03000005816

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

APPLICATION FOR LICENSURE AND/OR EXAMINATION

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.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

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

A. Type or print legibly with black ink only.
B. The licensure and application fee is not refundable.
C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue.

JAN 28 2002

PART I: Application Category Information

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

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

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☑ This is the first time I have made application for this profession in Illinois.
- ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: ______
- ☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- ☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

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

1. NAME — LAST: GITTLER FIRST: MANDY MIDDLE: LYNN
2. TITLE (e.g., M.D., D.D.S., etc.): M.D.
3. UNITED STATES SOCIAL SECURITY NO: [redacted]

4. PERMANENT MAILING ADDRESS — STREET: [redacted] CITY: Chicago STATE/COUNTRY: IL USA ZIP CODE: [redacted] COUNTY: Cook

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

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

7. PLACE OF BIRTH — CITY, STATE/COUNTRY: [redacted]
8. DATE OF BIRTH — Month, Day, Year: [redacted]
9. AGE: ___ ☑ Female ☐ Male

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work (206) 280-7182 (Area Code) Home [redacted] (Area Code)

PART III: Education Information

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

1 2 3 4 5 6 7 8 9 10 11 12 Graduated High School? ☑ Yes ☐ No Received OR G.E.D.? ☐ Yes ☐ No

2 NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3 LAST PRELIMINARY SCHOOL LOCATION (City and State)	4 DATE OF GRADUATION
KENWOOD ACADEMY	Chicago IL	0 6 / 1 9 8 8 (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	TO Month/Year	TYPE OF DEGREE EARNED
Univ of Illinois	Urbana, IL	9/1988	5/1992	B.S.
RUSH MEDICAL College	Chicago, IL	9/1994	6/1998	M.D
Roosevelt Univ.	Chicago, IL	6/1993	8/1993	—
Loyola Univ	Chicago, IL	5/1993	6/1994	—

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	TO Month/Year	Did You Complete Training?
Univ of WASHINGTON	SEATTLE WA	6/1998	6/2001	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last First MI): GITTLER, MANDY L

SS#: [redacted]

Profession: Physician

PART IV: Record of Licensure Information

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure Washington	Physician	39065		Active
State of Current Licensure where you most recently have been practicing WA	"	"		"
Other States of Licensure				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
Family Medicine Boards	WA	7/2001	(Passed, Failed, Absent) — Passed circled
USMLE Part 1	IL	6/1996	Passed
USMLE Part 2	IL	8/1997	Passed
USMLE Part 3	WA	1999	Passed

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

NAME (Last, First, MI): Gittel, Mary, L

SS#: [redacted]

Profession: Physician

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge if applicable, as well as a statement from the probation or parole office*		✓
2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition, (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes attach a detailed statement, including an explanation whether or not you are currently under treatment.*		✓
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*		✓
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*		✓

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

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

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

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

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

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

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

PART VIII: Child Support Information *(This part must be completed by all applicants)*

Every licensee is required by law to respond to the following question regardless of whether or not he or she is subject to a child support order.

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

☑ NO ☐ Yes

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

PART IX: Certifying Statement

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

Signature of Applicant ______ Date 1/21/02

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

NAME (Last, First, MI): Gittler, Mandy L

SS#:

Profession: Physician

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

WORK HISTORY

SUPPORTING DOCUMENT

WH

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

1 NAME LAST FIRST MIDDLE
GITTLER MANDY LYNN

2 DATE OF BIRTH [redacted] Month Day Year

3 SOCIAL SECURITY NUMBER [redacted]

4 ADDRESS STREET CITY STATE, ZIP CODE
[redacted]
Chicago, IL [redacted]

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

6 MAIDEN OR GIVEN SURNAME

7 CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

8. DATE FORM COMPLETED 1/22/2002

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

A NAME OF BUSINESS / INSTITUTION: Planned Parenthood of Western WA

JOB TITLE: Medical Doctor

ADDRESS STREET CITY, STATE, ZIP CODE:
2001 E. Madison St
Seattle WA, 98122-2959

DESCRIPTION OF DUTIES PERFORMED: Women's reproductive health and primary care

SUPERVISOR NAME: Cam McIntyre, MD

DATE OF EMPLOYMENT/ATTENDANCE: From 01/02/2001 (Month Day Year) To present / ____ (Month Day Year)

