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PAGE ONE

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised 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.

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.

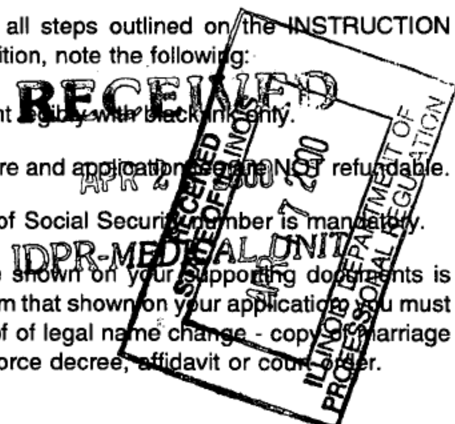
Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.

B. The licensure and application fees are NOT refundable.

C. Disclosure of Social Security number is mandatory.

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 - copy of marriage license, divorce decree, affidavit or court order.



PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Licensure	1 2 5	Nonexamination	$ 100.00

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, FIRST, MIDDLE): Xia Tian
2. TITLE (e.g., M.D., D.D.S., etc.): D.O.
3. SOCIAL SECURITY NUMBER: [redacted]

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

5. BUSINESS ADDRESS (STREET, CITY STATE/COUNTRY, ZIP CODE, COUNTY): 1023 Newcastle Westchester IL 60154-____

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

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 (312) 953-9667 (Area Code)   Home: [redacted] (Area Code)

IL486-1019 12/97 (LT)

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

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
Guangzhou #16-th High School	Guangzhou, China	05/90 (Month / Year)

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

1 2 (3) 4 5 6 7 8 — Graduated? [X] Yes [ ] No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	DATES OF ATTENDANCE TO Month/Year	TYPE OF DEGREE EARNED
Jinan University	Guangzhou, China	09/90	5/91	N/A
Triton College	RiverGrove, IL	01/92	05/93	N/A
University of Illinois at Chicago	Chicago, IL	01/93	08/94	B.S.
Chicago College of Osteopathic Medicine	Downers Grove, IL	09/94	05/98	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	DATES OF ATTENDANCE TO Month/Year	Did You Complete Training?
MidWestern University	Chicago, IL	06/98	06/99	[X] Yes [ ] No
Indiana University	Indianapolis, IN	07/99	12/99	[ ] Yes [X] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No

IL486-1019 12/97 (LT)

PAY TO THE ORDER OF BANK ONE, IL ACCT #51637700
APR 24 00
FOR DEPOSIT ONLY IL STATE TREASURER 2370240728 ▷071100269◁

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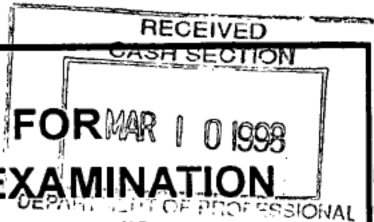
PAGE ONE



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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.
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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 Social Security number is mandatory.

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 - copy of marriage license, divorce decree, affidavit or court order.

PART I: Application Category Information

014010-98

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Licensure	1 2 5	Non-examination	$ 100.00

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 FIRST MIDDLE: Xia, Tian

2. TITLE (e.g., M.D., D.D.S., etc.): D.O.

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: Postdoctoral Education 20201 S. Crawford Av. Olympia Fields, Midwestern University/Chicago College of Osteopathic Medicine, IL. U.S.A. 60461 — COOK.

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

7. PLACE OF BIRTH CITY STATE/COUNTRY: [redacted]

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

9. AGE: 24 ☐ Female ☒ Male

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (708) (Area Code) 747-4000 X1133 Home: [redacted] (Area Code)

IL486-1019 07/97 (LT)

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
Guangzhou #16 High School	China	0 6 / 9 0 (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
Triton College	River Grove, IL	01/92	05/93	N/A
University of Illinois at Chicago	Chicago, IL	01/93	08/94	B.S.
Chicago College of Osteopathic Medicine	Downers Grove, IL	09/94	06/98	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?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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IDPR FOR DEPOSIT ONLY IL STATE TREASURER MAR 13 98 2370270728 FNB CENTRAL IL 071100272

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				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
NBOME I	IL	06/96	
COMPLEX II	IL	03/98	

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

PART VI: **Personal History Information** *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a 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)***

In accordance with 5 Illinois Compiled Statues 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.**

You **MUST** check one of the following:

- ☐ I am not more than 30 days delinquent in complying with a child support order.
- ☐ I am more than 30 days delinquent in complying with a child support order.
- ☒ I am not currently under any child support order.

