03000004901

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 are 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.

PART I: Application Category Information

614010 98

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	Acceptance of Examination	$300.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [x] 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 FIRST MIDDLE: Xia Tian
2. TITLE (e.g., M.D., D.D.S., etc.): D.O.
3. UNITED STATES SOCIAL SECURITY NO.: [redacted]
4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: [redacted]
5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: 1900 W Polk Chicago, IL 60612-____
6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED (SEE INSTRUCTIONS #5 ABOVE)
7. PLACE OF BIRTH CITY STATE/COUNTRY: [redacted]
8. DATE OF BIRTH Month Day Year: [redacted]
9. AGE: 28 ☐ Female ☒ Male
10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work (312) 633-6167 (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 (Month / Year)
No 16th High School	Guangzhon, China	0 5 / 1 9 9 0

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
Jinan Medical University	Guangzhon, China	7/90	6/91	N/A
Triton College	River Grove, IL	1/92	6/93	N/A
University of Illinois at Chicago	Chicago, IL	1/93	8/94	B.A.
Chicago College of Osteopathic Medicine	Downers Grove, IL	9/94	6/98	D.O

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?
Mid Western University	Olympia Fields, IL	7/98	6/99	☒ Yes ☐ No
Indiana University	Indianapolis, IN	7/99	12/00	☐ Yes ☒ No
Cook County Hospital	Chicago, IL	7/00	Present	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

SS#:

Profession:

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 IL	Tempory Licensure Physician / Surgeon	125-038412	6/22/98	lapsed
State of Current Licensure where you most recently have been practicing IL	Tempory Licensure Physician / Surgeon	125-038412	7/1/00	Active
Other States of Licensure				
IN	Tempory Medical Permit	11009606	7/1/99	lapsed

(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
Complex step I	IL	05/96	[redacted]
NBOME step II	IL	03/98	[redacted]
NBOME step III	IL	02/99	[redacted]

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

NAME (Last, First, MI):

SS#:

Profession:

NAME (Last, First, MI):

SS#:

Profession:

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.")

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

7/25/01

Date

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

Chicago College of Osteopathic Medicine

I HEREBY CERTIFY THIS TO
BE A TRUE AND CORRECT
COPY OF THE ORIGINAL.

Cristita Bonk 8/01/01

OFFICIAL SEAL
CRISTITA BONK
Notary Public - State Of Illinois
My Commission Expires 05/02/03

On the recommendation of the Faculty,
the Board of Trustees of Midwestern University
has conferred upon

Tian Xia

the Degree of

Doctor of Osteopathic Medicine

and has granted this Diploma as evidence that the requirements
prescribed by the College have been fulfilled for this Degree.

Given at the City of Chicago in the State of Illinois on the 7th day of June 1998

Chairman of the Board of Trustees

Secretary of the Board of Trustees

Kathleen H. Goeppinger, Ph.D.
President
Midwestern University

Dean

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: Xia — FIRST: Tran — MIDDLE:

2. DATE OF BIRTH (Month / Day / Year):

3. SOCIAL SECURITY NUMBER:

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.
Profession Name: Physician — Profession Code: 0 3 6

6. MAIDEN OR GIVEN SURNAME:

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

8. DATE FORM COMPLETED: 7/25/01

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: Cook County Hospital

ADDRESS (STREET, CITY, STATE, ZIP CODE): Dept of Phys Educ & Res, 1900 W Polk St. Rm 408, Chicago IL 60612

SUPERVISOR NAME: Dr Winnie

DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/2000 To 07/25/2001

HOURS WORKED PER WEEK: 85 hours

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

TOTAL TIME WORKED (Year/Month): 13 monthes

JOB TITLE: Anesthesia Resident

DESCRIPTION OF DUTIES PERFORMED: Duties pertinent to responsibilities of an anesthesia resident.

