

01000003301 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

-300	Turplored by the Forms Mariagement. Center.		
	e following materials are required to make Application for ensure and/or Examination in Illinois:	Carefully follow all steps outlined on the SHEET. In addition, note the following:	NSTRUCTION
1.	Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.	A. Type or print Ruber black in S	
2.	INSTRUCTION SHEET, which gives step by step application instructions for your profession.	B. The licensure and application source. C. Disclosure of Social Security of the	r is mandatow.
3.	REFERENCE SHEET, which gives detailed coding information for your profession.	D. If the name shown on your Appointment from that shown on your appointment from the	Mication and must
4.	SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.	submit proof of legal name change - license, divorce decree, affidavit or o	copysignarriage
	1		
-	RT I: Application Category Information		
	SEE REFERENCE SHEET, CHART I, PRIOR TO COMPLETING ITEMS 1 PROFESSION NAME 2. PROFESSION	3. LICENSURE METHOD	4. FEE
	emporary Physician CODE		
1	censure 1223	Nonexamination	\$ /00.00
В. (CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDIN		
	This is the first time I have made application for this profession in Illinois.	denied in Illinois. I am reapplying si	
⋈	I have previously made application for this profession ir	additional requirements.	
	Illinois. However, my previous application expired and I am now reapplying.	Name of the second seco	
l		Illinois. However, I am now applying u language.	inder new statutory
	Other:	-	
PA	RT II: Applicant Identifying Information - You and/or Continental Testing Service in wrapplication in order to receive any further	iting, of any address changes after you	file this
1.	NAME LAST FIRST MIDDLE 2	. TITLE (e.g., M.D., D.D.S., etc.) 3. SOCIAL SECUR	ITY NUMBER
	Xia Tian	D. 0.	
4.	PERMANENT MAILING ADDRESS STREET	CITY STATE/COUNTRY ZIP CODE	COUNTY
5.	BUSINESS ADDRESS STREET	CITY STATE/COUNTRY ZIP CODE	COUNTY
10	23 Newcastle Westchester		
	MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPP SEE D ABOVE)	ORTING DOCUMENTS WILL BE SUBMITTED.	,
7.	PLACE OF BIRTH CITY STATE/COUNTRY 8	DATE OF BIRTH 9	. AGE Female
		Month Day Year	⊠ Male
10.	TELEPHONE NUMBER WHERE YOU MAY BE REACHED		ividic
Wo	rk (312) 953-9667	Home: (
	(Area Code)	(Area Code)	

RAW TO THE CROSSICS

FCD CEPUSIT GULY

LECT CEPUSIT GULY

S270240728

COVINGENTE

COVIN

				(TI) 26/81 8101-989 II
ON 🗆 Yes 🗆 No				CO O S GYA
ON 🗆 səy 🗀			£0	DAN VO NUS ON EACH EACH ON EACH EACH EACH EACH EACH EACH EACH EACH
ON 🗆 Yes 🗆	1	2 %	11500	The State of the S
oN ⊠ sə □	15/21.	65/20	MI , Ellequester)	Indiana University
ON 🗀 SƏY 🔀	Month/Year	Month/Year 6 / 5 / 8	7I (cho2147)	M id Western 23702607269 Wn iven it
Did You' Complete	TTENDANCE TO	DATES OF A	LOCATION (City and State or Country)	SISSISMAN NOITUTITENI
مستعد الا	/	linical Training)	ofessional Training, Vocational Training, Practical or C	7 SPECIALIZED TRAINING (Résidency, Pr
				266232000 20003
			303	0.00 110 0.00 0.00 0.00 0.00 0.00 0.00 0.00
				33303160< + + + + + + + + + + + + + + + + + + +
D. 0	86/50	46/60	7 I	Chicago Callogresons
.5.8	15/80	56/19	11 (0801 h)	University of 1972 2 4 CD 12 2 4 CD 2 2 CD 17 2 CD 10 17 2 CD 10 17 CD 10 CD 1
V/ ~/	26/50	26/10	Liverbrow IL	ONCOURT (3000)
W/W	Month/Year	MonthYear	Etwargshows Chira	Jinan University ne Cior
TYPE OF	TTENDANCE TO	A 10 SETAD MORT	LOCATION (City and State or Country)	COLLEGE OR UNIVERSITY NAME (Undergraduate)
		oN □	ner of years completed) Graduated? Yes	5. CÓRLEGE OR UNIVERSITY (Circle numb
NOITAUDAF	4. DATE OF GF			S NAME OF LAST PRELIMINARY (SCHOOL) COCOLLOS HOND HON
oN □ səYÆ	oceived G.E.D.? ☑	98	nd High School or G.E.D. Circle number of years com Graduated High School? Yes	/)
		(beteld	Circle pumper of veare com	C. CONTRACTOR INCITACION VOLUMENTO I
			-u	PART III: Education Informatio