HOURS WORKED PER WEEK: Per Diem

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

TOTAL TIME WORKED (Year/Month): one year

B NAME OF BUSINESS / INSTITUTION: Seattle Medical and Wellness

JOB TITLE: Physician

ADDRESS STREET CITY, STATE, ZIP CODE:
1305 4th #1105
Seattle, WA 98101

DESCRIPTION OF DUTIES PERFORMED: Primary care, and women's reproductive health

SUPERVISOR NAME: Eileen Gibbons, MD

DATE OF EMPLOYMENT/ATTENDANCE: From 06/28/2001 (Month Day Year) To present, ____ (Month Day Year)

HOURS WORKED PER WEEK: 24

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

TOTAL TIME WORKED (Year/Month): 6 months

C NAME OF BUSINESS / INSTITUTION: Inter Island Medical Center

ADDRESS (STREET, CITY, STATE, ZIP CODE): Spring St. Friday Harbor, WA 98250

SUPERVISOR NAME: Kathy Guy

DATE OF EMPLOYMENT/ATTENDANCE: From 09/06/2001 (Month Day Year) To 10/31/2001 (Month Day Year)

HOURS WORKED PER WEEK: ~45

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

TOTAL TIME WORKED (Year/Month): 2 months

JOB TITLE: Physician

DESCRIPTION OF DUTIES PERFORMED: Primary care, urgent care, emergency care.

D. NAME OF BUSINESS / INSTITUTION: Cascade Family Clinic

ADDRESS (STREET, CITY, STATE, ZIP CODE): 7509 Custer Rd. W. Lakewood, WA 98499

SUPERVISOR NAME: Paula Macrie

DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/2001 (Month Day Year) To 08/01/2001 (Month Day Year)

HOURS WORKED PER WEEK: 15

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

TOTAL TIME WORKED (Year/Month):

JOB TITLE: Physician

DESCRIPTION OF DUTIES PERFORMED: Women's reproductive health and primary care

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E NAME OF BUSINESS / INSTITUTION: Univ of WASHINGTON

ADDRESS (STREET, CITY, STATE, ZIP CODE): 4245 Roosevelt way NE Seattle WA, 98105

SUPERVISOR NAME: David Losh, MD

DATE OF EMPLOYMENT/ATTENDANCE: From 06/24/1998 (Month Day Year) To 07/01/2001 (Month Day Year)

HOURS WORKED PER WEEK: 50-80.

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

TOTAL TIME WORKED (Year/Month): 3 years

JOB TITLE: Resident Physician

DESCRIPTION OF DUTIES PERFORMED: In-patient, and out-patient medicine for the department of family medicine. Included in this is adult and pediatric primary care, obstetrics, and womens reproductive health.

NAME (Last, First, MI): GITTLER, MANY L

SS#: [redacted]

Profession: Physician

IL486-1071 9/99 (LT)

RECEIVED JAN 28 2002 BY: .... 1/30 JJ

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.	CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING	SUPPORTING DOCUMENT **TN-MED** (DPR)

APPLICANT: *Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.*

1 NAME LAST / FIRST / MIDDLE	2 DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
GITTLER MANDY LYNN	[redacted] Month Day Year	[redacted]

4 ADDRESS STREET, CITY, STATE, ZIP CODE	5 REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application
[redacted] Chicago, IL [redacted]	Profession Name / Profession Code
6 MAIDEN OR GIVEN SURNAME —	
7 ILLINOIS TEMPORARY LICENSE NUMBER (If applicable) NA	8 ISSUANCE DATE

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 62786

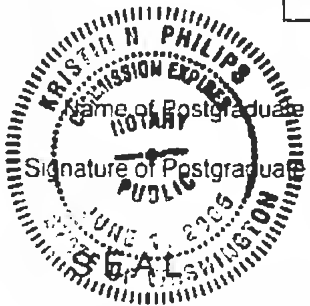
This is to certify that the above-named applicant satisfactorily completed 36 months of postgraduate clinical training in University of Washington Family Medicine Residency
(Name of Accredited Postgraduate Clinical Training Program)

from 6/25/1998 to 6/30/01 at the following hospital:

Hospital: FAMILY MEDICINE RESIDENCY PROGRAM
UWMC AT ROOSEVELT
Number and Street: 4245 ROOSEVELT WAY NE, BOX 354775
SEATTLE, WA [illegible]
City, State and Zip Code:

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

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



Name of Postgraduate Clinical Training Program Director: Robert Crittenden, MD, MPH

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 1/20/02

Telephone No: (206) 598-3883

FEB 04 2002

IL486-1535 10/99 (MD)

UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

Department of Family Medicine
Family Medicine Residency Program
UWMC Roosevelt, Box 354775
4245 Roosevelt Way NE
Seattle, Washington 98105
(206) 598-2883
Fax (206) 598-5769

August 19, 2002

To Whom It May Concern:

The University of Washington Family Practice Residency does not have an official seal.