B. NAME OF BUSINESS / INSTITUTION: Indiana University Medical Center

ADDRESS (STREET, CITY, STATE, ZIP CODE): 1120 S. Dr. Rm 224, Indianapolis IN 46202

SUPERVISOR NAME: Dr Bradom

DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/1999 To 12/31/1999

HOURS WORKED PER WEEK: 40 hours

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

TOTAL TIME WORKED (Year/Month): 6 monthes

JOB TITLE: Physical Medicine and Rehabilitation Resident

DESCRIPTION OF DUTIES PERFORMED: Duties pertinent to responsibilities of a resident of Physical Medicine and Rehabilitation

IL486-1071 9/99 (LT)

NAME (Last, First, MI):

SS#:

Profession:

C. NAME OF BUSINESS / INSTITUTION: MidWestern University / Edgewater Medical Center

ADDRESS (STREET, CITY, STATE, ZIP CODE): 5700 N. Ashland, Chicago IL 60660

SUPERVISOR NAME: Dr Olden

DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/1998 (Month/Day/Year) To 06/22/1999 (Month/Day/Year)

HOURS WORKED PER WEEK: 75 hours

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

TOTAL TIME WORKED (Year/Month): One year

JOB TITLE: Osteopathic Intern

DESCRIPTION OF DUTIES PERFORMED: Duties pertinent to the responsibility of an osteopathic intern.

D. NAME OF BUSINESS / INSTITUTION:

ADDRESS (STREET, CITY, STATE, ZIP CODE):

SUPERVISOR NAME:

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

HOURS WORKED PER WEEK:

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

TOTAL TIME WORKED (Year/Month):

JOB TITLE:

DESCRIPTION OF DUTIES PERFORMED:

E. NAME OF BUSINESS / INSTITUTION:

ADDRESS (STREET, CITY, STATE, ZIP CODE):

SUPERVISOR NAME:

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

HOURS WORKED PER WEEK:

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

TOTAL TIME WORKED (Year/Month):

JOB TITLE:

DESCRIPTION OF DUTIES PERFORMED:

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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
Xia Tian

2. DATE OF BIRTH
[redacted]
Month Day Year

3. SOCIAL SECURITY NUMBER
[redacted]

4. ADDRESS STREET CITY STATE ZIP CODE
[redacted]

5. REFER TO REFERENCE SHEET Record profession name and three digit profession code for which you are making Illinois application.
Physician — Profession Name
0 3 6 — Profession Code

6. MAIDEN OR GIVEN SURNAME

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

8. DATE FORM COMPLETED
8/22/01

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
N/A

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED I was Unemployed during this period due to my mother's illness.

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE
From 01 / 01 / 2000 (Month / Day / Year)
To 06 / 30 / 2000 (Month / Day / Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

B. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

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

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

RECEIVED
IDPR-MEDICAL UNIT

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
Xia Tian

2. DATE OF BIRTH [redacted]
Month Day Year

3. SOCIAL SECURITY NUMBER [redacted]

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

6. MAIDEN OR GIVEN SURNAME

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application
Physician — Profession Name
0 3 6 — Profession Code

7. ILLINOIS TEMPORARY LICENSE NUMBER (if applicable)
125-038412

8. ISSUANCE DATE
7/1/2000

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 12 months of postgraduate clinical training in TRANSITIONAL INTERNSHIP
(Name of Accredited Postgraduate Clinical Training Program)

from 6/22/98 to 6/21/99 at the following hospital:

Hospital: MIDWESTERN UNIVERSITY/CHICAGO COLLEGE of OSTEOPATHIC MEDICINE

Number and Street: 20201 S. CRAWFORD

City, State and Zip Code: OLYMPIA FIELDS, IL 60461

RECEIVED
AUG 3 0 2001
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I further certify that at the time of such training the program was accredited by:

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

Name of Postgraduate Clinical Training Program Director: [redacted] D.O.

Signature of Postgraduate Clinical Training Program Director: Gary L. Slick, D.O.

Date of this Certification: 8-15-01

Telephone No: 708/747-4000, X1335

SEAL

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
Xia Tian

2. DATE OF BIRTH
Month Day Year

3. SOCIAL SECURITY NUMBER

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.

Physician — Profession Name
0 3 6 — Profession Code

6. MAIDEN OR GIVEN SURNAME

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)
125-038412

8. ISSUANCE DATE
7/1/2000

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 13 months of postgraduate clinical training in Anesthesiology
(Name of Accredited Postgraduate Clinical Training Program)

from July 1, 2000 to July 24, 2001 at the following hospital:

Hospital: Cook County Hospital

Number and Street: 1835 West Harrison Street

City, State and Zip Code: Chicago, Illinois 60612

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: Alon P. Winnie, M.D.