MPORTANT 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 FORMAR 1 0 1998 LICENSURE AND/OR EXAMINATION

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

- Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
- INSTRUCTION SHEET, which gives step by step application instructions for your profession.
- REFERENCE SHEET, which gives detailed coding information for your profession.
- SUPPORTING DOCUMENTS forms, and/or any other

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

- 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

documentation you may be required application.	d to submit with your	license, divorce di	ecree, anidavit of c	ourt order.
PART I: Application Category Inf	ormation	(014010-	-98
A SEE REFERENCE SHEET, CHART I, PRIOR	TO COMPLETING ITEMS 1			
1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD		4. FEE
Temporary Physician Licensure	125	Non-examination		\$ 100.00
B. CHECK BOX INDICATING THE APPROPRIATE	INFORMATION REGARDING	YOUR APPLICATION		
☑ This is the first time I have made profession in Illinois.☐ I have previously made application		My application for denied in Illinois. additional requirements	am reapplying si	
Illinois. However, my previous appli now reapplying.		I have previously m Illinois. However, I language.		r this profession in inder new statutory
Other:				
PART II: Applicant Identifying I and/or Continental Ter application in order to	sting Service in write receive any further	nust notify the Departr ting, of any address ch r information. TITLE (e.g., M.D., D.D.S., etc.)	nent of Professi anges after you	file this
Xia, Tian		D. 0.		
4. PERMANENT MAILING ADDRESS		1 12		
	STREET	CITY STATE/COUNTRY	ZIP CODE	COUNTY
	STREET	CITY STATE/COUNTRY	ZIP CODE	COUNTY
5. Business address street Post doctoral Education 20 Midwestern University/Chingo Co	ozol S. Crawford Av llege of Osteopothic Med	CITY STATE/COUNTRY V. Olympia Fields, Licine, IL. U.S.A.	ZIP CODE	COUNTY COUNTY COOK .
	ozol S. Crawford Av llege of Osteopothic Med	CITY STATE/COUNTRY V. Olympia Fields, Licine, IL. U.S.A.	ZIP CODE	
5. BUSINESS ADDRESS STREET POST doctoral Education 20 Midwestern University/Chicago Co. 6. MAIDEN. GIVEN SURNAME, OR ANY NAME	ozol S. Crawford Av llege of Osteopothic Mea E(S) UNDER WHICH SUPPO UNTRY 8.	CITY STATE/COUNTRY V. Olympia Fields, licine, IL. U.S.A. C DRTING DOCUMENTS WILL BE	ZIP CODE S 0 4 6 1 -	

						CA86-1019 07/97 (L) 2370270728 FMB CENTRAL I
ON 🗆 Yes		3				86 E 1 9AM
□ Yes □ No						FOR DEPOSIT ONLY
ON 🗆 Yes						
ON 🔲 Yes 🔲 No						
ON 🗆 SƏA 🗀	Month/Year	Month/Year				ON I COSTA
Training?	OT	MORF	ountry)	(City and State or C		8<707<97€3МАИ ИОПТОТПЕИ
Did You Complete	ATTENDANCE.			LOCATION		
		(gninisal Training)	Practical or C	raining, Vocational Tra	T Isnoiseeld	7. SPECIALIZED TRAINING (Residency, Pro
	_				\[\big \big \big \big \big \big \big \big	M. SIAIE IKEASURA
		Į.			11	#461
			-			SAIOZIOZA SAIOZIOZA SAIOZIOZA SAIOZIOZA
.0.4	85/90	46/60		אז פאנטינה		Chicago College 3-to
۵, ۲.	15/80	86/10	71		17140	University of Chistolical Halls and Andrews An
V/N	25/50	76/10	71	731015	KING K	Aggin Colleging
	Month/Year	Month/Year				
DEGREE EARNED	O1 .	MORT	untry)	LOCATION (City and State or Co		COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)
TYPE OF	TTENDANCE	DATES OF A	<u> </u>	MOITADO		ANN ALIGERATION OF
	1 2 3 4 2 6 7 8 Graduated? Alex No					
NOITAUDA	4. DATE OF GR.		CHOOL LOCATION	T PRELIMINARY SC and State)	(City	S. NAME OF LAST PRELIMINARY SCHOOL ATTENDED TO A STENDED TO SCHOOL
ON □ SƏY[G.E.D.?	₽H		Graduated High School?		11 01 6 8 7 8 5 4 5 2 1
		pleted)	umber of years com	ool or G.E.D. Circle n	odo Sehe	1. PRELIMINARY EDUCATION (Elementary an
					u	PART III: Education Information