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.

[redacted] 2/18/98

Signature of Applicant 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.

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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	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Xia Tian	[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]	Temporary Physician Licensure (Profession Name) 1 2 5 (Profession Code)	
6. MAIDEN OR GIVEN SURNAME	7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☐	8. DATE FORM COMPLETED 3/17/00

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: Unemployed
ADDRESS STREET, CITY, STATE, ZIP CODE: N/A	DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME: N/A	
DATE OF EMPLOYMENT/ATTENDANCE: From 01/01/00 (Month/Day/Year) To 06/17/00 (Month/Day/Year)	
HOURS WORKED PER WEEK: N/A	
TYPE OF EMPLOYMENT: ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month)	

B. NAME OF BUSINESS / INSTITUTION: Indiana University	JOB TITLE: PGY2
ADDRESS STREET, CITY, STATE, ZIP CODE: 1120 S. Dr RM 224 Indianapolis IN 46202	DESCRIPTION OF DUTIES PERFORMED: As a PGY2 resident. My duties included teaching students and in charge of rehabilitation floor
SUPERVISOR NAME: Dr Kaelin	
DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/99 (Month/Day/Year) To 12/31/99 (Month/Day/Year)	
HOURS WORKED PER WEEK: 45	
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month): 6 monthes	

COMPLETE THE REVERSE SIDE OF THIS FORM

C. NAME OF BUSINESS / INSTITUTION
Midwestern University / EMC

ADDRESS STREET, CITY, STATE, ZIP CODE
5700 N Ashland
Chicago IL 60660

SUPERVISOR NAME
Dr Olden

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 22 / 98 (Month / Day / Year)
To 06 / 21 / 99 (Month / Day / Year)

HOURS WORKED PER WEEK
75 hrs

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
1 year

JOB TITLE
Intern

DESCRIPTION OF DUTIES PERFORMED
As the osteopathic traditional intern, My duties included teaching students and in charge of GME, ICU floors...

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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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]

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

6. MAIDEN OR GIVEN SURNAME

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

8. ISSUANCE DATE
6/22/98

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 internal medicine internship
(Name of Accredited Postgraduate Clinical Training Program)
from 6/28/98 to 6/21/99 at the following hospital:

Hospital: Edgewater Hospital
Number and Street: 5700 N. Ashland
City, State and Zip Code: Chicago, IL

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: Michael R. Olden, D. O.
Signature of Postgraduate Clinical Training Program Director: [redacted]
Date of this Certification: 3/22/00
Telephone No: 773-878-6000

SEAL

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.*		

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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

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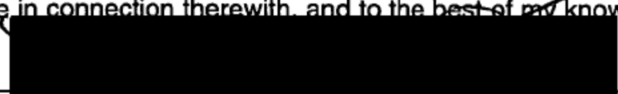
Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.



Signature of Applicant

3/15/00

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.

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	Temporary Physician Licensure	125-038412	6/22/98	Lapsed
State of Current Licensure where you most recently have been practicing. IN	Temporary Medical Permit	11009606	7/1/99	Active
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
Complex Step I	IL	05/96	
NBOME Step II	IL	03/98	
NBOME Step III	IL	02/99	

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

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NOTE: **An applicant shall not commence specialty/residency training before he or the hospital/institution receives written notice of the approval of his application from the Department of Professional Regulation.**

APPLICANT: **Complete the applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the remainder of the form.**

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
XIA TIAN	[redacted] Month Day Year	[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.	
6. MAIDEN OR GIVEN SURNAME SAME	TEMPORARY PHYSICIAN LICENSURE (Profession Name)	1 2 5 (Profession Code)

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
COOK COUNTY HOSPITAL	07 / 01 / 00 (Month Day Year)	06 / 30 / 03 (Month Day Year)
D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE	E. SPECIALTY / RESIDENCY NAME	
1900 W. POLK ST. RM. 408 CHICAGO, IL. 60612	ANESTHESIOLOGY	
F. BUSINESS TELEPHONE NUMBER	G. YEAR OF POSTGRADUATE TRAINING	
Area Code (312) 633-6705	1ST YR. RESIDENT	

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Professional Regulation, the applicant is found to be eligible for licensure.