Signature of Postgraduate Clinical Training Program Director: MD

Date of this Certification: July 24, 2001

SEAL

Telephone No: 312-633-3360

National Board of Osteopathic Medical Examiners

8765 W. Higgins Road, Suite 200, Chicago, IL 60631 (773)714-0622 Fax (773)714-0631

TRANSCRIPT

	Scaled Score 1	Standard Score 2
PART I/Level 1		
Anatomy		
Physiology		
Biochemistry		
Pharmacology		
Pathology		
Microbiology		
Osteopathic Principles		
Total Score		

Minimum Total Passing Scaled Score or Standard Score 75/400.

PART II/Level 2		
Total Score		

Minimum Total Passing Scaled Score or Standard Score 75/400

PART III/Level 3		
Total Score		

Minimum Total Passing Scaled Score or Standard Score 75/350.

1 Examinations taken prior to February 1987 are reported as scaled scores
2 Beginning in 1987 NBOME criteria for certification are based upon candidate's total score in Part I, Part II and Part III and not scores of individual subjects within each part
3 Prior to March 1990, Part II included the areas of 'Preventative Maintenance and Public Health and Medical Jurisprudence'. Currently, those are combined in the area of 'Community Medicine' and Medical Humanities'
4 Effective February 1995, the COMLEX Level 3 exam replaced the Part III exam
5 Effective March 1997, the COMLEX Level 2 exam replaced the Part II exam
6 Effective June 1998, the COMLEX Level 1 exam replaced the Part I exam

I, Joseph F. Smoley, Ph.D., Executive Director of the National Board of Osteopathic Medical Examiners, Inc. do hereby certify the above to be a true report of the record of

Tian Xia, D.O

issued Certificate of Completion No. 32582 on April 21, 1999

August 7, 2001
Date Prepared

Joseph F. Smoley, Ph. D.
Executive Director

RECEIVED
AUG 10 2001
IDPR-MEDICAL UNIT

The Federation of State Medical Boards
of the United States, Inc
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

August 08, 2001

Attn: Alicia Purchase
Illinois Dept. of Reg. & Ed.
320 W. Washington Street
Springfield, IL 62786

Re: Board Action Query Dated: August 08, 2001
Your Reference Number:
FSMB Batch Number: BQ584610

The following is a final report of the search results from the Board Action Data Bank as of August 08, 2001 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of August 08, 2001

Item	Name	DOB	SSN	School	Yr/Grad	Request ID
2						
3						
4						
5						
6						
7						
1						
8	XIA, TIAN				1998	

Health Professions Bureau

402 West Washington Street, Room W041
Indianapolis, Indiana 46204

Telephone (317) 232-2960
Fax (317) 233-4236
http://www.ai.org/hpb

August 16, 2001

Illinois Dept of Professional Regulation
320 West Washington, L & T-1
Springfield IL 62786

To Whom It May Concern:

THIS IS TO CERTIFY THAT:	TIAN XIA
BECAME A LICENSED:	Medical Residency Permit
NUMBER ISSUED:	11009606A
ISSUANCE DATE:	07/01/1999
EXPIRATION DATE:	06/30/2000
STATUS:	Expired
BASIS OF LICENSURE:	Endorsement
SCHOOL/GRADUATION DATE: Indiana University Medical Center	CHICAGO COLLEGE OF OSTEOPATH 01/01/1998

RECEIVED
AUG 27 2001
IDPR-MEDICAL UNIT

Notice:

Our agency has recently converted to a new computer system which has incorporated month and day to the graduation date. However, our old system only indicated year of graduation. You will find the graduation date listed 01/01/year of graduation. Please consider the verification valid although the graduation date may conflict with the applicant's month and day the year should be accurate.

Unless otherwise indicated, the State of Indiana has not disciplined this license. If other information is needed, please contact the Records Division at (317) 233-4409.

Profession: 036
Date: 8-13-01 Initials: TR

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.
X	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.
X	25. Submit a list of your work experience from 1-1-00 to 6-30-00. 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.
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.
	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:

*30/31 - Received TN-MED from Cook County Hospital for 13 months of training. Need TN-MED verifying 11 additional months of clinical training. 24 mos required.

IL486-1588 5/94 (LT)

Profession: 036

Date: 8-23-01 Initials: TR

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. X 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. X Submit a list of your work experience from 1-1-00 to 6-30-00. 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.
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.
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:

IL486-1568 5/94 (LT)