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				
1				

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

PART V: Record of Examination

If you have evertaken 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.

STATE	MONTH/YEAR	EXAM RESULTS
エム	06/96	(Passed, Failed, Absent)
IL	03/98	
	IL	IL 06/96

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

check if iter than the	Ay 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.					
	85/81/2					
bettimdus	Under penalties of perjury, I declare that I have examined the application and all supporting documents by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.					
	PART IX: Certifying Statement					
	S I am not currently under any child support order.					
	l am more than 30 days delinquent in complying with a child support order.					
	ा am not more than 30 days delinquent in complying with a child support order.					
	You MUST check one of the following:					
ton si eda	In accordance with 5 Illinois Compiled Statues 100/10-65(c), applications for renewal of a license or a new license include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or a more than 30 days delinquent in complying with a child support order. Failure to certify shall result in discipling action, and making a false statement may subject the licensee to contempt of court.					
	PART VIII: Child Support Information (This part must be completed by all applicants)					
ON SE	e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated?					
	d) Record the number of times you have taken this exam in Illinois or any other state:					
	c) CHART IV - Find your School of Graduation and enter school code:					
	b) CHART III - Select the examination site you desire and enter Test Center Code:					
	a) CHART II - Select examination(s) you desire and enter Test Codes.					
	Refer to the REFERENCE SHEET enclosed with this application package and complete the following:					
	PART VII: Examination Coding Information (This part is for examination applicants only)					
	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.					
	 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. 					
	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; (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.					
	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.					
YES NO	PART VI: Personal History Information (This part must be completed by all applicants)					

(L1) 76/70 6101-38411

. .

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 rized to photocopy this form if additional	r been employed you may stop at box 8. You are authospace is required.
1. NAME LAST FIRST MIDDLE	2 DATE OF BIRTH 3. SOCIAL SECURITY NUMBER Month Day Year
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. Temporary Physician Licensure 1 2 5 Profession Name Profession Code
6. MAIDEN OR GIVEN SURNAME	7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. 8. DATE FORM COMPLETED 3/17/00
RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History must account for the entire time period including periods of unemployment are	beginning with present employment and concluding with graduation. You nd volunteer work, etc.
A. NAME OF BUSINESS/INSTITUTION	JOB TITLE Uremployed
ADDRESS STREET, CITY, STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME N/A	
TOTAL TIME WORKED (Year/Month) HOURS WORKED PER WEEK HOURS WORKED PER WEEK HOURS WORKED PER WEEK TYPE OF EMPLOYMENT Full-time Part-time	
B. NAME OF BUSINESS/INSTITUTION	JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE 1/20 S. DY RM 224 Indianapilis IN 46202 SUPERVISOR NAME DX Kaelin DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From D Z / D I / 9 9 TYPE OF EMPLOYMENT TO 1/2 / 3 1 / 9 9 TYPE OF EMPLOYMENT TO Month Day Year TOTAL TIME WORKED (Year/Month) 6 M On thes	PGYZ DESCRIPTION OF DUTIES PERFORMED As a PGYZ resident. My duties included teaching students and in charge of rehabilitation floor