Signature of Program Director

ALON P. WINNIE
Print Name of Program Director

PROGRAM DIRECTOR
Title

3-24-00
Date

SEAL

IL486-0272 12/93 (MD)

01000004703

PAGE ONE

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

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.

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

A. Type or print legibly with black ink only.

B. The licensure and application fee are NOT refundable.

C. Disclosure of Social Security number is mandatory.

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 - copy of marriage license, divorce decree, affidavit or court order.

6

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Tian Xia	1 2 5	Nonexamination	$ 100

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, FIRST, MIDDLE): Xia, Tian
2. TITLE (e.g., M.D., D.D.S., etc.): D. O.
3. SOCIAL SECURITY NUMBER: [redacted]

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

5. BUSINESS ADDRESS (STREET, CITY STATE/COUNTRY, ZIP CODE, COUNTY):

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

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7. PLACE OF BIRTH (CITY, STATE/COUNTRY): [redacted]

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

9. AGE: 25 ☐ Female ☒ Male

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (773) 878-6000 (Area Code) Home: ([redacted] (Area Code)

IL486-1019 12/97 (LT)

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)
Guangzhon #16 High Schol	China	05/90

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

1 2 (3) 4 5 6 7 8

Graduated? ☒ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
Jinan University	Guangzhon, China	09/90	5/91	N/A
Triton College	River Grove, IL	01/92	05/93	N/A
University of Illinois at Chicago	Chicago, IL	01/93	08/94	B.S.
Chicago College of Osteopathic Medicine	Downers Grove, IL	09/94	05/98	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)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
Edgewater Medical Center – University	Chicago, IL	06/98	06/99	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

IL486-1019 12/97 (LT)

IDPR FOR DEPOSIT ONLY IL STATE TREASURER
APR 27 99
2370270728 FNB CENTRAL IL 071100272

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	Temporary Licensure physician/surgeon	125-038412	6/22/98	Active
State of Current Licensure where you most recently have been practicing. IL				
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
Complex step I	IL	05/96	
NBOME Step II	IL	03/98	
NBOME step III	IL	0[illegible]	

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

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a 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)***

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.**

You **MUST** check one of the following:

☐ I am not more than 30 days delinquent in complying with a child support order.

☐ I am more than 30 days delinquent in complying with a child support order.

☒ I am not currently under any child support order.

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 4/13/99

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.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised 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.	**CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM**	SUPPORTING DOCUMENT **CA-MED**

NOTE: An applicant shall not commence specialty/residency training before he or the hospital/institution receives written notice of the approval of his application from the Department of Professional Regulation.

APPLICANT: Complete the applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the remainder of the form.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Xia Tran	[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]	Temporary Licensure	
6. MAIDEN OR GIVEN SURNAME	Physician / Surgeon (Profession Name) — 125 (Profession Code)	

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
Swedish Covenant Hospital	07 / 01 / 99 (Month Day Year)	06 / 30 / 2002 (Month Day Year)
D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE	E. SPECIALTY / RESIDENCY NAME	
5145 N. California Chicago, IL 60625	Family Practice	
F. BUSINESS TELEPHONE NUMBER	G. YEAR OF POSTGRADUATE TRAINING	
Area Code (773) 989—3808	First for Family Practice	

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Professional Regulation, the applicant is found to be eligible for licensure.