Sincerely,

Robert A. Crittenden, MD MPH
Residency Program Director

RECEIVED
AUG 2 9 2002
IDPR-MEDICAL UNIT

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

1300 SE Quince St • P.O. Box 47866 • Olympia, Washington 98504-7866

March 27, 2002

Illinois State Board of Medical Examiners
320 West Washington L & T-1
Springfield IL 62786

To Whom It May Concern:

I, Betty Elliott, Program Representative, do hereby certify that a standard search of the available records of the Medical Quality Assurance Commission indicates the following:

PHYSICIANS NAME	**Mandy Gittler, MD**
LICENSE NUMBER:	**MD00039065**
ISSUE DATE:	**08-30-2000**
EXPIRATION DATE	**11-21-2002**
DATE OF BIRTH:	

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED

If our records above show that the licensee has been disciplined, photocopies from the public file are available upon written request. Send request to the Medical Quality Assurance Commission, Public Disclosure Desk, PO Box 47866, Olympia, WA 98504-7866

The information above is the only certification information by the Commission. To expedite the certification process, the above format is the standard format prepared for all professions regulated by this Commission.

If you wish to continue with the processing of this application, please contact me by telephone at (360) 236-4785, by email at betty.elliott@doh.wa.gov, or in writing at Department of Health, Medical Quality Assurance Commission, PO Box 47866, Olympia, Washington 98504-7866.

Sincerely,

(SEAL)

Betty Elliott
Licensing Representative

RECEIVED
APR 0 3 2002
IDPR-MEDICAL UNIT

American Board of Family Practice, Inc

Founded 1969

2228 Young Drive
Lexington, Kentucky 40505-4294
Tel (859) 269-5626 or (888) 995-5700
Fax (859) 335-7501 or (859) 335-7509

Robert [redacted]nt, M.D., Executive Director
Joseph W. Tollison, M.D., Deputy Executive Director
Terrence M. Leigh, Ed.D., Associate Executive Director
Paul R. Young, M.D., Senior Executive
Roger M. Bean, CPA, Chief Financial Officer

January 29, 2002

To Whom It May Concern:

This letter will verify that MANDY LYNN GITTLER, MD, is certified by the American Board of Family Practice (ABFP) for the period 2001-2008. This certification is time limited for a period of seven years and must be renewed through successful completion of the ABFP recertification process and examination.

Sincerely,

[redacted]

Debbie Wilson
Verifications

dw

RECEIVED
FEB 13 2002
IDPR-MEDICAL UNIT

Profession: 76

Date: [illegible] Initials: [illegible]

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

1. Submit the required fee of $________ made payable to the Department of Professional Regulation. This fee is not refundable	
2. Your application is being returned for completion of Part ________	
3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from ________ to ________	
4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).	
5. Submit proof that you are a lawfully admitted alien.	
6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.	
7. When your application is complete, the Medical Licensing Board will review your qualifications.	
8. Your application will be reviewed by the Medical Licensing Board on ________	
9. Submit completed **CA-MED** form which indicates beginning and ending program dates	
10. Submit **CA-LTD** form.	
11. Submit **ED-MED** form (certification of education).	
12. Submit **ED-NON** form completed in its entirety.	
13. Affidavits, (**ED-AFF** forms) must be completed in accordance with DPR policy. Copy of policy attached.	
14. **Verification of Pass/Fail Exam History**—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.	
15. Submit official premedical/medical transcript with school seal afixed.	
16. Submit photocopy of your degree	
17. Submit proof of Titulo or Acta.	
18. Submit proof of Social Service or Fifth pathway.	
19. Submit proof of E.C.F.M.G. certification.	
20. Submit copy of evaluation form for each of the following core rotations: 1. ________ 2. ________ 3. ________ 4. ________ 5. ________	