	17486-1071 6/93 (LT-Back)
	PATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From Month Day . Year TO Month Day Vear Month)
· '	SUPERVISOR NAME
DESCRIPTION OF DUTIES PERFORMED	ADDRESS STREET, CITY , STATE, ZIP CODE
31111 800	E. NAME OF BUSINESS/INSTITUTION
	SUPERVISOR NAME DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From Month Day Year TO Month Day Year TOTAL TIME WORKED (YearMonth)
DESCRIPTION OF DUTIES PERFORMED	ADDRESS STREET, CITY, STATE, ZIP CODE
BOTITLE	D. NAME OF BUSINEŚS/INSTITUTION
JOBTILE JOBTIL	C. NAME OF BUSINESS / INSTITUTION ADDRESS STREET, CITY STATE, ZIP CODE SUPERVISOR NAME TO Month Day Year TYPE OF EMPLOYMENT TOTAL TIME WORKED (YearMonth) TOTAL TIME WORKED (YearMonth)

IMPORTANT NOTICE: Completion of this form is recessary for consideration for licensure under 225 of the thinots Compiled Statutes (Chapter 111 of the Minots Revised Statutes). Disclosure of this information is

CERTIFICATION OF

SUPPORTING DOCUMENT

TALACE

(DPR)					
duate					
ER					
ind three					
ion.					
, _					
sion Code					
62786					
This is to certify that the above-named applicant satisfactorily completed 12 months of postgraduate clinical training ininternal medicine internship (Name of Accredited Postgraduate Clinical Training Program)					

PA	RT VI: Personal History Information (This part must be completed by all applicants)
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.
PA	RT VII: Examination Coding Information (This part is for examination applicants only)
Re	fer 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?
PA	RT VIII: Child Support Information (This part must be completed by all applicants)
inc mo	accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall clude the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not one than 30 days delinquent in complying with a child support order. Failure to certify shall result in disciplinary tion, and making a false statement may subject the licensee to contempt of court.
Yo	u MUST check one of the following:
1	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.
	am not currently under any child support order.
PA	RT IX: Certifying Statement
by	der penalties of perjury, I declare that I have examined the application and all supporting documents submitted me in connection therewith, and to the best of per knowledge, they are true, correct, and complete. Signature of Applicant signature above authorizes the Department of Professional Regulation to reduce the amount of this check if
the	e amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the puired fee hereunder, but in no event shall such reduction be made in an amount greater than \$50

IL486-1019 12/97 (LT)

Record of Licensure Information

:VI TAA9

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 in support of your application of licenseived and submitted may result in denial of your application or other appropriate action.

(If additional space is needed, attach a separate sheet.)							
		1					
!		1					
!	1						
,							
i		1					
,		1					
				Other States of Licensure			
-3/112H	14/1/1		Permit	practicing. I. A.			
ON ST X	66/1/2	9 0 9 8 0 0 1 /	Tern porary Medical	State of Current Licensure where you most recently have been			
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	2.1.10		Lizensure Ternporany Medical	7]			
Lapsed	86/22/9	125-038912	Temperary Physician	State of Original Licensure			
LICENSE STATUS (Active, Lapsed, etc.)	DATE OF ISSUANCE	LICENSE NUMBER	PROFESSION NAME	STAT2			
	were emiliary to the state of t						

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 application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE action.

(If additional space is needed, attach a separate sheet.)				
				(4
				æ
			٨	2
	86/20	71	111 doll	2 WO a W
	85/50	71	l	ZWOAN
	95/50	71	I PAS C	Complex
STJUSBR MAXB	RABYHTNOM	BTAT2	NOITANIMAXE OF EXAMINATION	

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 informa-

CERTIFICATE OF ACCEPTANCE **FOR**

SUPPORTING DOCUMENT

tion is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.	ESIDENCY PROGRAM	CA-IVIED	
NOTE: An applicant shall not commence specia receives written notice of the approval Regulation.	of his application from the Dep	partment of Professional	
APPLICANT: Complete the applicant section of this form you for specialty/residency training, for co			
1. NAME LAST FIRST MIDDLE XIA TIAN	2. DATE OF BIRTH 3. Month Day Year	SOCIAL SECURITY NUMBER	
4. ADDRESS STREET, CITY, STATE, ZIP CODE	REFER TO REFERENCE SHEET. Recordigit profession code for which you are many the second s		
6. MAIDEN OR GIVEN SURNAME SAME	TEMPORARY PHYSICIAN L	ICENSURE 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	0 7 /0 1 /0 0 Month Day Year	$\frac{0}{\text{Month}} \frac{6}{2} \frac{3}{2} \frac{0}{2} \frac{3}{2} \frac{3}{2} \frac{3}{2}$	
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	G	
Area Code () 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.			

