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 AND/OR EXAMINATION

	2 / 0 0 9 8 0
The following materials are required to make Application for Licensure and/or Fxamination in Illinois:	Carefully follow all steps outlined on the INSTRUCTION SIEET. In addition, note the following:
1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.	A. Type or print legibly with black ink only.
INSTRUCTION SHEET, which gives step by step application instructions for your profession.	The licensure fee and application fee are NOT refundable. C. Disclosure of Social Security number is not mandatory. It
REFERENCE SHEET, which gives detailed coding information for your profession.	is used only to ensure identification, accuracy and to expedite processing of your application.
 SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with 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.	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, my previous application expired and I am now reapplying.	I have previously made application for this profession in Illinois. However, I am now applying under new statutory
Other:	language.
	Day office afficient to the part to
PART I: Application Category Information (See REFERE!	
1 PROFESSION NAME 2 PROFESSION J.	
CODE	CCEPTANCE OF Examination \$ 300.00
Physician / Surgeon 03 6 A	CCEPTANCE OF EXAMINATION \$ 300.00
Physician / Surgeon 03 6 A	CCEPTANCE OF EXAMINATION \$ 300.00
Physician / Surgeon 03 6 A	CCEPTANCE OF EXAMINATION \$ 300.00
Physician Surgeon 03 6 A	CCEPTANCE OF EXAMINATION \$ 300.00
Physician Surgeon 03 6 Address STREET CITY	CCEPTANCE OF EXAMINATION \$ 300.00
Physician / Surgeon 036 A PART II: Applicant Identifying Information L NAME LAST FIRST MIDDLE 12 FAINES, LARRY 4. PERMANENT MAILING ADDRESS STREET CITY CHIC	CCEPTANCE OF EXAMINATION \$ 300. ** TITLE (cg. M.D. D.D.S., etc.) 1 SOCIAL SECURITY NUMBER M.D. STATE, COUNTY ZIP CODE COUNTY
PART II: Applicant Identifying Information L NAME LAST FIRST MIDDLE 2 FAINES, LARRY 4. PERMANENT MAILING ADDRESS STREET CITY S. BUSINESS ADDRESS STREET CITY EMERGENCY MEDICINE COOK COUNTY HOSP 1835 W. HATTISON CO	CCEPTANCE OF EXAMINATION \$ 300. ** THE (CR. M.D. D.D.S. (CC.) I SOCIAL SECURITY NUMBER M.D. STATE/COUNTRY ZIP CODE COUNTY AGO IL 60607 COOK STATE/COUNTRY ZIP CODE COUNTY CHICAGO IL 60612 Cook
PART II: Applicant Identifying Information L NAME LAST FIRST MIDDLE 2 FAINES, LARRY 4. PERMANENT MAILING ADDRESS STREET CITY S BUSINESS ADDRESS STREET CITY EMERGENCY MEDICINE COOK COUNTY HOSP, 1835 W. HALLISON DER W. (SEE D. ABOVE)	CCEPTANCE OF EXAMINATION \$ 300. ** THE (CR. M.D. D.D.S. (CC.) I SOCIAL SECURITY NUMBER M.D. STATE/COUNTRY ZIP CODE COUNTY AGO IL 60607 COOK STATE/COUNTRY ZIP CODE COUNTY CHICAGO IL 60612 Cook
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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 C	Received 5.E.D.?] Yes □ No
2 NAME OF LAST PRELIMINARY SCHOOL ATTENDED	1. LAST PRELIMINARY SCHOOL LOG (City and State) Newark, NJ	CATION		GRADUATION / 7 7 Year
5 CULLEGE OR UNIVERSITY (Circle numb				
1 2 3 💢 5 6 7 🛞	Graduated? Yes :	No	1000	
6 COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF A	10	TYPE OF DEGREE FARNED
Amherst College	Amherst, MA	Month Year 9/77	Month/Year 6/82	BA
Unio. of MEDICINE + DENTISTRY - NEW JERSEY MEDICAL SCHOOL	NEWARK, NJ	9/84	5/88	MD 032
RUTGERS UNIVERSITY	NEWARK, NJ	9/82	9/84	
7 SPECIALIZED TRAINING (Residency, Pro	fessional Training, Vocational Training, Pract	ical or Clinical Tr	ainus)	
INSTITUTION NAME	LOCATION			Did You Complete
INSTITUTION INTAKE	(City and State or Country)	FROM	то	Training?
MACNEAL HOSPITAL	BERWYN, IL	Month/Year	Month/Year 6/89	Yes No
COOK COUNTY HOSPITAL	Chicago, IL	7/89	Present	☐ Yes ☑ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