[redacted]
Signature of Program Director

Walten I. Baba, M.D., Ph.D.
Print Name of Program Director

Director, Family Practice Residency Program
Title

April 20, 1999
Date

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IL486-0272 12/93 (MD)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statues (Chapter 111 of the Illinois Revised 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	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	2. DATE OF BIRTH (Month Day Year)	3. SOCIAL SECURITY NUMBER
Xia Tian	[redacted]	[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]	Profession Name: Temporary Licensure physician / Surgeon	Profession Code: 1 2 5
6. MAIDEN OR GIVEN SURNAME	7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☐	8. DATE FORM COMPLETED 4/13/99

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	JOB TITLE
Mid Western University / Edgewater Medical Center	Intern
ADDRESS STREET, CITY, STATE, ZIP CODE: 5700 N. Ashland Chicago IL 60660	DESCRIPTION OF DUTIES PERFORMED: As the osteopathic traditional intern. duties include work and in charge of general medical floor. I.C.U. and work on/with different services.
SUPERVISOR NAME: Dr Olden D.O.	
DATE OF EMPLOYMENT/ATTENDANCE: From 06/22/98 To 06/21/99	
HOURS WORKED PER WEEK: 75 hrs	
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month): 12 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)	

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COMPLETE THE REVERSE SIDE OF THIS FORM

C. 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)

D. 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)

E. 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)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised 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.	**CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM**	SUPPORTING DOCUMENT **CA-MED**

NOTE: An applicant shall not commence specialty/residency training before he or the hospital/institution receives written notice of the approval of his application from the Department of Professional Regulation.

APPLICANT: Complete the applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the remainder of the form.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Xia Tian	[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]	
6. MAIDEN OR GIVEN SURNAME	Temporary Physician License — Profession Name; 1 2 5 — Profession Code

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
Midwestern University/Chicago College of Osteopathic Medicine	06/22/98 (Month Day Year)	06/21/99 (Month Day Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE	E. SPECIALTY / RESIDENCY NAME
Postdoctoral Education c/o 20201 S. Crawford Avenue Olympia Fields, IL 60461	Transitional Internship
F. BUSINESS TELEPHONE NUMBER	G. YEAR OF POSTGRADUATE TRAINING
Area Code (708) 747-4000 x1335	PGY-1

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Professional Regulation, the applicant is found to be eligible for licensure.

[redacted]
Signature of Program Director

Gary L. Slick, D.O.
Print Name of Program Director

Director of Medical Education
Title

2/25/98
Date

IL486-0272 12/93 (MD)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statues (Chapter 111 of the Illinois Revised 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	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	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Xia Tian	[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]	Temporary Physician Licensure — Profession Name; 1 2 5 — Profession Code

6. MAIDEN OR GIVEN SURNAME	7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☐	8. DATE FORM COMPLETED
		2/18/98

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	JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED I do not plan to work between graduation and internship.
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)	

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)	

COMPLETE THE REVERSE SIDE OF THIS FORM

C. 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)

D. 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)

E. 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)

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION

June 22, 2000

Tian Xia DO

Dear Dr. Xia:

Your application for temporary licensure in Illinois has been approved, and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 07/01/2000. Assuming you remain in the training program listed below, this license will be valid until 06/30/2003.

PROGRAM: Anesthesiology Training
TRAINING FACILITY: Cook County Hospital

Utilization of this license is limited to the training program listed above. It may not be used for any clinical medical practice which occurs outside the residency program; i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferable from one program/institution to another.

Applications for temporary licensure transfers must be filed with the Department at least 60 days prior to commencement of the new program. You are not eligible to begin a new training program until your current temporary license has been returned to the Department and a license has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of the temporary license. Any violation of that Act may result in disciplinary action by this Department.

If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department of Professional Regulation, 320 West Washington Street, Springfield, Illinois 62786.

Alicia Purchase, Manager
Medical Unit

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION

June 21, 2000

Tian Xia DO

Dear Dr. Xia:

Your application for temporary licensure in Illinois has been approved, and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 07/01/2000. Assuming you remain in the training program listed below, this license will be valid until 06/30/2003.

PROGRAM: Anesthesiology Training
TRAINING FACILITY: Cook County Hospital

Utilization of this license is limited to the training program listed above. It may not be used for any clinical medical practice which occurs outside the residency program; i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferable from one program/institution to another.

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Alicia Purchase, Manager
Medical Unit