ALON P. WINNIE Print Name of Program Director PROGRAM DIRECTOR Title 3-24-00

SEAL

+ * * 1 .



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.



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

- Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
- INSTRUCTION SHEET, which gives step by step application instructions for your profession.
- REFERENCE SHEET, which gives detailed coding information for your profession.
- 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.

application.	o to outsime wan your			
PART I: Application Category Int	ormation .			
A. SEE REFERENCE SHEET, CHART I, PRIOF	TO COMPLETING ITEMS 1	THROUGH 4		
1. PROFESSION NAME	2. PROFESSION	3. LICENSURE METHOD		4. FEE
Tian Xia	^{CODE} 2 5	Nonexaminat	ion	\$ 100
B. CHECK BOX INDICATING THE APPROPRIATE	INFORMATION REGARDING	•		
This is the first time I have made profession in Illinois. I have previously made application	de application for this	☐ My application for	l am reapplying s	ad previously been since I have fulfilled
Illinois. However, my previous appli now reapplying.				or this profession in under new statutory
Other:				
and/or Continental Tesapplication in order to	receive any further		3. SOCIAL SECU	
Xia, lian		D, O.		
4. PERMANENT MAILING ADDRESS	STREET	CITY STATE/COUNTRY	ZIP CODE	COUNTY
5. BUSINESS ADDRESS STREET		CITY STATE/COUNTRY	ZIP CODE	COUNTY
6. MAIDEN, GIVEN SURNAME, OR ANY NAME (SEE D ABOVE)	E(S) UNDER WHICH SUPPO	DRTING DOCUMENTS WILL BE	RECE	IN E
7. PLACE OF BIRTH CITY STATE/CO		DATE OF BIRTH Month Day	Year PR-M	9. VAGE
10. TELEPHONE NUMBER WHERE YOU MAY	DE DEACUED		- 1/1	Nigle

					END CENTRAL I FWD CENTRAL I CT10027028	I V
						(TJ) 76/S1 6101-884JI
oN □ səY □					99 Y S 99A	
ON 🗆 SƏX 🗀				# ¥3	IDPR POG DEPOSIT ONL PLEASTE TREASUR	9
ON □ Yes □ No				la, cashin A		•
ON 🗆 səx 🗀						i)
oN J⊠ səy □	159\\dagger \dagger 0	Month/Year 8 / 8 / 8 / 8 / 8	1I, 0607. À) V	TO LEGISTRA	bedge water by - Notes l
7 Training?	ОТ	MOAT	(City and State or Country)		NAME	NOITUTITSNI
Did You Complete	TTENDANCE	Inical Italing)	onal Training, Vocational Training, Practical or Cl LOCATION	roteșsio	Aldigid-(Hesigancy, Fi	7. SPECIALIZED IN
·		(1	FOR STATE TREASURI	
			· -		BdOl -	
					7/7001100 3/48/1804118	2.1429e2720
D-0	85/50	15/60	7 JULY STOWN	oq	87.10.201.63	Chicas,
.2.2	16/80	26/10) I (0 post)	12	68 777 8 all	UNTVENTUM
D/M	Σb/ 5 8	26/10	LI , SMRD JA	97.7	DPK SAM BEPOSIT ONLY STATE STATE) retil
W/N	Month/Year 791	Month/Year	sang Zhon, China	119	भू !इक्टां म	J. Narit
TYPE OF	TTENDANCE TO	DATES OF AT	LOCATION (City and State or Country)		IVERSITY NAME and Graduate)	6. COLLEGE OR UNI (Undergraduate
5. COLLEGE OR UNIVERSITY (Circle number of years completed) 1 2 3 4 5 6 7 8 Graduated?						
0 6/						
1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed) Graduated A 5 6 7 8 9 10 11 12 A 5 6 7 8 9 10						
				uo	itsmnotal noits	PART III: Educ



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	Temporary licensur physician /surgeon	e 125-03841 Z	6/22/98	Active
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

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

PART V: Record of Examination

If you have ever 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	エレ	05/96	
Complex step I NBOME Step II	IL	0 3 /98	
NBOME Step II	エレ	OLGE	
		APR 2	₆ 1999
		Sall as	MCAL UNIT
		IDPR-ME	,-
(If additional space is no	eeded, attach a separate		