PAGE THREE

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you have given his 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 appropria action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure ILLINOIS	FIEXIBLE	125-022116	6/27/88	(temporary) Lapsed
State of Current I icensure where you most recently have been practicing. ILLINOIS	EMERGENCY MEDICINE	125-022116	7/01/89	(temporary) ACTIVE
Other States of Licensuce	2-12-11-2			
n/A		**************************************		
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(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	MONTHEYEAR	EXAM RESULTS
N/B	IL	3/89	(Passed, Failed, Absent

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

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TA	1	JUNE.	TIPL.	14-460
DA	(7)	147	Π	S

PAI	T VI:	Personal History Information (This part must be completed by all Applicants)	YES	NO
	violation	a been convicted of any criminal offense in any state or in federal court tother than minor traffic sy? If yes, attach a statement for each conviction including date and place of conviction, nature of the and if applicable, the date of discharge from any penalty imposed		X
	condition disease o interferes	now suffer, have you suffered from, been diagnosed as having, or been treated for any disease or a which is generally regarded by the medical community as chronic, i.e. (1) mental or emotional recondition, (2) alcohol or other substance angesty obvered disease or condition that presently with your ability to practice your profession of the profession o		×
.3	Have yo professio	n been denied a professional license of permit, or privilege of taking an examination, or had a nal license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If i.e., detailed explanation.		X
		u ever been discharged other than honorably from the armed service or from a city, county, state or osition? If yes, attach a detailed explanation.		X
5	Are you	a U.S. citizen OR a lawfully admitted alien of the United States?	×	
PA	RT VII:	Examination Coding Information (This part is for Examination Applicants only)		
		REFERENCE SHEET enclosed with this application package and complete the following: 11 - Select examination(s) you desire and enter Test Codes.		
c)	or any o	Center Code. SCHOOL CODE IV - Find your School of Graduation and enter school code. 14 5 14 15 14 15 16 16 16 16 16 16 16 16 16 16 16 16 16		
	l-xamina graduate	ation scores to the education program-remember (and a		
PA	RT VIII	: Certifying Statement	1-18ac	- 1.2.
Uh	der penal acction t	ties of perjury, I declare that I have examined the application and all supporting documents submitted therewith, and to the best of my knowledge, they are true, correct, and complete.	d by n	ne in
	,	Sknature of Applicant 1510 July 17 17 90		

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WORK HISTORY

SUPPORTING DOCUMENT

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SUPPORTING DOCUMENT

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14 Carting in an ideas with country your training. Return the completed form
2. DATE OF BIRTH 3. SOCIAL SECURITY NUMBER
Month Day Year
REFER TO REFERENCE SHEET. Record profession flame and three digit profession code for which you are making Illinois application.
Physician / Surgeniu 036 Profession Neme Profession Code
8. ILLINOIS TEMPORARY CERTIFICATE OF REGISTRATION NUMBER (II Applicable) ISSUANCE DATE (II Applicable)
125-022116 07/01/89
10. SUPERVISOR/INSTRUCTOR NAME
A point policy to the applicant
B. INSTITUTION/BUSINESS NAME
MacNeal Hospital D. INSTITUTION/BUSINESS STREET ADDRESS
3249 S. Oak Park Avenue
F. INSTITUTION/BUSINESS CITY, STATE, ZIP CODE
Berwyn, Illingis 60402
Berwyn, Illinois 60402 H. INSTITUTION/BUSINESS TELEPHONE NUMBER
AREA CODE (7 0 8 , 7 9 5 3 4 0 0
J. TRAINING CLOCK HOURS APPLICANT COMPLETED
L. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE
IXI Yes { 1 No
L FACILITY, INDICATE THE SETTING (S) IN WHICH TRAINING WAS

