOTIFYING THE DEPARTMENT OF PROFESSIONAL REGULATION OF ANY FAILURE ON THE PART OF THE APPLICANT TO COMPLETE THE REQUIREMENTS FOR GRADUATION

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

Joseph P. Tassoni, Ph.D.
Print Name of School Official

X [redacted]
Signature of School Official

Associate Dean of Student Affairs
Title

April 19, 1988
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 _____, 19____

_____
Date of Expiration

_____
Signature of Notary Public

RETURN THIS FORM TO APPLICANT

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.

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY / RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA - MED

0 0 8 9 7 1 8 9 0 1 2 9

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 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 FIRST MIDDLE: Faines Larry

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

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted] Jersey City, NJ 07302

5. REFER TO REFERENCE SHEET Record profession name and three digit profession code for which you are making Illinois application.
Temporary Licensure (Profession Name) 1 2 5 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

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

A. HOSPITAL/INSTITUTION NAME: MacNeal Hospital

B. BEGINNING DATE: 06 / 27 / 88 (Month Day Year)

C. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE:
3249 South Oak Park Avenue
Berwyn, IL 60402

D. ENDING DATE: 06 / 30 / 89 (Month Day Year)

E. BUSINESS TELEPHONE NUMBER: Area Code (312) 795-3400

F. SPECIALTY / RESIDENCY NAME: Transitional

G. YEAR OF POSTGRADUATE TRAINING: First

I do hereby declare that the above named applicant has been accepted for specialty/residency training as indicated above.

[redacted]
Signature of Administrator

Elizabeth B. Frye, M.D.
Print Name of Administrator

SEAL

Acting Program Director
Title

April 25, 1988
Date

IL486-0272 1/88 (MO)

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

WH

APPLICANT: *Complete Work History beginning with present employment and concluding with graduation. If never employed, complete items 1 through 6 as instructed and print N/A in the first box titled "Description of Duties Performed." You are authorized to photocopy this form if additional space is required.*

1. NAME LAST FIRST MIDDLE: FAINES LARRY

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

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted] JERSEY CITY NJ 07302

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

TEMPORARY LICENSURE — Profession Name

1 2 5 — Profession Code

6. MAIDEN OR GIVEN SURNAME

7. RECORD WORK HISTORY CHRONOLOGICALLY – BEGIN WITH PRESENT EMPLOYMENT.

A. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE: N/A

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From ___ / ___ / ___ (Month / Day / Year)

To ___ / ___ / ___ (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

B. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From ___ / ___ / ___ (Month / Day / Year)

To ___ / ___ / ___ (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

C. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From ___ / ___ / ___ (Month / Day / Year)

To ___ / ___ / ___ (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

Complete the Reverse Side of this Form →

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

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CERTIFICATE OF ACCEPTANCE FOR SPECIALTY / RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA - MED

0 0 8 9 1 8 9 0 1 2 9

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 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 FIRST MIDDLE: Faines Larry

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

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted] Jersey City, NJ 07302

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

Temporary Licensure (Profession Name) 1 2 5 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

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

A. HOSPITAL/INSTITUTION NAME: MacNeal Hospital

B. BEGINNING DATE: 06 / 27 / 88 (Month / Day / Year)

C. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: 3249 South Oak Park Avenue, Berwyn, IL 60402

D. ENDING DATE: 06 / 30 / 89 (Month / Day / Year)

E. BUSINESS TELEPHONE NUMBER: Area Code (312) 795-3400

F. SPECIALTY / RESIDENCY NAME: Transitional

G. YEAR OF POSTGRADUATE TRAINING: First

I do hereby declare that the above named applicant has been accepted for specialty/residency training as indicated above.

[redacted]
Signature of Administrator

Elizabeth B. Frye, M.D.
Print Name of Administrator

Acting Program Director
Title

April 25, 1988
Date

SEAL

IL486-0272 1/88 (MD)

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. If never employed, complete items 1 through 5 as instructed and print N/A in the first box titled "Description of Duties Performed." You are authorized to photocopy this form if additional space is required.*

1. NAME LAST FIRST MIDDLE: FAINES LARRY

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

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: 208 BRUNSWICK #2 JERSEY CITY NJ 07302

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

TEMPORARY LICENSURE (Profession Name) — 1 2 5 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

7. RECORD WORK HISTORY CHRONOLOGICALLY – BEGIN WITH PRESENT EMPLOYMENT.

A. NAME OF BUSINESS/INSTITUTION:

JOB TITLE:

ADDRESS STREET, CITY, STATE, ZIP CODE: N/A

DESCRIPTION OF DUTIES PERFORMED:

SUPERVISOR NAME:

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

TOTAL TIME WORKED (Yr./Mo.):

HOURS WORKED PER WEEK:

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

B. NAME OF BUSINESS/INSTITUTION:

JOB TITLE:

ADDRESS STREET, CITY, STATE, ZIP CODE:

DESCRIPTION OF DUTIES PERFORMED:

SUPERVISOR NAME:

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

TOTAL TIME WORKED (Yr./Mo.):

HOURS WORKED PER WEEK:

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

C. NAME OF BUSINESS/INSTITUTION:

JOB TITLE:

ADDRESS STREET, CITY, STATE, ZIP CODE:

DESCRIPTION OF DUTIES PERFORMED:

SUPERVISOR NAME:

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

TOTAL TIME WORKED (Yr./Mo.):

HOURS WORKED PER WEEK:

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

Complete the Reverse Side of this Form →

NAME OF BUSINESS/INSTITUTION | JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE | DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ __ / __ __ / __ __
Month Day Year

To __ __ / __ __ / __ __
Month Day Year

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

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Month Day Year

To __ __ / __ __ / __ __
Month Day Year

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HOURS WORKED PER WEEK

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

0 0 5 1 0 0 0 2 0 0 6

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION
320 West Washington, 3rd Floor
Springfield, Illinois 62786

RECEIVED
STATE OF ILLINOIS
OCT 31 1990
DEPARTMENT OF
PROFESSIONAL REGULATION

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 Professional Regulation 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 LARRY FAINES, M.D.

Hospital or Business Name COOK COUNTY HOSPITAL
Include Department, if Applicable

Business Address 1835 W. HARRISON
Number and Street

CHICAGO (City) 60612 (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.

X [redacted]
Signature of Applicant

EDP 11-30-90 10

Fee: $ 5.00 Practitioner

$ _____ Non Practitioner

Make check or money order payable to:
Department of Professional Regulation

OFFICIAL USE ONLY
State No. 036-81591-1
Receipt No. _____
OFFICIAL USE ONLY

RECEIVED
HEALTH SERVICES SECTION
NOV 02 1990
DEPARTMENT OF PROFESSIONAL REGULATION

IL486-0600 1/88 (CT)

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

1. Professional Activity: (Check one only)

0991 3 730

[ ] (B) Retail Pharmacy

[✓] (C) Practitioner

1. Physician — Professional License No. 036-081591
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 Administration No. _____

2. Drug Schedules: (Circle all applicable)

(II) (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.

CT-20b (Revised 5/87)