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.
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 knewledge, they are true, correct, and complete.
PART IX: Certifyling Statement
I am not currently under any child support order.
I am more than 30 days delinquent in complying with a child support order.
I am not more than 30 days delinquent in complying with a child support order.
You MUST check one of the following:
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 VIII: Child Support Information (This part must be completed by all applicants)
e) Do you authorize the Department to release your Licensure Examination Scores to The education program from which you graduated?
d) Record the number of times you have taken this exam in Illinois or any other state:
c) CHART IV - Find your School of Graduation and enter school code:
b) CHART III - Select the examination site you desire and enter Test Center Code:
and enter Test Codes.
Refer to the REFERENCE SHEET enclosed with this application package and complete the following:
PART VII: Examination Coding Information (This part is for examination applicants only)
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.
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.
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; (2) alcohol or other substance abuse; 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.
PETSONAL History Information (This part must be completed by all applicants) 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.

(TJ) 76/S1 6101-884JI

y Col

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.

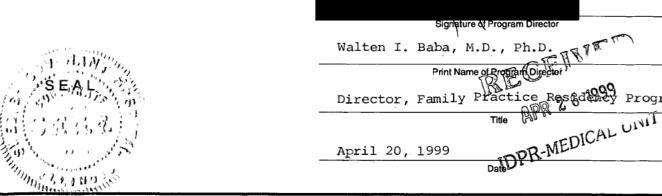
CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

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 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. NAME DATE OF BIRTH SOCIAL SECURITY NUMBER 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. Temporary Licensure Physician / Surgeon
Profession Name 6. MAIDEN OR GIVEN SURNAME ADMINISTRATOR: Complete the remainder of this form and return it to the applicant. C. ENDING DATE HOSPITAL/INSTITUTION NAME . B. BEGINNING DATE Swedish Covenant Hospital 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 (7 7 3) 9 8 9 -3 8 0 8 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.



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

Management Center	
APPLICANT: Complete Work History. If you have neve	r been employed you may stop at box 8. You are autho- space is required.
1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH 3. SOCIAL SECURITY NUMBER Month Day Year
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. Temporary Licensure Profession Name Profession Code
6. MAIDEN OR GIVEN SURNAME	7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. 8. DATE FORM COMPLETED 4//3/99
RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History must account for the entire time period including periods of unemployment a	
A. NAME OF BUSINESS/INSTITUTION Mid Western University / Edge water Medical Contex	JOB TITLE In Jern
Mid Western University/Edgewater Medical Center ADDRESS STREET, CITY STATE, ZIP CODE 5700 N. Archland Chitago IL 60660 Dr Olden D.O.	DESCRIPTION OF DUTIES PERFORMED As the Osterpathiz straditional Intern chapters include work and in charge of seneral medical thory. I. C. U. and work ordwith different rervices.
SUPERVISOR NAME	theory I.C. U. and work on with
From Don't Day Year TYPE OF EMPLOYMENT	different rervices.
To $\frac{0.6}{Month}$ / $\frac{2.1}{Day}$ / $\frac{9.9}{Year}$ SFull-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 HOURS WORKED PER WEEK	RECEIVED APR 2 6 1999 IDPR-MEDICAL UNIT
From	APR 26 1999
TOTAL TIME WORKED (Year/Month)	IDPR-MEDICAL OF

	17486-1071 6/93 (LT-Back
	TOTAL TIME WORKED (Year/Month)
	To Month 1 Day 1 D
	From Month Day Year TYPE OF EMPLOYMENT
	DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK
	SUPERVISOR NAME
	27777 dostradans
реѕсиртіои ог рутіеѕ реягоямер	ADDRESS STREET, CITY , STATE, ZIP CODE
JOB TITLE	E. NAME OF BUSINESS/INSTITUTION
3 TIT 801	E NAME OF BUSINESS (INSTITUTION
	TOTAL TIME WORKED (Year/Month)
	amit-ths9 Classification amit-Illu3 Classification and Classification amit-Illu3 Classification and Classifi
	From Month Lay Vest Type OF EMPLOYMENT
	DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK
	AMAN AOSIVABAUS
DESCRIPTION OF DUTIES PERFORMED	ADDRESS STREET, CITY, STATE, ZIP CODE
ELITTE GOL	D. NAME OF BUSINESS/INSTITUTION
	TOTAL TIME WORKED (Year/Month)
	emit-the9 emit-III.3 = -//- or
	From
	DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK
	SUPERVISOR NAME
DESCRIPTION OF DUTIES PERFORMED	ADDRESS STREET, CITY, STATE, ZIP CODE
BJTIT BOL	C. NAME OF BUSINESS/INSTITUTION