RECORD ANY ADDIT	IONAL COMMENTS YOU WISH TO MAKE	REGARDING THE	APPLICANT'S TRAIN!	NG.
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49				
certify that the infor	mation recorded herein is true and correct	according to the of	ficial records of this in	stitution.
	5 50 60 E			
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Academic Direc	tor Internal Medicine		7-24-	70 -
INSTITUTION	NOTE: If the institution does not he	ave a seal this form	must be noterized	
SEAL		*	, · · · ·	* : V: 13.
OR	Subscribed and sworn before me this _	day of		, 19
NOTARY SEAL	Date of Expiration		Signature of	Notary Public
	RETURN THIS	FORM TO APPLI	CANT	
				

IMPORTANT	NOTICE	Completion of
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CERTIFICATION

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SUPPORTING DOCUMENT

2. DATE OF BIRTH J. SOCIAL SECURITY NUMBER Month Day Year 5. REFER TO REFERENCE SHEET. Record profession name and three disprofession code for which you are making tilings application.
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5. REFER TO REFERENCE SHEET. Record profession name and three digital profession code for which you are making tilings application.
1
Physician Surgeon 036 Profession Name
8. ILLINOIS TEMPORARY CERTIFICATE OF REGISTRATION
125-022116 07/01/89
10. SUPERVISOR/INSTRUCTOR NAME
CONSTANCE GREENE, MD
storthe completed fame to the applicant.
B. INSTITUTION/BUSINESS NAME
Cook County Hospital
D. INSTITUTION/BUSINESS STREET ADDRESS
1900 W POIK Street
F INSTITUTION/BUSINESS CITY, STATE, 21P CODE
Chicago Il 60612
H. INSTITUTION/BUSINESS TELEPHONE NUMBER
AREA CODE (3 1 2 6 33 - 322 6
J. TRAINING CLOCK HOURS APPLICANT COMPLETED
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AL FACILITY, INDICATE THE SETTING (5) IN WHICH TRAINING WAS

RECORD ANY ADDITIO	DNAL COMMENTS YOU WISH TO MAKE	REGARDING THE APPLICANT'S TRAINING.	
		<u> </u>	
I certify that the inform	nation recorded herein is true and correct	according to the official records of this institution.	
		2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
	ounty Hospital	Signature of School Official	
Associate Me	edical Director	7/27/90	4 7
	. Title	Date	
INSTITUTION .	NOTE: If the institution does not ha	ve a seal, this form must be notarized.	
SEAL	Subscribed and sworn before me this	day of	
OR	occounted and sworn perpre me (nis	, 19	
NOTARY	Date of Expiration	Signatur of Notary Public	191
SEAL		- 2000	444

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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 SURE / EXAMINATION

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

- Four page APPLICATION FOR LICENSURE/ EXAMINATION. MENT HISDOW
- 2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.

DESTRUCTION OF THE WAY

- 3. REFERENCE SHEET, which gives detailed coding information for your profession.
- 4. SUPPORTING DOCUMENTS, forms you may be required to submit with your application.

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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.
- Disclosure of Social Security number is not mandatory. It is used only to ensure identification, accuracy and to expedite processing of your application.
- 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 dicense. divorce decree, affidavit or court order.
- 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 It Application Category	Information. (See REF	FRENCE SHEET, CHART I, P	rior to exampleting PART1.
1, PROFESSION NAME	2. PROFESSION	3. LICENSURE METHOD	4. FEE
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PART II: Apolicies Identifying	Information.	NT 1 80 1	61 14
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5. BUSINESS ADDRESS STREET	,	CITY STATE/COUNTRY	zip cobe cooki v
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A House a first and an agent of		and the — we les	
7. PLACE OF BIRTH CITY	STATE/COUNTRY	8. DATE OF BIRTH	FILE STAGE ING
		Month Day Year	29
10. TELEPHONE NUMBER WHERE YO	MAY BE REACHED	a monthly had a common a grant or publication was to man as	
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1 2 3 4 5 6 7 8	of years completed) Graduated? [Yes	i IINo	F-14	
6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION {City and State or Country}	DATES OF A	TO	TYPE OF DEGREE EARNED
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MICHENL HOSPINL	BERWYN, IL	6 88	6/89	Yes [] No
			d now like	[] Yes [] No
				[] Yes [] No
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Control of the contro		X V		[] Yes [] No

PART IV: Record of Licensus 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 endosed with this Application packagemax anstruct 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. Fedure to the disclose all licenses held may result in denial of your application or other appropriate action.