	21. Complete **AF-MED** form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s). 1. ________ 2. ________ 3. ________ 4. ________ 5. ________
	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
	25. Submit a list of your work experience from ________ to ________. You must account for entire time period since graduation from medical school (Supporting Document WH).
	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
X	28. Have your *Step 1, 2, 3* scores forwarded directly from *USMLE*
	29. Submit evidence of remedial training
X	30. Submit **TN-MED** form signed by program director, with seal of hospital. *See Below*
X	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on offiical stationary must be attached verifying no seal exists.)
	32. Sign form(s) where indicated.
	33. Submit certification of original/current licensure (Supporting Document CT) from ________
	34. Submit proof that you are Board-certified in a specialty.
	35. Submit restoration questionnaire (Supporting Document RS).
	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
	37. Returning original documents.

Other Instructions: *#31 - HAVE HOSPITAL SUBMIT LETTER IF NO SEAL EXISTS. OR COMPLETE NEW FORM WITH SEAL.*

IL 486-1568 5/94 (LT)

Profession: 036

Date: 2-11-02 Initials: [illegible]

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

	1. Submit the required fee of $________ made payable to the Department of Professional Regulation. This fee is not refundable.
	2. Your application is being returned for completion of Part ________
	3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from ____________________ to ____________________.
	4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s)
	5. Submit proof that you are a lawfully admitted alien
	6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response
	7. When your application is complete, the Medical Licensing Board will review your qualifications.
	8. Your application will be reviewed by the Medical Licensing Board on____________________
	9. Submit completed CA-MED form which indicates beginning and ending program dates
	10. Submit CA-LTD form.
	11. Submit ED-MED form (certification of education).
	12. Submit ED-NON form completed in its entirety.
	13. Affidavits, (ED-AFF forms) must be completed in accordance with DPR policy. Copy of policy attached.
	14. Verification of Pass/Fail Exam History—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.
	15. Submit official premedical/medical transcript with school seal afixed.
	16. Submit photocopy of your degree
	17. Submit proof of Titulo or Acta.
	18. Submit proof of Social Service or Fifth pathway.
	19. Submit proof of E.C.F.M.G. certification.
	20. Submit copy of evaluation form for each of the following core rotations: 1 ________ 2 ________ 3 ________ 4 ________ 5 ________
	21. Complete AF-MED form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s). 1 ________ 2 ________ 3. ________ 4. ________ 5. ________
	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
	25. Submit a list of your work experience from ________ to ________. You must account for entire time period since graduation from medical school (Supporting Document WH).
	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
	28. Have your ____________________ scores forwarded directly from ____________________.
	29. Submit evidence of remedial training.
X	30. Submit TN-MED form signed by program director, with seal of hospital.
	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on offical stationary must be attached verifying no seal exists.)
	32. Sign form(s) where indicated
X	33. Submit certification of original/current licensure (Supporting Document CT) from State of Washington
	34. Submit proof that you are Board-certified in a specialty.
	35. Submit restoration questionnaire (Supporting Document RS)
	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
	37. Returning original documents.

Other Instructions:

IL486-1588 5/94 (LT)

Profession: .036

Date: 2-5-02 Initials: [illegible]

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

	1. Submit the required fee of $________ made payable to the Department of Professional Regulation. This fee is not refundable.
	2. Your application is being returned for completion of Part ________
	3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from ________ to ________.
	4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).
	5. Submit proof that you are a lawfully admitted alien.
	6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.
	7. When your application is complete, the Medical Licensing Board will review your qualifications.
	8. Your application will be reviewed by the Medical Licensing Board on ________
	9. Submit completed **CA-MED** form which indicates beginning and ending program dates.
	10. Submit **CA-LTD** form.
	11. Submit **ED-MED** form (certification of education)
	12. Submit **ED-NON** form completed in its entirety.
	13. Affidavits, (ED-AFF forms) must be completed in accordance with DPR policy. Copy of policy attached.
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X	15. Submit official premedical/medical transcript with school seal affixed.
	16. Submit photocopy of your degree.
	17. Submit proof of Titulo or Acta.
	18. Submit proof of Social Service or Fifth pathway.
	19. Submit proof of E.C.F.M.G. certification.
	20. Submit copy of evaluation form for each of the following core rotations: 1. ________ 2. ________ 3. ________ 4. ________ 5. ________
	21. Complete **AF-MED** form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s). 1. ________ 2. ________ 3. ________ 4. ________ 5. ________
	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
	25. Submit a list of your work experience from ________ to ________. You must account for entire time period since graduation from medical school (Supporting Document WH).
	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached Instructions.
	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
	28. Have your ________ scores forwarded directly from ________
	29. Submit evidence of remedial training.
X	30. Submit **TH-MED** form signed by program director, with seal of hospital. (See #31)
X	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on offical stationary must be attached verifying no seal exists.)
	32. Sign form(s) where indicated.
X	33. Submit certification of original/current licensure (Supporting Document CT) from Washington (See #31)
	34. Submit proof that you are Board-certified in a specialty.
	35. Submit restoration questionnaire (Supporting Document RS).
	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
	37. Returning original documents.