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 informa-

CERTIFICATE OF ACCEPTANCE FOR

SUPPORTING DOCUMENT

tion is VOLUNTA result in this form	ARY. However, failure to comply may in not being processed. This form has by the Forms Management Center.			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 BIR		SOCIAL SECURITY NUMBER	
4 ADDRESS	STREET CITY STATE ZIP CODE			cord profession name and three making Illinois application.	
6. MAIDEN O	R GIVEN SURNAME	Temporar	y Physician Profession Name	License 1 2 5 Profession Code	
ADMINIS	ADMINISTRATOR: Complete the remainder of this form and return it to the applicant.				
A. HOSPITAL	INSTITUTION NAME	B. BEGINNING (DATE	C. ENDING DATE	
	western University/Chicago College f Osteopathic Medicine	0 6 /2 Month	2 2 / 9 8 Day Year	06/21/99 Month Day Year	
D. BUSINESS	ADDRESS STREET, CITY, STATE, ZIP CODE	E. SPECIALTY /	RESIDENCY NAME		
c/o	tdoctoral Education 20201 S. Crawford Avenue moia Fields, IL 60461	Trans	itional Inter	nship	
	TELEPHONE NUMBER	G. YEAR OF PO	OSTGRADUATE TRAIN	ING	
Area Co	de(<u>708</u>) <u>747—4000</u> 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.					



Signature of Program Director		
Gary L. Slick, D.O.		
Print Name of Program Director		
Director of Medical Fducation		
Title		
2/25/98		
Date		

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. SOCIAL SECURITY NUMBER 2. DATE OF BIRTH 1. NAME LAST Month REFER TO REFERENCE SHEET. Record profession name and three digit 4. ADDRESS profession code for which you are making Illinois application. Lemnorary Physician Licensure CHECK HERE IF YOU HAVE 8. DATE FORM COMPLETED 6. MAIDEN OR GIVEN SURNAME NEVER BEEN EMPLOYED. 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. JOB TITLE A. NAME OF BUSINESS / INSTITUTION DESCRIPTION OF DUTIES PERFORMED STREET, CITY, STATE, ZIP CODE ADDRESS I do not plan to work between graduation and internship. SUPERVISOR NAME DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time B. NAME OF BUSINESS/INSTITUTION JOB TITLE STREET, CITY, STATE, ZIP CODE DESCRIPTION OF DUTIES PERFORMED ADDRESS SUPERVISOR NAME DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time □ Part-time Month Day TOTAL TIME WORKED (Year/Month)

	IL486-1071 6/93 (LT-Back)
	TOTAL TIME WORKED (Year/Month)
	əmit-tins Day Linat Dati-time T
	From Month Day Year TYPE OF EMPLOYMENT
	DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK
	змаи яогіуязчог
·	
DESCRIPTION OF DUTIES PERFORMED	ADDRESS STREET, CITY, STATE, ZIP CODE
JUB TITLE	E. NAME OF BUSINESS/INSTITUTION
	TOTAL TIME WORKED (Year-Month)
	To Part-time Dad-time
	From Month Day Year TYPE OF EMPLOYMENT
	DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK
	SUPERVISOR NAME
DESCRIPTION OF DUTIES PERFORMED .	ADDRESS STREET CITY STATE, ZIP CODE
элп вог	D. NAME OF BUSINESS/INSTITUTION
	TOTAL TIME WORKED (Year/Month)
	emit-fime Damit-llu1 Damit-time of
	From Month Day Year TYPE OF EMPLOYMENT
	DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK
	SUPERVISOR NAME
DESCRIPTION OF DUTIES PERFORMED	ADDRESS STREET, CITY, STATE, ZIP CODE
JOB TITLE	C. NAME OF BUSINESS/INSTITUTION

*7

STATE OF ILLINOIS DEPARTMENT OF PROFESSIONAL REGULATION

June 22, 2000

Tian Xia DO

. 174

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.

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