	PROFESSION NAME	LICENSE NUMBER		(Active, Lephed, etc.)
- III	LARRY FAINES M.D.	125-022116	6/27/88	ACTIVE
State of Current Licensure where you most recently have been practicing.		6 K W.	I ASSEMPTS	
Other States of Licensure	Talenta and an analysis of the Control		1	
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(If additional space is nadded, attach a separate sheet.)

PART Vi. Record of Exemination

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 extempt may result in the denial of your application or other appropriate action.

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PAGE FOUR

PARY VI: Pareonal History Information (Fris part must be completed by all Applicants)	YEB	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 data 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 panalties imposed, or if such copies are not obtainable, a notarized statement explaining their unavailability.		/
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 yas, attach a detailed explanation.		
 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; mental or emotional disease or condition; alcohol or substance abuse? If yes, attach a datailed explanation. 	- 1	_
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.		سسنا
 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. 	-	-
 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?	/	4
PART VIII: Examination Coding Information (This part is for Examination Applicants Utily)		
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.] E	
b) CHART III — Select the examination site you desire and enter Test Center Code. SCHOOL CODE		
c) CHART IV — Find your School of Graduation and enter school code.		
d) Record the number of times you have taken this exam in Illinois or any other state.		
e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated? [] Yes [] No	44.5	
PAULY VIII; Cartifying Statement		
Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in therewith, and to the best of my knowledge, they are true, correct, and complete.	connecti	on
merative, and to all orally knowledge, they are true, correct, and complete.		
Signature of Applicant Date	•	7
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IMPORTANT NOTICE: Completion of this form is necessary for consideration for ficensure under Chapter 111 of the Filing's Revited Statutes. This form has been approved by the Forms Management Center.

WORK HISTORY

SUPPORTING DOCUMENT

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4 ADDRESS STREET, CITY, STA	TE, ZIP CODE	5. REFER TO REFERENCE SHE	ET. Record profession name and three digit
	CHICATO TI LOVA	profession code for which you	no making minos application.
6. MAIDEN OR GIVEN SURNAME	1. DATE FORM COMPLETED	LARRY FAINES	M.D.
		Profession Name	Profession Code
8. RECORD WORK HISTORY CHRO		RESENT EMPLOYMENT.	
A NAME OF BUSINESS/INSTITUTIO		JOB TITLE	or INTERN
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BERWYN IL, 60	1402		
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From / /	HOURS WORKED PER WEEK		
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To Month Day Year	Full time Part time		
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D. NAME OF BUSINESS/INSTITUTIO	n .	JOB TITLE
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From / / / /	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 Hillinois Revised Statutes. This form has been approved by the Forms Management Center.

CERTIFICATE OF ACCEPTANCE FOR

SPECIALTY / RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

NOTE: An applicant shall not commence specialty residency train of his application from the Department of Professional Re	ning before he or the hospital/institution receives written notice of the approval
APPLICANT: Complete the Applicant section of this form, then forward training, for completion of the remainder of the form.	d it to the hospital/institution that has accepted you for specialty/rasidency
I NAME LAST FIRST MIDDLE	2. DATE OF BIRTH 3 SOCIAL SECURITY NUMBER
FAINES LARRY	Month Day Year
4 ADDRESS STREET CITY, STATE, ZIP CODE	 REFER TO REFERENCE SHEET. Record profession name and three dig profession code for which you are making litinois application.
6 MAIDEN OR GIVEN SURNAME	Profession Name Profession Code
ADMINISTRATOR: Complete the remainder of this form and return (it to the applicant.
A. HOSPITAL/INSTITUTION NAME	8 BEGINNING DATE
COOK COUNTY HOSPITAL	0 7 / 0 1 / 8 9
C BUSINESS ADDRESS STREET, CITY STATE, ZIP CODE 1835 WEST HARRIOSN STREET	D ENDING DATE
CHICAGO, IL 60612	0 6 / 3 0 / 91 Month / Day / Year
E BUSINESS TELEPHONE NUMBER	F. SPECIALTY / RESIDENCY G. YEAR OF POSTGRADUATE
Area Code () 6 3 3 _ 6 7 0 5	EMERGENCY MEDICINE FIRST
	cepted for specialty/residency training as indicated above if, subsequent the Department of Professional Regulation, the applicant is found to be
	Signature of Program Director Solut Ton (in M) Print Name of Program Director
SEAL	4-25-69
	C416





PAGE ONE

IMPORTANT NOTICE: completion of this form is necessary for consideration for licensure under Chapter 13 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

APPLICATION FOR L'ICENSURE PERAMINATION

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

- Four page APPLICATION FOR LICENSURE/ EXAMINATION.
- INSTRUCTION SHEET, which gives step by step application instructions for your profession.
- REFERENCE SHEET, which gives detailed coding information for your profession.
- 4. SUPPORTING DOCUMENTS, forms you make a figured to submit with your application pp 2 7 1988
- 5. SCAN FORM, must be complete with your application.

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

- 1. Type or print legibly with black link only.
- 2. The licensure fee and application for are NOT refundable.
- Disclosure of Social Security number is not mandatory. It is used only to ensure identification, accuracy and to expedite processing of your application.
- - 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.

Temporary Licensure	1 2 5	Selection with the selection	\$100.00
PART III' Applicant identifying Info		Apple Control	
FAINES LARR	WIDDLE	MR.	MICIAL SECURITY NUMBER
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PAGE FOUR

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PART IV: Record of Lice				
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STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS
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State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				
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PART V: Record of East				
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MPORTANT NOTICE: Completion of his form is necessary for consideration or incensure under Chapter 111 or the linois Revised Statutes. This form has earl approved by the Forms Mark 141.	CERTI	FICATION	(1) 이번(2) - 11년				ED - MED.
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NAME OF INSTITUTION ATTENDE	D					8 8	PLETION
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or its designated testing service the in							
Date							of Applicant
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IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 11! if the illinois Revised Statutes. This form has been approved by the Forms Manage-

CERTIFICATE OF ACCEPTANCE FOR

SPECIALTY / RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA - MED

NOTE: An applicant small not commence specialty/residency trains of his application from the Department of Professional Reg		n receives written notice of the approval
PPLICANT: Complete the Applicant section of this form, then formers training, for completion of the remainder of the form.	it to the hospital/Institution that has i	y (v
NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Faines Larry ADDRESS STREET, CITY, STATE, ZIPCODE	Month Day Year	
ADDRESS STREET, CITY, STATE, ZIPCODE 01303 Tersey City, NJ MAIDEN OR GIVEN SURNAME	Temporary Licen.	EET Record profession name and three are making litinois application.
DMINISTRATOR: Gampleto the remainder of this form and return it	7.4	
HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	
MacNeal Hospital	0 6 / 2 7 / 8 8	
BUGINESS ADDRESS STREET, CITY, STATE, ZIP CODE	D. ENDING DATE	
3249 South Oak Park Avenue Berwyn, IL 60402	0 6 /3 0 / 8 9	
BUSINESS TELEPHONE NUMBER	F. SPECIALTY / RESIDENCY	G. YEAR OF POSTGRADUATE
Area Code (3 1 2) 7 9 5 - 3 4 0 0	Transitional	First
I do hereby declare that the above named applicant has been ac	ccepted for specialty/residency tra	ining as indicated above.
	5 Signature	of Aqmin/Arator
CEAL	Elizabeth B. Frye M.	D e di Administrator
SEAL	Acting Program Direc	tor
	Acting Trogram Office	Title
	April 25, 1988	

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

WORK HISTORY

SUPPORTING DOCUMENT

APPLICANT: Complete Work History beginning with present angle present and concluding 6 or instructed and prime N/A in the first bell virtual "Description of Durabell additional grown is required: production, If never unplayed, complete items I throu and: You are authorized to physiology this form it

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MAIDEN OR GIVEN SURNAME		Profession Name Profession Code
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IMPORTANT NOTICE: Completion of this form is necessary for consideration. For licensure under Chapter 11: If the tiling is Revised Statutes. This form has been approved by the Forms Management Center.

CERTIFICATE OF ACCEPTANCE FOR

CA-MED

SUPPORTING DOCUMENT

SPECIALTY / RESIDENCY PROGRAM

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PPLICANT: Complete the Applicant section of this form; then formere training, for completion of the remainder of the form.	· 2 (4)-345	
NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Faines Larry	Month Day Year	
Jersey City, NJ	acatesian and a far water un	Sure Profession Code
DMMNISTRATOR: Compared to reveledor of this form and return in	to the applicant.	
A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	
MacNeal Hospital	0 6 / 2 7 / 8 8 Month / Day / Year	
BUGINESS ADDRESS STREET, CITY, STATE, ZIP CODE	D. ENDING DATE	
3249 South Oak Park Avenue Berwyn, IL 60402	0 6 / 3 0 / 8 9	!
BUSINESS TELEPHONE NIMBER	F. SPECIALTY / RESIDENCY	Q. Y'AR OF POSTGRADUATE
Area Code (3 1 2) 7 9 5 = 3 4 0 0	Transitional	First
I do hereby declare that the above named applicant has been as		aining as indicated above.
SEAL	Elizabeth B. Frye M	ne of Administrator
SEAL	Elizabeth B. Frye M Priol Nam Acting Program Direc	
SEAL		

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

WORK HISTORY

SUPPORTING COCLMENT

WH

APPLICABIT: Complete Work History beginning with present engineering and completely with production. If never employed, complete items I through a singer-could and print NAA in the Safe belt titled "Business of Business Forteness." You are authorized to physicapy this form if

Additional space is requi			
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108 BRUNSWER #2 JER	SEY CIT! NI 07302		
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STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION
320 West Washington, 3rd Floor
Springfield, Illinois 62788



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.

lospital or Business NameCOOK CO	INCHES DOSATE	L. Dent, if Applicable	
Business Address 1835 W. H.	ARRISON Number at	of Street	
CHICAGO	60612	Cook	
City	ZIP Cook	County	
		819	P
Pee: S_5.00_ Practitionar		OFFICIAL USE ONLY	P 30
Fee: S <u>5.00</u> Practitioner S Non Practitioner		OFFICIAL USE ONLY	
		1000	
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S Non Practitioner Make check or money order payable to:		State NoS6 - 815 91 -	
S Non Practitioner Make check or money order payable to:		State NoS6 - 815 91 - Receipt No DEFICIAL USE ONLY	

		TO THE PARTY OF		
	APPLICATION FOR STAT	E CONTROLLED SUBSTANCE	S REGISTRA	ATION
1. Professio	mai Activity: (Check one only	De 1 O YOM		
व व्याप	Retail Pharmacy	NAW HEAT HINDING	August 1	First State
INIC	Practitioner	DEPT. OF THEAS, STATE OF IL	036-	081591
144	1. Physician	Professional License No	A pledent	
	2. Dentist	Professional License No	PARTIES IN	CONTRACTOR OF THE SECOND
	3. Podlatrist	Professional License No	And Albertales of SA	PA STANDARDS
	4. Veterinarian	Professional License No	ALVES OF STREET	
[] (E	Hospital	Pharmacy Permit No	BALL PSUSSI	
	*Hospitals with drug rooms,	use Drug Enforcement Administra	ation Number.	P. 42-16-5
[] (F)	*Teaching Institution	Drug Colora ment Are	u tion No	
2. Drug Sch	edules: (Circle all applicable)		*	
		NHO 190 €	(W)	©
3. Have you	ever been convicted of a felor	y under any manages sederal law n	elating to cont	rolled substances
[] Yes	MNo	FAY INTERCENCE IN CORRESP CEPT. OF TREAS. STATE OF IL		
	previous registration hald by t denied or is it pending action?	he applicant under the Controlled	Substances /	Act been surrende
I J Yes	M No			

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