Other Instructions:

IL486-1588 5/94 (LT)

00050000408 70743

(DO NOT USE THIS APPLICATION FOR RENEWAL OF AN EXISTING LICENSE)

IMPORTANT NOTICE: Completion of this form is required by 720 of the Illinois Compiled Statutes . Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application. This form has been approved by the Forms Management Center.

APPLICATION FOR STATE CONTROLLED SUBSTANCES

DO NOT SUBMIT APPLICATION ... HAS BEEN ISSUED! CONTR... ISSUED TO A ...

GITTLER, MANDY LYNN MD
04-29-03
By: NON-EXAM ASG: jploeser
SSN: [redacted]
APR 30 2003

336069798

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

A. Type or print legibly with bl...
B. The fee is $5 - Make che... Regulation. THIS FEE IS N... required for each registrat...
C. Disclosure of your U.S. soc... This disclosure is mandate... social security number will be provided to the Department of Public Aid to assist in the identification of persons who are more than 30 days delinquent in complying with a child support order.
D. Submit application and fee to:
   Department of Professional Regulation
   320 West Washington, 3rd Floor - CMU 2
   Springfield, Illinois 62786

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

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

PART I: Application Category Information

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

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATE SOCIAL SECURITY NO.
GITTLER	MANDY	LYNN	MD	[redacted]

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

5. NAME OF BUSINESS AND LOCATION (STREET/CITY /ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED
Planned Parenthood
1200 N. LaSalle
Chicago,
IL 60610+_____

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

7. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Work (206) 280-7182
Area Code
Home ([redacted]
Area Code

PART III: Professional Activity

Practitioner - Check and complete one of the following.

		Professional License Number
☐Dentist	019 -	
☑Physician	036	107772
☐Podiatrist	016 -	
☐Veterinarian	090 -	

Drug Schedule: (Circle the schedules for which you are applying)
(II) (IIN) (III) (IIIN) (IV) (V)

FOR OFFICIAL USE ONLY FEE $5

BNDD Number: Type: Suffix:
Schedule Codes: Additional Function: A Card Code: K
Issuance Date (Month/Day/Year)

RECEIVED APR 30 2003 IDPR-HSC

IL486-0500 05/00 (LT)

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

NAME (Last, First, MI): Gittler, Mandy L

PART V: Child Support Information (*This part must be completed by all applicants.*)

Every licensee is required by law to respond to the following question regardless of whether or not he or she is subject to a child support order:

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

☑ NO ☒ Yes MG

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

SS#: [redacted]

PART VI: Certifying Statement

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

April 3, 2003
Date of Application

MANDY GITTLER
Print Name of Applicant

[redacted]
Signature of Applicant

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

Profession: Physician

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

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

FOR OFFICIAL USE ONLY

Lic#: 336-091669
GITTLER, MANDY L
[redacted] 04/23/2012
By:NON-EXAM
SSN: [redacted]

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

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

PART I: Application Category Information

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

PART II: Applicant Identifying Information

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

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

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

National Healthcare 7405 N. University St. Peoria IL 61614

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

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

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

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

Work (773) 252-3600 FAX (773) 252-0310
Area Code Area Code

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

PART III: Drug Schedule

Circle the schedules for which you are applying:

II IIN III IIIN IV V (all circled)

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 -
☒	Physician	036 - 107772
☐	Podiatrist	016 -
☐	Veterinarian	090 -

PART V: **Personal History Information** *(This part must be completed by all Applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		✓
2. Have you been convicted of a felony?		✓
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.		✓
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.		✓
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.		✓
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? If yes, attach a detailed explanation.		✓

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

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

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

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

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

PART VII: Certifying Statement

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

1/10/12
Date of Application

Signature of Applicant

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

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

NAME (Last, First, MI):

SS#:

Profession: