Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

PAT QUINN
Governor

MANUEL FLORES
Acting Secretary

JAY STEWART
Director
Division of Professional Regulation

December 4, 2013

D Janis
Ja2013@rediffmail.com

To whom it may concern:

Thank you for writing to the Illinois Department of Financial and Professional Regulation (IDFPR) with your request for information pursuant to the Illinois Freedom of Information Act, 5 ILCS 140/1 et seq.

We received your request for the following:

- *Information related to Erin Lee King,including: lawsuits, all complaints and disciplinary actions, all applications and reapplications, all hospital admitting privileges, all limited licenses and temporary licenses, all Controlled Substance Licenses (CS-3s), all Controlled Substance Licenses (CS-3s) applications, all Controlled Substance Additional Location License Applications, all criminal documents, all Board of Medicine Licenses, all license (aka written agreement) with a licensed laboratory, all hospital privileges in an Illinois based hospital, all supervisory agreements/documents related to his supervising nurses.*

Please find the attached requested documents in the possession of the Illinois Department of Financial and Professional Regulation. To view the physician profile, please visit the IDFPR website at https://www.idfpr.com/Applications/Professionprofile/default.aspx?AspxAutoDetectCookieSupport=1.
In the event the Department has received any complaint(s), conducted any investigation(s), retained any materials relevant to your request, or redacted any information from the documents provided this information would be exempt from disclosure through FOIA under 5 ILCS 140/7(a), (b), (c), (d)(ii), (d)(iv), (f), 225 ILCS 60/36, and 68 IL Admin. Section 1285.310

FOIA Sec. 7. Exemptions.

(1) When a request is made to inspect or copy a public record that contains information that is exempt from disclosure under this Section, but also contains information that is not exempt from disclosure, the public body may elect to redact the information that is exempt. The public body shall make the remaining information available for inspection and copying. Subject to this requirement, the following shall be exempt from inspection and copying:

(a) Information specifically prohibited from disclosure by federal or State law or rules and regulations implementing federal or State law.

(b) Private information, unless disclosure is required by another provision of this Act, a State or federal law or a court order.

(c) Personal information contained within public records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, unless the disclosure is consented to in writing by the individual subjects of the information. "Unwarranted invasion of personal privacy" means the disclosure of information that is highly personal or objectionable to a reasonable person and in which the subject's right to privacy outweighs any legitimate public interest in obtaining the information. The disclosure of information that bears on the public duties of public employees and officials shall not be considered an invasion of personal privacy.

(d) Records in the possession of any public body created in the course of administrative enforcement proceedings, and any law enforcement or correctional agency for law enforcement purposes, but only to the extent that disclosure would:

(ii) interfere with active administrative enforcement proceedings conducted by the public body that is the recipient of the request;

(iv) unavoidably disclose the identity of a confidential source, confidential information furnished only by the confidential source, or persons who file complaints with or provide information to administrative, investigative, law enforcement, or penal agencies; except that the identities of witnesses to traffic accidents, traffic accident reports, and rescue reports shall be provided by agencies of local government, except when disclosure would interfere with an active criminal investigation conducted by the agency that is the recipient of the request;

(f) Preliminary drafts, notes, recommendations, memoranda and other records in which opinions are expressed, or policies or actions are formulated, except that a specific record or relevant portion of a record shall not be exempt when the record is publicly cited and identified by the head of the public body. The exemption provided in this paragraph (f) extends to all those records of officers and agencies of the General Assembly that pertain to the preparation of legislative documents.

(IL Medical Practice Act) Sec. 36: ...All information gathered by the Department during its investigation including information subpoenaed under Section 23 or 38 of this Act and the investigative file shall be kept for the confidential use of the Secretary, Disciplinary Board, the Medical Coordinators, persons employed by contract to advise the Medical Coordinator or the Department, the Disciplinary Board's attorneys, the medical investigative staff, and authorized clerical staff, as provided in this Act...

(68 IL Admin Section 1285.310)

a) All investigative procedures, information arising out of the investigation of complaints, activities of the Complaint Committee, and informal conferences shall be confidential.

You may appeal the partial denial of this request by filing a Request for Review within 60 days with the Public Access Bureau in the Attorney General's Office (contact information listed below).

Office of the Attorney General
500 S. 2nd Street
Springfield, Illinois 62706
Phone:
1-877-299-FOIA
(1-877-299-3642)
Fax: (217) 782-1396

You also have the right to seek judicial review by filing a court case.

Very truly yours,

Mark Thompson
Deputy General Counsel
Illinois Department of Financial and Professional Regulation
100 West Randolph Street, Ste. 9-300
Chicago, IL 60601

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3465403

RECEIVED
CASH SECTION
MAR 0 9 2006
Div. of Professional Regulation

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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

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

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

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

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
PHYSICIAN	~~036~~ 035	non-examination ~~application~~	$ 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: extension temporary license
- ☐ 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. 125-0 46463

PART II: Applicant Identifying Information - You must notify the Department of Financial and Professional Regulation - Division 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	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
KING	ERIN	LEE	MD	[redacted]

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

5. BUSINESS ADDRESS STREET	CITY	STATE/COUNTRY	ZIP CODE	COUNTY
333 E. Superior Rm 107	CHICAGO, IL		60611-____	COOK

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME
	BROWN

8. PLACE OF BIRTH CITY	STATE/COUNTRY	9. DATE OF BIRTH	10. AGE
[redacted]			

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED	12. PREFERRED e-MAIL
Work ([redacted]	

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI): KING, ERIN, L

SS#: [redacted]

Profession: PHYSICIAN

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
LANGLEY HIGH SCHOOL	MCLEAN, VA	06 / 1993 (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)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
STANFORD UNIVERSITY	STANFORD, CA	9/93	6/97	BA
GEORGETOWN UNIVERSITY	WASHINGTON, DC	06/95	08/95	none
WASHINGTON UNIV SCHOOL OF MEDICINE	ST. LOUIS, MO	06/98	06/03	M.D.

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?
NORTHWESTERN UNIVERSITY	CHICAGO, IL	06/03	present	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): KING ERIN L

SS#: [redacted]

Profession: PHYSICIAN

PART IV: Record of Licensure Information

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure ILLINOIS	PHYSICIAN (TEMPORARY)		6/03	temporary 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
USMLE STEP 1		6/99	(Passed), Failed, Absent)
USMLE STEP 2		10/02	PASSED

(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.*		X
2. Have you been convicted of a felony?		X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		X
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		X
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		X

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. [ ][X][ ][ ][ ][ ]

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: [ ][ ]

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

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

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

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

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

PART 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]
Signature of Applicant

3/7/06
Date

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

NAME (Last, First, MI): KING, ERIC, L

SS#: [redacted]

Profession: PHYSICIAN

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

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 Financial and 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: KING; FIRST: ERIN; MIDDLE: LEE

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

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 — Profession Name: 125 — Profession Code

6. MAIDEN OR GIVEN SURNAME: KING

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

A. HOSPITAL/INSTITUTION NAME: Northwestern Mcgaw Medical Center

B. BEGINNING DATE: 06 / 17 / 2006 (Month / Day / Year)

C. ENDING DATE: 06 / 16 / 2007 (Month / Day / Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: 333 E Superior #180 Chicago IL 60611

E. SPECIALTY / RESIDENCY NAME: obstetrics & gynecology

F. BUSINESS TELEPHONE NUMBER: Area Code (312) 926-7522

G. YEAR OF POSTGRADUATE TRAINING: 3

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 Financial and Professional Regulation, the applicant is found to be eligible for licensure.

SEAL

[redacted]
Signature of Program Director

Magdy Milad
Print Name of Program Director

Program Director
Title

2/8/06
Date

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

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
KING	ERIN	LEE	[redacted]	[redacted]

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

5. REFER TO REFERENCE SHEET, Record profession name and three digit profession code for which you are making Illinois application.
PHYSICIAN (Profession Name) 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: KING

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☒

8. DATE FORM COMPLETED: 3/7/2006

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: MCGAW MEDICAL / NORTHWESTERN

JOB TITLE: RESIDENT PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE: 333 E Superior - PRENTICE HOSPITAL CHICAGO, IL 60611

DESCRIPTION OF DUTIES PERFORMED: RESIDENT in DEPT OB/GYN

SUPERVISOR NAME: MAGDY MIYAD

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / __ / 2003 (Month Day Year)
To __ / present (Month Day Year)

HOURS WORKED PER WEEK: 80

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

TOTAL TIME WORKED (Year/Month): 2 years / 9 mos.

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):

State of Illinois

11601643

Department of Professional Regulation

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

LICENSE NO.
125-046463

STARTED: 06/17/2003

EXPIRES
06/16/2006

LICENSED MEDICAL TEMPORARY

ENTITLES LICENSEE TO PERFORM ONLY SUCH ACTS AS MAY BE PRESCRIBED BY, AND INCIDENTAL TO, SUCH PROGRAM OF
Obstetrics & Gynecology

ERIN LEE KING MD
MCGAW MEDICAL CENTER/NORTHWESTERN
DEPT OF GME
645 N MICHIGAN AVE STE 1058A
CHICAGO, IL 60611

The official status of this license can be verified at www.ildpr.com

Robert E Hewson Jr. ACTING DIRECTOR

Issued under the authority of
The State of Illinois
Department of Professional Regulation

vv DETACH POCKET CARD HERE vv

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION
SPRINGFIELD

EXPIRES:

VOID VOID VOID

VOID VOID VOID

VOID VOID VOID

The official status of this license can be verified at www.ildpr.com

Robert E Hewson Jr. ACTING DIRECTOR 11601643

^^ DETACH POCKET CARD HERE ^^

00026

THIS LICENSE MUST BE CONSPICUOUSLY DISPLAYED AT ALL TIMES IN YOUR OFFICE OR PLACE OF BUSINESS IN ACCORDANCE WITH THE LAW.

Northwestern University
Feinberg School of Medicine

Section of Graduate Medical Education
Department of Obstetrics and Gynecology
Prentice Women's Hospital
and Maternity Center
333 East Superior Street, Suite 185
Chicago, Illinois 60611-3095

Magdy P. Milad, MD, MS
Division Head
Professor

mmilad@nmh.org
Phone 312-926-7522
Fax 312-926-7976

NORTHWESTERN
UNIVERSITY

March 8, 2006

To Whom It May Concern:

This letter is to certify that Dr. Erin King is extending her temporary license for the period of one year in order to complete a four-year residency program in Obstetrics and Gynecology at Northwestern University.

Sincerely,

[redacted]

Magdy P. Milad, MD, MS
Residency Program Director

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION

May 28, 2003

Erin Lee King MD
[redacted]

Dear Dr. King:

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 06/17/2003. Assuming you remain in the training program listed below, this license will be valid until 06/16/2006.

PROGRAM: Obstetrics & Gynecology
TRAINING FACILITY: Mc Gaw Med Ctr Northwestern

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.

Sandy Dunn, Manager
Medical Unit

FC: lv3.125

[redacted]

01000002306 94654 APR - 3 2003

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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:

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2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

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

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

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician License	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	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
King, Erin, Lee	M.D.	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

[redacted]

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

N/A

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

N/A

7. PLACE OF BIRTH CITY STATE/COUNTRY	8. DATE OF BIRTH	9. AGE
[redacted]	[redacted]	

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (N/A) _____ - _____ Home: ([redacted]
(Area Code) (Area Code)

X

NAME (Last, First, MI): King, Erin, L

SS#: [redacted]

Profession: temp. physician license

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
Langley High School	McLean, Virginia	06/1993 (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)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
Stanford University	Stanford, CA	09/93	06/97	B.A.
WASHINGTON UNIV.	ST. Louis, Mo	08/98	05/03	M.D.

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?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): King, Eric L

SS#: [redacted]

Profession: temp. physician license

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)
USMLE Step 1	CA	07/00	Passed
USMLE Step 2	MO	[redacted]/02	Passed

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

NAME (Last, First, MI): King Erin L

SS#: [redacted]

Profession: temp. physician license

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.*		X
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.*		X
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.*		X
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.*		X

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

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

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

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

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

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

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

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

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

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

☒ NO ☐ Yes

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

PART IX: Certifying Statement

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

[redacted] 3/27/03

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.

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): King, Erin L.

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 License (Profession Name) — **125** (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

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

A. HOSPITAL/INSTITUTION NAME: **McGaw Medical Center of Northwestern University**

B. BEGINNING DATE: 06 / 17 / 03 (Month / Day / Year)

C. ENDING DATE: 06 / 16 / 06 (Month / Day / Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: **645 N. Michigan Ave., Suite 1058A, Chicago, IL 60611**

D. SPECIALTY / RESIDENCY NAME: Obstetrics and Gynecology

F. BUSINESS TELEPHONE NUMBER: **Area Code (312) 503-7975**

G. YEAR OF POSTGRADUATE TRAINING: 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.

SEAL

[redacted]
Signature of Program Director

Magdy P. Milad MD MS
Print Name of Program Director

Program Director
Title

March 20, 2003
Date

IL 486-0272 12/93 (MD)

4/9

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 ILCS 60/1 et.seq. Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

RECEIVED
MAY 19 2003
IDPR-MEDICAL UNIT

SUPPORTING DOCUMENT

CERTIFICATION OF EDUCATION ED - MED

APPLICANT: ***Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.***

1. NAME LAST FIRST MIDDLE: KING ERIN LEE

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 License (Profession Name) 1 2 5 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: KING

7. NAME OF INSTITUTION ATTENDED: Washington University School of Medicine

8. DATE OF GRADUATION / COMPLETION: 05 / 16 / 2003 Month Day Year

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Professional Regulation or its designated testing service the information requested below.

3/31/03 Date

[redacted] Signature

SCHOOL OFFICIAL: ***Complete the bottom portion of this page and the reverse side, then return to the applicant.***

A. NAME OF INSTITUTION: Washington University School of Medicine

B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE: 660 S. Euclid Box 8107 St. Louis, MO 63110

C. INDICATE YEAR BY YEAR THE DATES OF ATTENDANCE IN COLLEGE (Both pre-medical and medical education must be included)

Pre-Med From ___/___/1993 To ___/___/1997 (Month Day Year)

MED 1 From 08/17/1998 To 05/28/1999

MED 2 From 08/16/1999 To 05/26/2000

Leave of Absence From 06/01/2000 To 05/31/2001

MED 3 From 06/11/2001 To 05/26/2002

MED 4 From 06/17/2002 To 05/16/2003

D. *Total academic years attended* 4 / ___ / ___ (Years / Months / Days)
OR
Total calendar years attended ___ / ___ / ___ (Years / Months / Days)

E. TYPE OF DEGREE OR CERTIFICATE AWARDED: Doctor of Medicine

F. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET: 05/16/2003 Month Day Year

G. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED: 05/16/2003 Month Day Year

H. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

[✓] *Applicant has graduated on* 05/16/2003 Month Day Year

[ ] *Applicant will graduate on* ___/___/_____ Month Day Year

[✓] *Applicant has completed program on* 05/16/2003 Month Day Year

[ ] *Applicant will complete program on* ___/___/_____ Month Day Year

I. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:

J. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

NAME (Last, First, MI):

RECEIVED
MAY 1 9 2003
IDPR-MEDICAL UNIT

SS#:

WHEN THIS FORM IS CERTIFIED PRIOR TO THE ACTUAL GRADUATION OF THE APPLICANT, THE SCHOOL OFFICIAL IS RESPONSIBLE FOR NOTIFYING THE DEPARTMENT OF PROFESSIONAL REGULATION OF ANY FAILURE ON THE PART OF THE APPLICANT TO COMPLETE THE REQUIREMENTS FOR GRADUATION.

I certify that the information recorded herein is true and correct according to the official records of this institution.

[redacted]

DEBORAH A. MUNOZ-REGISTRAR
ASSISTANT DEAN FOR ACADEMIC AFFAIRS School Official
SCHOOL OF MEDICINE
WASHINGTON UNIVERSITY
660 SOUTH EUCLID AVENUE, BOX 8021
ST. LOUIS, MO 63110 Name of School Official

SCHOOL SEAL

Title

5/16/2003
Date

Profession:

RETURN THIS FORM TO APPLICANT

[redacted]

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

WORK HISTORY

SUPPORTING DOCUMENT

WH

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

1. NAME — LAST: King — FIRST: Erin — MIDDLE: Lee

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. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☒

8. DATE FORM COMPLETED 3/27/2003

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

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)

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION

March 27, 2006

Erin Lee King MD
[redacted]

Dear Dr. King:

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 06/17/2006. Assuming you remain in the training program listed below, this license will be valid until 06/16/2007.

PROGRAM: Obstetrics & Gynecology
TRAINING FACILITY: Mc Gaw Med Ctr Northwestern

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 Financial and Professional Regulation, Division of Professional Regulation, 320 West Washington Street, Springfield, Illinois 62786.

Sandy Dunn, Manager
Medical Unit

FC: lv3.125

THE McG[redacted] MEDICAL CENTER OF NORTHWESTE[redacted]N UNIVERSITY

OFFICE OF GRADUATE MEDICAL EDUCATION
312 503-7975
Fax 312 503-5230

SUITE 1058-A
645 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60611-0402

May 15, 2003

Illinois Department of Professional Regulation
320 W Washington St.
Medical Unit # 1
Springfield, Illinois 62791

Re: Inquiring about why the following licenses have not been issued:

COHEN, Eric [redacted] FILE REMAINS HERE SINCE 4/21 REVIEW. HE DOES NOT GRADUATE UNTIL 5/19 & DOCS CANNOT BE SUBMITTED UNTIL AFTER GRAD

DOLAN, Mark ED-MED

FAZILAT, Golarch COPY OF DIPLOMA

HIGUCHI, Colin ED-MED

KING, Erin ED-MED

If you have any questions regarding this application, please feel free to call me at (312) 503-4748

AL 5/15

Sincerely,

[redacted]
Kate Kuhel
Graduate Medical Education

Profession: 425

Date: 4/6/92 Initials: AA

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

N/CGAS MED CTR

RE: ERIN KING

Return this form with the requested materials to:

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

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

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

Other Instructions:

RECEIVED

JUL 10 2006

BY:.....

APPLICATION FOR LICENSURE AND/OR EXAMINATION

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

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

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

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

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
PHYSICIAN	036	examination	$ 635

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [X] This is the first time I have made application for this profession in Illinois.
- [ ] I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- [ ] Other: _____

PAID JUL 10 2006 BY: 890581

- [ ] 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 Financial and Professional Regulation - Division 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	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
KING	ERIN	LEE	M.D.	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

[redacted]

5. BUSINESS ADDRESS STREET	CITY	STATE/COUNTRY	ZIP CODE	COUNTY
333 E. SUPERIOR ST #107	CHICAGO,	IL	606LL-____	COOK

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME
	BROWN

8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH	10. AGE
[redacted]		

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED	12. PREFERRED e-MAIL
Work ([redacted]	

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI): KING, ERIN C

SS#: [redacted]

Profession: PHYSICIAN

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
LANGLEY HIGH SCH.	MCLEAN, VA	06 / 1993 (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	DATES OF ATTENDANCE TO Month/Year	TYPE OF DEGREE EARNED
STANFORD UNIVERSITY	PALO ALTO, CA	09/93	06/97	B.A.
GEORGETOWN UNIV.	WASHINGTON, DC			none
WASHINGTON UNIV. SCHOOL OF MEDICINE	ST. LOUIS, MO	08/98	06/03	M.D

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?
MCGAW MEDICAL CTR @ NORTHWESTERN UNIV.	CHICAGO, IL	06/03	Present	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): KING, ERIN L

SS#: [redacted]

Profession: PHYSICIAN

PART IV: Record of Licensure Information

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure ILLINOIS	PHYSICIAN Temporary	125046463	6/03	active
State of Current Licensure where you most recently have been practicing.	same			
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)
USMLE Step 1		6/99	(Passed) Failed, Absent
USMLE Step 2		10/02	passed

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

NAME (Last, First, MI): KING ERIN L

SS#: [redacted]

Profession: PHYSICIAN

PART VI: Personal History Information *(This part must be completed by all applicants)*

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

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: [ ][ ]

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

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

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

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

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

PART 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]
Signature of Applicant

3/7/06
Date

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

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION TESTING PROGRAM
CONTINENTAL TESTING SERVICES, INC. P. O. BOX 100 LaGrange, IL 60525-0100

ERIN L KING
[redacted]

DATE PRINTED: 12/7/2006
LICENSURE FEE: $300.00
SCHOOL #/TEST DATE: 036924 11/14/2006

Licensed Physician & Surgeon

SOC SEC #: [redacted]

OVERALL EXAM RESULT: Pass

USMLE 91 Pass 11/16/2006

The required passing score is 75.

To apply for licensure in the State of Illinois, detach and complete the bottom portion of this form, and return it to the Illinois Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois, 62791 along with the licensure fee as indicated above. Fees must be in the form of a check or money order made payable to the Division of Professional Regulation.

LICENSURE APPLICATION

ERIN L KING
[redacted]

DATE PRINTED: 12/7/2006
LICENSURE FEE: $300.00
SCHOOL #/TEST DATE: 036924 11/14/2006

Licensed Physician & Surgeon

SOC SEC #: [redacted]

NOTE: Do not submit this form until such time as you have completed the required number of months of postgraduate clinical training (24 months). Upon completion of training, form TN-MED (Certification of Postgraduate Clinical Training) must be submitted.

NAME/ADDRESS CHANGE ONLY
If your name, as shown above, differs from the one that is to be printed on your license, print your NEW NAME on the line provided and submit a copy of a legal document showing your name change (Marriage License, Divorce Decree, etc.) with this form. If your address differs from the address shown above, print the NEW ADDRESS below. If a spelling error has occurred, print your name exactly as it should appear on your license on the NEW NAME line below.

NEW NAME : _____

NEW ADDRESS : _____

CITY : _____ STATE : _____ ZIP : _____ COUNTY : _____

APPLICANT SIGNATURE

Upon receipt of this Application For Licensure, the Department of Professional Regulation will determine your eligibility for licensure. If there are no deficiencies, your license will be issued in approximately four weeks.

_____ APPLICANT SIGNATURE
(APPLICATIONS MUST BE SIGNED)

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.

Continental Testing Services, Inc.
P.O. Box 100, LaGrange, IL 60525 (708) 354-9911

OK

USMLE CHECKLIST- 036 – Licensed Physician Surgeon

Date of Screening: 7-18-06

Name: King, Erin L [redacted]

✓ 1. USMLE APPLICATION — Fee 635

✓ 2. 4 page Application Jacket — CTS Fee 89.05

✓ 3. TN-Med form (24 months of residency completed)

✓ 4. WH form

✓ 5. Original Pre-Medical Transcript

✓ 6. Original Medical Transcript

✓ 7. Board Scores directly from Boards

✓ 8. Copy of Medical Diploma

___ 9. FCVS

___ 10. Copy of ECFMG — Temp #: 12504646 3

___ 11. Fifth Pathway — Active ✓ Expired _____

___ 12. AF-Med

___ 13. ED-Non

0 # of Failures with Additional Training Completed on _____

_____ Year of First Pass and 7 Years Expire(s/d) on _____

Licensure Fee $_____ Sent to IDFPR _____

_____ Controlled Substances app received and $5 fee received _____ Yes _____ No

_____ Sent to IDPR on _____

U.S. AND CANADIAN EDUCATED
EXAMINATION APPLICATION REVIEW SHEET (US)

Forward the following categories of applications to DPR to review:

1. Questionable foreign education records.
2. Applications that have no educational records or verifying affidavits of education have been submitted.
3. Applications for restoration, endorsement, or acceptance of examination.
4. Applicants who have failed the examination on five (5) occasions and have subsequently pursued further education.
5. Fifth Pathway.
6. Applications for persons who graduated from medical school more than five years prior to the date of application who do not hold a valid Illinois temporary license.

I. EXAMINATION APPLICATION JACKET (US)

A. Part 1- A Application Category Information
#1 indicates Licensed Physician/Surgeon
#2 indicates 036
#3 indicates exam or examination
#4 indicates appropriate fee

Part 1- B one of the five (5) boxes must be checked

B. Part II. Applicant Identifying Information
Numbers 1 through 10 completed (social security number not mandatory).

C. Part III Education Information
#1-5 completed.
#6 must indicate **EVERY MEDICAL SCHOOL ATTENDED, AND SCHOOL GRANTING THE DEGREE MUST BE ACCREDITED** by LCME, AOA, or LMCC.
#7 should indicate specialty/residency training completed from an ACGME, AOA, or Canadian accredited program.

D. Part IV. Record of Licensure Information
Review for other possible licenses. CT Forms must be submitted for permanent licenses. This includes jurisdictions located outside the United States.

Foreign Educated
EXAM APPLICATION REVIEW SHEET (Continued)

E. Part V. Record of Examination
Must list any examination taken to qualify for licensure. Each attempt must be listed.
Applicants for licensure who have been unsuccessful in five (5) examinations (any component, Part or Step of examinations accepted by the Department), conducted in this state or in any other jurisdiction shall be deemed ineligible for further examination until such time as applicant has submitted proof, subsequent to his fifth failure, of one of the following:

1) a course of clinical training or not less than twelve (12) months in an approved hospital in the United States, or

2) a course of study of nine (9) months in length (one academic year) which includes no less than 25 clock hours per week of basic sciences and no less than 40 clock hours per week of clinical sciences, or

3) any other formal professional study or training in an accredited medical college or hospital approved by the Medical Licensing Board and the Department.

F. Part VI. Personal History Information
#1-4 must be answered no. (If yes is checked, flag mini-application, and forward application to DPR upon successful completion of examination.
#5 may be answered either yes or no but must be answered. If yes is checked, flag mini-application, and forward application to DPR upon successful completion of examination.

G. Part VII. Examination Coding Information
Only items a, b, and d, need be completed.

H. Part VIII. Child Support Information
Must be completed by all applicants. (If yes is checked and case file is complete, applicant may be scheduled for exam. Forward file to DPR for review.)

I. Part IX. Certifying Statement
Must be signed and dated by applicant.

Foreign Educated
EXAM APPLICATIONS REVIEW SHEET (Continued)

II. EXAMINATION SUPPORTING DOCUMENTS (US)

A. MEDICAL SCHOOL DIPLOMA
A copy of the applicant's official medical school diploma must be submitted.

B. OFFICIAL TRANSCRIPTS
Official transcripts of a two-year course of instruction, prerequisite to professional training in a college of liberal arts or medical college issued by the school with school seal affixed must be submitted.
Official transcripts issued by the medical or osteopathic college or university with school seal affixed.

C. CT form must be submitted from jurisdiction original and current licensure.
#1-8C in applicant section completed by applicant (social security number NOT mandatory).
Jurisdiction of current licensure of most recent practice_____.
No derogatory information.
Signed and sealed by licensing agency/board.
Must be returned directly from the state licensing agency/board.
Jurisdiction of original licensure _____.
No derogatory information.
Signed and sealed by licensing agency/board.
Must be returned directly from the state licensing agency/board.

D. WH
All information is completed to verify work history from graduation to present.
Review for need to refer on Intent to Deny. If yes, flag-mini-application and send file to DPR upon successful completion of exam.

E. TN-MED
#1-8 in applicant section completed by applicant (social security number NOT mandatory).
No derogatory information shown.
Certifying official section completed, signed and dated by the clinical training program director.
Institution seal is affixed.
Verification of at least twelve (12) calendar months of specialty/residency training from an approved training program completed in the U.S. or Canada. (Refer to page 1, of Examination Qualifications #4 for specifics.)

F. CHECK OR MONEY ORDER
Appropriate fee must be remitted by certified check or money order.

EXAM APPLICATION REVIEW SHEET (Continued)

III. EXAMINATION GENERAL REQUIREMENTS (US)

Any documents in a language other than English must be accompanied by an official translation. (Policy L&T 81-7B)

If the name on any of the documents is different from that shown on the application, then supply proof of name change (copy of marriage certificate, divorce decree, affidavit, or court order). (Policy L&T 82-1A)

If applicant is unable to verify education records (i.e., no transcript or diploma), he must comply with supporting documents in Policy (Policy L&T 81-5B) and appear for interview before Board.

Intent to Deny case handling procedures can be found in the L&T Division Case Management Manual in the "Exceptions to System" Chapter (Pg. 14.104E).

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(CTS)

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

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
KING	ERIN	LEE	[redacted]	[redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

PHYSICIAN (Profession Name) — 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable): 125-046463

8. ISSUANCE DATE: 6/2003

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:

Continental Testing Services, Inc.
P.O. Box 100
LaGrange, Illinois 60525-0100

This is to certify that the above-named applicant satisfactorily completed 24 months of postgraduate clinical training in Northwestern / McGaw Medical Center
(Name of Accredited Postgraduate Clinical Training Program)

from 6/20/2003 to 7/15/2005 at the following hospital:

Hospital: Northwestern Memorial Hospital

Number and Street: 333 E Superior Suite 186

City, State and Zip Code: Chicago IL 60611

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

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

Name of Postgraduate Clinical Training Program Director: Magdy Milad

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 7/15/05

SEAL

Telephone No: 312 926 7522

IL486-1535 08/04 (MD)

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

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: KING ERIN LEE

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
PHYSICIAN (Profession Name) 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: KING

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☒

8. DATE FORM COMPLETED: 3/7/06

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: McGAW MEDICAL CTR @ NORTHWESTERN UNIV.
JOB TITLE: RESIDENT PHYSICIAN
ADDRESS STREET, CITY, STATE, ZIP CODE: 333 E. SUPERIOR ST. #107 CHICAGO IL 60611
DESCRIPTION OF DUTIES PERFORMED: RESIDENT OBSTETRICS AND GYNECOLOGY
SUPERVISOR NAME: MAGDY HILAL
DATE OF EMPLOYMENT/ATTENDANCE: From 06 / 2003 (Month / Year); To present
HOURS WORKED PER WEEK: 80
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month): 2 YEARS 9 MOS.

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 ___ / ___ / _____
HOURS WORKED PER WEEK:
TYPE OF EMPLOYMENT: ☐ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month):

ISSUED: 07/14/2005

TRANSCRIPT FROM WASHINGTON UNIVERSITY SCHOOL OF MEDICINE IN ST. LOUIS

FOR: KING, ERIN LEE

ID: [redacted]

SSN: [redacted]

PLACE OF BIRTH: REDWOODCITY,CA

DATE OF BIRTH: [redacted]

HOME ADDRESS: [redacted]

MATRICULATION DATE: 08/11/1998

FIRST YEAR CURRICULUM

YR	DEPT	COURSE	CLK-HR	GRD	ABBREVIATED COURSE TITLE
YR98	M04 ELECT-WI	5002	[redacted]		CLINICAL ANATOMY
YR98	M04 ELECT-WI	5017			CLINICAL CORRELATIONS IN NEUROSCIENCES
YR98	M04 ELECT-WI	525H			CONTEMPORARY ISSUES IN BIOMEDICAL ETHICS
YR98	M04 ELECT-WI	525H			CONTEMPORARY ISSUES IN BIOMEDICAL ETHICS
YR98	M04 ELECT-WI	527H			OCCUPATIONAL AND ENVIRONMENTAL MEDICINE
YR98	M04 ELECT-WI	582			ALZHEIMER'S DISEASE
YR98	M05 ANATNEURO	501A			HUMAN ANATOMY AND DEVELOPMENT
YR98	M15 BIOCHEM	502			MOLECULAR FOUNDATIONS OF MEDICINE
YR98	M25 MEDICINE	502			PHYSICIANS, PATIENTS & SOCIETY: CLINICAL MEDICINE I
YR98	M25 MEDICINE	503			PHYSICIANS, PATIENTS & SOCIETY: MEDICINE & HUMAN VALUES
YR98	M30 MOLMB	511			MEDICAL GENETICS
YR98	M30 MOLMB	523			IMMUNOLOGY
YR98	M30 MOLMB	526			MICROBES AND PATHOGENESIS
YR98	M35 NEUROL	554			NEURAL SCIENCES
YR98	M75 CELLBIO	503			CELL & ORGAN SYSTEMS BIOLOGY
YR98	M80 OTHER	501			CLINICAL EPIDEMIOLOGY AND BIOSTATISTICS

SECOND YEAR CURRICULUM

YR	DEPT	COURSE	C	ABBREVIATED COURSE TITLE
YR99	M25 MEDICINE	602		PHYSICIANS, PATIENTS & SOCIETY: CLINICAL MEDICINE II
YR99	M25 MEDICINE	603		PHYSICIANS, PATIENTS & SOCIETY: MEDICINE & HUMAN VALUES II
YR99	M25 MEDICINE	604		PHYSICIANS, PATIENTS AND SOCIETY: CLINICAL SKILLS
YR99	M25 MEDICINE	605A		INFECTIOUS DISEASES
YR99	M25 MEDICINE	606A		RHEUMATOLOGY
YR99	M25 MEDICINE	611B		CARDIOVASCULAR DISEASE
YR99	M25 MEDICINE	612B		PULMONARY DISEASES
YR99	M25 MEDICINE	613B		RENAL & GENITOURINARY DISEASES
YR99	M25 MEDICINE	615A		ENDOCRINOLOGY AND METABOLISM
YR99	M25 MEDICINE	620A		GASTROINTESTINAL AND LIVER DISEASES/NUTRITION
YR99	M25 MEDICINE	625A		HEMATOLOGY AND ONCOLOGY
YR99	M35 NEUROL	632		DISEASES OF THE NERVOUS SYSTEM
YR99	M45 OBGYN	635B		OBSTETRICS AND GYNECOLOGY
YR99	M55 OTO	660A		OTOLARYNGOLOGY
YR99	M60 PATH	665		PATHOLOGY
YR99	M65 PEDS	640A		PHYSICIANS, PATIENTS AND SOCIETY: PEDIATRICS
YR99	M70 MOLBIO/PHA	670A		PRINCIPLES OF PHARMACOLOGY

GRADE DISTRIBUTION FREQUENCIES

TOTAL	H	HP	P	NC	F	I	W	DF	CR	NCR	AU	N
[redacted]												

Washington University in St. Louis
SCHOOL OF MEDICINE

OFFICE OF THE ASSISTANT DEAN FOR
ACADEMIC AFFAIRS AND REGISTRAR
660 South Euclid Ave. Campus Box 8021
St. Louis, MO 63110
(314) 362-6848

To Whom It May Concern:
The Family Educational Rights and Privacy Act of 1974 prohibits release of this information to another party without the prior written consent of the person whose name appears herein.

JUL 14 2005

Official with embossed seal:
Deborah A. Monolo, Registrar
Washington University
School of Medicine - St. Louis

Unless the face of the transcript is stamped otherwise, the student is in good standing.

TRANSCRIPT NOMENCLATURE

Each Washington University School of Medicine course enrollment entry is preceded by the year designated YR followed by the last two digits of the academic year in which the course was taken or begun (e.g., YR78 the academic year 1978-79). After the year designation, the following is indicated respectively: department number, department name, course number, units of credit associated with the course, grade, and course title. The symbol "AS" (Advanced Standing) to the left of an entry indicates credit granted by Washington University School of Medicine on the basis either of transfer from another institution or by examination. The Washington University School of Medicine equivalent course is indicated followed by the units of credit granted. The source of the credit appears at the end of the entry.

CREDIT

As reported to the Liaison Committee on Medical Education, representing the Council on Medical Education of the American Medical Association and the Executive Council of the Association of American Medical Colleges, credit hours for courses are expressed in terms of clock hours the scheduled hours per year of actual lecture and laboratory contact between faculty and students. These clock hours are not to be interpreted as semester or quarter hours. A full-time student in the medical curriculum at Washington University School of Medicine attends an average of 38.5 clock hours per week.

GRADING SYSTEM

A Pass/Fail grading system is employed for the first part of the first year through 1989-90. Effective for the 1990-91 academic year, a Pass/Fail grading system is employed for the entire first year. At the conclusion of each academic year when all the official grades have been received, the official transcript, in addition to listing courses and grades achieved, gives the grade distribution in each course with the exception of elective courses. The grades are: H Honors (for truly outstanding performance); HP High Pass (for very good work); P Pass (for satisfactory work); F Fail (clearly unsatisfactory performance); DF (through 1989-90) Deferred; DF (effective 1990-91) Deficiency (marginal performance with some deficiency that must be removed); I Incomplete (course work has not been completed); W Withdrawal; NG Course credit earned, students not graded; CR/NCR Credit or No Credit.

DATES OF ATTENDANCE

Dates of attendance are listed as Standard Academic Periods, the standard beginning and ending dates for each academic period of the student's course enrollments. Each course is listed on the transcript with a YR designation that matches a standard academic period.

SYSTEM OF COURSE NUMBERING

Courses numbered 500(0) to 599(9) are primarily first-year medical courses.
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Courses numbered 700(0) to 799(9) are primarily clinical clerkships.
Courses numbered 800(0) to 999(9) are primarily elective courses.

Courses at the 800 level with an "A" as the fourth digit (e.g. 800A) are seminar courses that meet two to four times per week for 12 to 18 weeks. These courses are not required, and no credit toward graduation is given for them.

Revised 03.04

FOR: KING, ERIN LEE ID: [redacted] SSN: [redacted]

SECOND YEAR CURRICULUM

YR	DEPT	COURSE	[redacted]	ABBREVIATED COURSE TITLE	GRADE DISTRIBUTION FREQUENCIES [redacted] G F I W DF CR NCR AU N
YR99	M85	PSYCH 676A		DISEASES OF THE NERVOUS SYSTEM: PSYCHIATRY	1

CLINICAL CLERKSHIPS (THE [redacted] YEAR CONSISTS OF 48 WEEKS)

YR	DEPT	COURSE	[redacted]	ABBREVIATED COURSE TITLE	[redacted] STRIBUTION FREQUENCIES [redacted] G F I W DF CR NCR AU N
YR01	M25	MEDICINE 710		MEDICINE CLERKSHIP	
YR01	M26	FAMP 712		AMBULATORY CLERKSHIP: FAMILY PRACTICE	
YR01	M35	NEUROL 720		NEUROLOGY CLERKSHIP	1
YR01	M45	OBGYN 730		OB/GYN CLERKSHIP	
YR01	M65	PEDS 760		PEDIATRIC CLERKSHIP	
YR01	M85	PSYCH 770		PSYCHIATRY CLERKSHIP	
YR01	M95	SURGERY 790		INTEGRATED SURGICAL DISCIPLINES CLERKSHIP	1

COMPLETED AMBULATO[redacted]

ELECTIVE COURSES (36 WEE[redacted] VE WORK REQUIRED FOR GRADUATION)

YR	DEPT	COURSE	[redacted]	ABBREVIATED COURSE TITLE
YR02	M05	ANATNEURO 820		TEACHING ASSISTANT IN HUMAN ANATOMY
YR02	M10	ANESTH 811		CARDIOTHORACIC ANESTHESIOLOGY
YR02	M25	MEDICINE 830		DERMATOLOGY
YR02	M45	OBGYN 840		MATERNAL-FETAL MEDICINE SUBINTERNSHIP
YR02	M45	OBGYN 899		SP STDY OB-GYN
YR02	M60	PATH 815		OB-GYN PATHOLOGY SUBINTERNSHIP
YR02	M65	PEDS 861		NEWBORN MEDICINE
YR02	M80	OTHER 856		HEALTH ADMINISTRATION I
YR02	M90	RADIOL 805		RADIOLOGY- MALLINCKRODT INSTITUTE OF RADIOLOGY

TOTAL CLOCK HOURS: 4479.0

STANDARD ACADEMIC PERIODS

YR98 (400-599 COURSES) 08/17/98-05/28/99
YR99 (600-699 COURSES) 08/16/99-05/12/00
YR01 (700-799 COURSES) 06/11/01-05/31/02
YR02 (800-999 COURSES) 06/17/02-05/04/03

DEGREE GRANTED:

05/16/03 DOCTOR OF MEDICINE

THERE ARE NO ENTRIES BELOW THIS LINE

[redacted]

ISSUED TO:
Continental
Testing Services

Washington University in St. Louis

SCHOOL OF MEDICINE

OFFICE OF THE ASSISTANT DEAN FOR ACADEMIC AFFAIRS AND REGISTRAR
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Revised 03.04

STANFORD UNIVERSITY

OFFICE OF THE REGISTRAR
STANFORD, CA 94305-3005

Name : King,Erin Lee
Student ID : [redacted]

Roger Printup
University Registrar

This officially issued and signed transcript is printed on red SCRIP-SAFE® security paper with the name of the university printed in white type across the face of the document. A raised seal is not required. When photocopied a security statement concerning the institution name will appear. A BLACK ON WHITE OR A COLOR COPY SHOULD NOT BE ACCEPTED!

Page No. 1
Print Date : 19Jul 2005

----- Stanford Degrees Awarded -----
Degree : Bachelor of Arts
Confer Date : 15Jun 1997
Plan : Human Biology with Honors

------- Academic Program -------
Program : Undergraduate Matriculated
16Jan 1996 : Human Biology (BA) Honors
Completed Program

Permit Services Only, 01Apr 1997 - 13Jun 1997

------- Transfer Credit --------
Applied Toward Undergraduate Matriculated Program
Transfer Credit from Georgetown University
Quarter Units Posted:

Total Quarter Units Posted:

Allowable APtransfer credit subject to restrictions.

---- Advanced Placement Test Credit ----
Applied Toward Undergraduate Matriculated Program

1993-1994 Autumn
Advanced Placement Government & Politics: U.S.
Advanced Placement U.S. History
Advanced Placement English Literature & Composit
Advanced Placement Mathematics: Calculus BC
Total Quarter Units Posted:

Allowable APtransfer credit subject to restrictions.

----- Beginning of Academic Record ----
1993-1994 Autumn

Course		Title
CHEM	31	CHEMICAL PRINCPLS
DRAMADANTI		BALLET I
DRAMADANSO		MOD DANCE II

[redacted]

1993-1994 Autumn (Continued)

Course		Title
HISTORY	1	EUR: MIDDLE AGES
WCT	2B	WRITING&CRIT THINK

1993-1994 Winter

Course		Title
HISTORY	2	EUROPE AND BEYOND
MATH	42	CALCULUS
PSYCH	118	EARLY CHILDHOOD DEV

1993-1994 Spring

Course		Title
CHEM	33	STRUC REACT
HISTORY	3	EUROPE:1789 - PRES
RELIGST	8	RELIG IN AMERICA

1994-1995 Autumn

Course		Title
CHEM	35	ORG MONO CMPDS
HUMBIO	2A	GENE/EVOL/ECOLOGY
HUMBIO	2B	CULT/EVOL/SOCIETY

1994-1995 Winter

Course		Title
BIOSCI	44X	CORE LAB
CHEM	131	ORG POLY COMP
HUMBIO	3A	CELL, DEVELOP. BIO
HUMBIO	3B	HUMAN LIFE CYCLE

1994-1995 Spring

Course		Title
CHEM	36	CHEM SEPARATNS
HUMBIO	4A	THE HUMAN ORGANISM
HUMBIO	4B	HUMAN PREDICAMENT
HUMBIO	107	BIO & SPACE EXPLOR

1995-1996 Autumn

Course		Title
BIOSCI	154	HUMAN DEVELOPMENT
CS	105A	INTRO TO COMPS
HUMBIO	191	JR. HONORS SEMINAR

[redacted]

1995-1996 Autumn (Continued)

Course		Title
PSYCH	111	DEV PSYCH

1995-1996 Winter

Course		Title
ASTRNMY	15A	TOPICS IN MOD ASTR
BIOSCI	112	HUMAN PHYSIOLOGY
HUMBIO	128	HUM DEV BIO & MED
PSYCH	185B	DISABILITY STUDY

1995-1996 Spring

Course		Title
ANTHRO	1	SOCIAL&CULT ANTHRO
ATHLETIC	177	WEIGHT TRAIN: WOMEN
HISTORY	165C	20TH CENTURY US
HUMBIO	110L	VERT. BIO LAB

1996-1997 Autumn

Course		Title
CHEM	130	IDENTIFICATION
ENGLISH	173A	SHAKESPEARE
HUMBIO	160	HEALTH CARE IN USA
HUMBIO	193	RESEARCH IN HUMBIO
HUMBIO	197	H BIO INTERNSHP

1996-1997 Winter

Course		Title
CHEM	135	PHYS. CHEM. PRIN.
HUMBIO	193	RESEARCH IN HUMBIO
HUMBIO	194	HONORS
HUMBIO	199	SPECIAL PROJECTS
SUC	133	CHILDREN & SOCIETY

END OF TRANSCRIPT

[redacted]

Transcripts Issued To:

Erin King

[redacted]

To be valid, this POSTALBOXX™ field must display a colored background.

Office of the University Registrar
Stanford University
Stanford, California 94305-3005

Grade point average and rank in class are not computed and are not available. Four grading systems are used at Stanford University. The general University grading system is used in all courses except those taught in the School of Law, the Graduate School of Business, or to M.D. students in the School of Medicine.

Academic programs include a status effective the day the transcript was printed. Stanford University uses the following program statuses:

Active: Student is currently active in the program indicated.
Leave of Absence: Student is currently on an official leave of absence from active study.
Completed: Student program requirements have been met and the degree has been awarded (degree programs only).
Discontinued: Student no longer enrolled in program (includes post-doctoral scholars whose appointments have ended).
Dismissed: Student was dismissed from the University.
Cancelled: Student deceased while enrolled and program cancelled or student administratively withdrawn for cause.

CHRONOLOGY OF GENERAL UNIVERSITY GRADING SYSTEM

Current (effective Autumn Quarter 1995-96)

A	Excellent
B	Good
C	Satisfactory
D	Minimal Pass
NP	Not Passed
CR	Credit (student-elected satisfactory; 'C-' or better equivalent)
S	Satisfactory ('A', 'B', 'C', equivalent)
NC	No Credit (unsatisfactory performance, 'D+' or below equivalent)
I	Incomplete
L	Pass, letter grade to be reported
N	Continuing Course
RP	Repeated Course
*	No Grade Reported
W	Withdrew

Note: The grades A, B, and C were modified, NP and W were added, and '+' was changed to CR.

Autumn 1994-95: RP was introduced to replace the original grade for a course later retaken. The grade of I (incomplete) was changed to automatically lapse to NP or NC after one year.

Effective Autumn Quarter 1989-90

A	Exceptional Performance
B	Superior Performance
C	Satisfactory Performance
D	Minimal Pass
L	Pass, letter grade to be reported
+	Satisfactory, student elected (A, B, or C)
S	Satisfactory, no option (A, B, or C)
N	Continuing Courses
*	No Grade Reported
I	Incomplete

Note: The P notation has been changed to S (Satisfactory). The lowest acceptable grade for either S or '+' is now C-.

Effective Autumn Quarter 1975-76

A	Exceptional Performance
B	Superior Performance
C	Satisfactory Performance
D	Minimal Pass
L	Pass, letter grade to be reported
+	Pass, student elected (A, B, C, or D)
P	Pass, no option (A, B, C, or D)
N	Continuing Courses
*	No Grade Reported
I	Incomplete

Note: Under this system, Stanford restored the D grade (defining it as "Minimal Pass"). Pass notations ('+' and P) were redefined to accommodate all passing grades, A through D.

Summer Quarter 1972-73: P was introduced to denote pass in a course offered only pass/no credit at the option of the instructor.

Spring Quarter 1971-72: '+' and '-' as grade modifiers were reintroduced for all students.

Autumn Quarter 1971-72: '+' and '-' as grade modifiers were reintroduced for graduate students.

Effective Autumn Quarter 1970-71

A	Exceptional Performance
B	Superior Performance
C	Satisfactory Performance
L	Pass, letter grade to be reported
+	Pass, student elected (A, B, or C)
N	Continuing Course
*	No Grade Reported
I	Incomplete

Note: The grades A, B, C, and + were retained; D, E, F, W, and '-' were dropped from the grading system. Under the prior system the University maintained records of all courses a student attempted. But under the revised system, the only courses recorded were those that were successfully completed or for which an I (incomplete) grade was given. The revised system also allowed a student or instructor to request the deletion of an I grade from a student's record if the student did not meet the requirements of the course within the time limit determined by the instructor. The use of the modifying suffixes '+' and '-' appended to letter grades was discontinued.

Effective Autumn Quarter 1963-64

A	Excellent
B	Good
C	Satisfactory
D	Minimum Credit
E	Conditioned
F	Failed
N	Continuous Course
W	Unauthorized Withdrawal
	Incomplete
*	No Grade Reported
+	Passed Without Defining Grade
	Failed Course Taken Pass/Fail

Prior to Autumn Quarter 1963-64

A	Excellent
B	Good
C	Fair
D	Barely Passed
E	Conditioned
F	Failed
N	Continuous Course
W	Unauthorized Withdrawal
	Incomplete
*	No Grade Reported
+	Passed Without Defining Grade
	Failed Course Taken Pass/Fail

CHRONOLOGY OF THE SCHOOL OF LAW GRADING SYSTEM

Units earned at School of Law courses are semester units.

Current (effective Autumn Semester 2001-2002)

4.3, 4.2	A+
4.1, 4.0, 3.9	A
3.8, 3.7, 3.6, 3.5	A-
3.4, 3.3, 3.2	B+
3.1, 3.0, 2.9	B
2.8, 2.7, 2.6, 2.5	B-
2.2	Restricted Credit
2.1	Failure
I	Incomplete
K	Credit (student elected)
KM	Credit (mandatory)
RK	Restricted Credit
NK	Failure
N	Continuing Course
*	No Grade Reported

Note: The grading system was revised to a number system with letter equivalents and the grades of 2.3 and 2.4 (C+) were eliminated.

Effective Autumn 1983-84

A+	4.3, 4.2
A	4.1, 4.0, 3.9
A-	3.8, 3.7, 3.6, 3.5
B+	3.4, 3.3, 3.2
B	3.1, 3.0, 2.9
B-	2.8, 2.7, 2.6, 2.5
C+	2.4, 2.3
R	2.2 (restricted credit)
F	2.1 (failure)
N	Continuing Course
I	Incomplete
*	No Grade Reported
K	Credit (student elected)
KM	Credit (mandatory)
RK	Restricted Credit

Note: The C, C-, D+, D and D- grades were eliminated. The Grade of R (Restricted Credit) was established with the value of 2.2. The RK and F grades were redefined to a value of 2.2 and 2.1 respectively. Students may elect to take a limited number of courses on the K, RK, NK system. K shall be awarded for work that is comparable to numerical grades 4.3 - 2.3, RK for 2.2, and NK for 2.1.

Effective Autumn 1969: A second grading system was introduced with the following values:

K	Credit (4.3 - 2.3)
RK	Restricted Credit (2.2 - 1.5)
NK	No Credit (1.4 - 0.0)

Prior to Autumn 1969-70

A+	4.3, 4.2
A	4.1, 4.0, 3.9
A-	3.8, 3.7, 3.6, 3.5
B+	3.4, 3.3, 3.2
B	3.1, 3.0, 2.9
B-	2.8, 2.7, 2.6, 2.5
C+	2.4, 2.3
C	2.2, 2.0, 2.1
C-	1.9, 1.7, 1.6, 1.5
D+	1.4, 1.3, 1.2
D	1.1, 1.0, 0.9
D-	0.8, 0.7, 0.6
F	0.0

Note: This system employs letter grades with numerical equivalents.

THE SCHOOL OF MEDICINE GRADING SYSTEM

The following grades are used in reporting on the performance of students in the M.D. program:

+	Pass: Indicates that the student has demonstrated to the satisfaction of the department or teaching group responsible for the course that s/he mastered the material taught in the course.
EX	Exempt: Course exempted by examination. No units granted.
N	Continuing Course
I	Incomplete

CHRONOLOGY OF THE GRADUATE SCHOOL OF BUSINESS GRADING SYSTEM

Current (Effective Autumn 2000-01)

H	Honors
HP	High Pass
P	Pass
LP	Low Pass
U	Unsatisfactory
EX	Course Exempted (does not affect grade point calculations)
+	Pass (LP or better)

Effective Autumn Quarter 1971-72

H	Distinction: Work that is of markedly superior quality.
P+	Work that is of high quality and exceeds in a significant way all of the basic requirements of the course.
P	Pass: Work that is of good quality and clearly satisfies all the basic requirements of the course.
P-	Low Pass: Work that satisfies most of the basic requirements of the course but is deficient in some minor way.
U	Unsatisfactory: Work that does not satisfy the basic requirements of the course and is deficient in significant ways.
EX	Course Exempted (does not affect grade point calculations)
+	Pass (P- or better)

NAME: Erin Lee King
STUDENT NUMBER: [redacted]
ADMITTED FROM:

GEORGETOWN UNIVERSITY

OFFICE OF THE UNIVERSITY REGISTRAR
WASHINGTON, D.C. 20057
(202) 687-4020

COURSE NUMBER	TITLE	GRADE	SEM. HRS. EARN.	QUAL. PTS.
	Entering Program:			
	School of Continuing Studies			
	Non-degree Program			
	Undeclared			
	----------Summer 1992----			
MATH-005	INTRODUCTION TO STATISTICS	[redacted]		
PSYC-001	GENERAL PSYCHOLOGY			
	----------Summer 1995----			
PHYS-031	ELEMENTARY PHYSICS LAB I			
PHYS-032	ELEMENTARY PHYSICS LAB II			
PHYS-041	ELEMENTARY PHYSICS I			
PHYS-042	ELEMENTARY PHYSICS II			
	EHRS QHRS QPTS QP			
Current	8 8 29.66 3.7[redacted]			
Cumulative	14 14 53.66 3.8[redacted]			
	----------End of Undergraduate Record----------			

COURSE NUMBER	TITLE	GRADE	SEM. HRS. EARN.	QUAL. PTS.

[redacted]

07-13-05
27

Erin Lee King
1337 Macbeth St.,
Mclean VA 22102

ISSUED DIRECTLY TO STUDENT

OFFICIAL TRANSCRIPTS BEAR SIGNATURE STAMP WITH UNIVERSITY SEAL.
SEE REVERSE SIDE FOR EXPLANATION OF GRADES, COURSE LEVEL, AND COURSE TYPE.

GEORGETOWN UNIVERSITY
EXPLANATION OF GRADING SYSTEM

Effective Fall 1993

Undergraduate Grading System

Grade	Quality Points	Description
A	4.00	Superior
A−	3.67	
B+	3.33	
B	3.00	Good
B−	2.67	
C+	2.33	
C	2.00	Adequate ('93-'98 Average)
C−	1.67	
D+	1.33	
D	1.00	Minimum Passing
F	0.00	Failure
W		Withdrawal
*S		Satisfactory (A,B,C)
*U		Unsatisfactory
AU		Audit
IP		In Progress
NR		Grades not yet reported
N		Incomplete (a temporary grade which must be resolved within a specified time)

FOR GRADUATION: a) Minimum Quality Point Index of 2.0
b) 120 to 142 semester hours, depending on individual program.

Graduate Grading System

Grade	Quality Points	Description
A	4.0	
A−	3.67	
B+	3.33	
B	3.0	
B−	2.67	
C	2.0	
F	0.0	
I		Incomplete
W		Withdrawal
*S		Satisfactory
*U		Unsatisfactory
AU		Audit
IP		In Progress
NR		Grades not yet reported

No Quality Points are presented on graduate records.

SEMESTER IS 15 WEEKS

* Not included in the quality hours or Q.P.I.

Grades for courses taken in overseas study programs are recorded as given at the host institution.

September 1982 - August 1993
Undergraduate Grading System

A	SUPERIOR	F	FAILURE	AU	AUDIT
B	GOOD	W	WITHDRAWAL	IP	IN PROGRESS
C	AVERAGE	*S	SATISFACTORY (A,B,C.)	NR	NO GRADE
D	PASSING	U	UNSATISFACTORY		REPORTED

IN COURSES APPLICABLE TO THE DEGREE SOUGHT, QUALITY POINTS ARE ASSIGNED AS FOLLOWS:
A - 4, B - 3, C - 2, D - 1, F - 0

A PLUS SIGN AFTER A GRADE CARRIES AN ADDITIONAL .5 QUALITY POINT PER CREDIT.

*CREDITS ADDED IN TOTAL EARNED, NOT IN THE QUALITY HOURS, OR Q.P.I.

June 1988 - August 1993
Graduate Grading System

A	EXCELLENT	F	FAILURE	U	UNSATISFACTORY
B+	SUPERIOR	I	INCOMPLETE	AU	AUDIT
B	GOOD	W	WITHDRAWAL	IP	IN PROGRESS
C	FAIR	S	SATISFACTORY	NR	NO GRADE REPORTED

NO QUALITY POINTS ARE ASSIGNED TO COURSES TAKEN AS A GRADUATE STUDENT.

EXPLANATION OF THE UNDERGRADUATE AND GRADUATE COURSE NUMBERING SYSTEM

COURSE LEVEL	NUMBERS
UNDERGRADUATE ONLY	001 - 199
UPPERCLASS UNDERGRADUATE	200 - 299
UNDERGRADUATE TUTORIALS, READINGS, RESEARCH	300 - 349
UPPERCLASS UNDERGRADUATE & GRADUATE	350 - 499
GRADUATE LECTURES	500 - 699
GRADUATE SEMINARS	700 - 899
GRADUATE RESEARCH, TUTORIALS, READINGS	900 - 998
THESIS RESEARCH	999

FORM ID.6056A, 1/97

Erin L. King
2650 N. Halsted St. Apt. #2
Chicago IL 60614

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

570-39-8615

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Federation Place, PO Box 619850, Dallas, TX 75261-9850 – Telephone (817) 868-4041

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JUL 15 2006

Recipient:

Illinois Department of Financial and Professional Regulation
ATTN: Sandy Dunn, Section Manager
3rd Floor, Unit IV
320 W Washington Street
Springfield, IL 62786

Examinee: King, Erin
Alt Name(s): King, Erin Lee

Examinee ID#: [redacted]
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
07/07/2000	[redacted]					

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
10/03/2002	[redacted]					

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Patent 5636874

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination results is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word VALID will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT, will appear prominently across the face of the entire document.

INTERPRETATION OF RESULTS

USMLE transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., "Incomplete." On those Step examinations for which numeric scores are reported, two different scales are used. The first is a three-digit score scale on which most scores fall between 140 and 260. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration. The second is a two-digit scale on which a score of 75 is the recommended minimum passing score. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points on the three-digit scale and 1 to 2 points on the two-digit scale.

STEP 2 CLINICAL SKILLS (CS)

The Clinical Skills (CS) component of Step 2 was introduced in 2004 and the USMLE transcript has been modified to reflect this change. The Step 2 examination that existed prior to the introduction of Step 2 CS continues to be administered as the Clinical Knowledge (CK) component of Step 2. The label "Step 2 CK" is used for this examination whether taken before or after the introduction of the Step 2 CS component.

Step 2 CS results are reported as pass or fail. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

Some individuals may be required to take and pass Step 2 CS prior to registering for Step 3. Transcript users can find information on eligibility requirements for all USMLE examinations in the *USMLE Bulletin of Information* and from periodic CS updates, available at the USMLE website (www.usmle.org).

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

Universitas Washingtoniana

SANCTI LUDOVICI
IN CIVITATE MISSOURIENSI

salutem omnibus has litteras lecturis quibus nos infrascripti,
morem exemplumque maiorum secuti,
cum doctrinam adeptos tum ipsam doctrinam in comitiis sollemnibus honore augendi,
testamur nos ornavisse

Erin Lee King

perfectis omnibus quae requiruntur probataque eruditione laudabili,
gradu atque titulo

Medicinae Doctoris

eique concessisse omnia iura privilegia beneficia huic gradu pertinentia,
in cuius rei testimonio nos pro auctoritate nobis commissa hisce litteris Universitatis sigillo munitis
subscripsimus nomina nostra die XVI *mensis Maii anno* MMIII.

Mark A Wrighton
Cancellarius

William A Peck
Decanus

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Illinois Division of Professional Regulation

4:03:41 PM

You requested license number: 125-046463

Licensee's Name	DBA / AKA	License Number	License Status	City, State	Program Name	Program Start Date	Issuance Date	Current Exprtn	Ever Discpined?
ERIN LEE KING MD		125046463	ACTIVE	CHICAGO, IL	Obstetrics & Gynecology	06/17/2006	06/17/2003	06/16/2007	N

Page 1

APPLICATION TRANSMITTAL - Physician

(This transmittal must accompany the application.)

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
KING	ERIN	LEE	[redacted] Month Day Year	

4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO BOXES A-1 AND A-2 IN PART I ON YOUR APPLICATON FOR LICENSURE/EXAMINATION.
[redacted]	Physician (Profession Name) — 0 3 6 (Profession Code)

In the area below, indicate whether you have enclosed the 4-page application and the other items listed below or if you have requested an item to be forwarded directly to the Department by another entity (i.e. exam scores).

Enclosed	Requested	Description
✓		4-page Application for Licensure and/or Examination
✓		Application Fee
✓		Form WH (required for all applicants)
[redacted]		FCVS Physician Profile
✓	[redacted]	TN-MED Form
		ECFMG Certificate (Copy) N/A
✓		Medical School Diploma (Copy)
✓	✓	Proof of Pre-Medical and Medical Education (Official transcript of grades issued by medical college or university with school seal affixed) from: WASHINGTON UNIVERSITY, STANFORD UNIVERSITY, GEORGETOWN UNIV.
		AF-MED N/A
		ED-NON N/A
		5th Pathway/Social Service N/A
[redacted]	✓	Certification of Licensure (CT) from original and current state of licensure
[redacted]	✓	Exam Scores (Sent directly from USMLE, FLEX, National Board, LMCC or State Board)
The above items are those documents most frequently requested. In the area below, list any other documentation you are submitting with your application that may be required for licensure.		

Remarks: _____

IL486-1914 05/02 (MD)

RECEIVED
CASH SECTION

JUN 4 - [redacted]009404

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

Div. of Professional Regulation

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

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

DO NOT SUBMIT APPLICATION UNTIL A PERMANENT PRACTITIONERS LICENSE HAS BEEN ISSUED! CONTROLLED SUBSTANCES LICENSE WILL NOT BE ISSUED TO A TEMPORARY LICENSE HOLDER!

1. Every person who prescribes or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Financial and Professional Regulation in accordance with the Illinois Controlled Substances Act.
2. A separate controlled substances registration is required for each place of professional practice or [illegible]s are stored or [illegible]egistration is [illegible] Substances

RECEIVED JUN 12 2007 IDFPR-MODESK

KING, ERIN LEE
336 Cred #2300085 06/08/2007
By:NON-EXAM
SSN:570-39-8615

A. Type or print legibly with black ink only.
B. The fee is $5 - Make check payable to the Department of Financial and Professional Regulation. THIS FEE IS NOT REFUNDABLE! (Separate application/fee is required for each registration.)
C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

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

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

PART I: Application Category Information

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

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATE SOCIAL SECURITY NO.
KING	ERIN	LEE	M.D.	[redacted]

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

5. NAME OF BUSINESS AND LOCATION (STREET/CITY /ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED
Progressive Care for Women
676 N. Saint Clair #1800
Chicago, IL 60611+____

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

7. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Work ([redacted]
Home ([redacted]

PART III: Professional Activity

Practitioner - Check and complete one of the following.

	Professional License Number
☐Dentist	019 -
☒Physician	036 - 117422
☐Podiatrist	016 -
☐Veterinarian	090 -

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

FOR OFFICIAL USE ONLY FEE $5

BNDD Number: ☐☐—☐☐☐—☐☐☐☐ Type: ☐ Suffix: ☐

Schedule Codes: ☐☐☐☐☐☐☐ Additional Function: A Card Code: K

Issuance Date (Month/Day/Year) ☐☐—☐☐—☐☐☐☐

PART IV: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you ever been charged or convicted of any drug related criminal offense in any state or in federal court? *If yes, attach a statement for each conviction including dates and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.*		X
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.*		X
3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		X
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.*		X
5. Has any previous registration held by the applicant under the Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? *If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.*		X

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

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

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

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

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

PART VI: Certifying Statement

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

5/24/07
Date of Application

Erin King
Print Name of Applicant

[redacted]
Signature of Applicant

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

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

NAME (Last, First, MI): KING, ERIN
SS#: [redacted]
Profession: Physician

Electronic Renewal Record

Exit | Find Another

License Number	036117422
Pin	[redacted]
Phone	[redacted]
Authorization	[redacted]
SSN	[redacted]
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	5/4/2011
Renewal Fee	$300.00
Fee Type	R
Service Fee	$5.00

Method | Credited:

User Responses

1	SSN		9	MD2	Y
2	IA1	N	10	MD3	Y
3	PH1	N	11	CS1	N
4	PH2	N	12	CE1	Y
5	PH3	N	13		
6	PH4	N	14		
7	MD1	N	15		
8	MD1A	Y			

Electronic Renewal Record

Exit | Find Anoth

License Number	036117422
Pin	[redacted]
Phone	[redacted]
Authorization	[redacted]
SSN	[redacted]
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	4/29/2008
Renewal Fee	$300.00
Fee Type	3
Service Fee	$5.00

Method | Credited:

User Responses

1	SSN		9		
2	IA1	N	10		
3	PH1	N	11		
4	PH2	N	12		
5	PH3	N	13		
6	PH4	N	14		
7	CS1	N	15		
8					

Electronic Renewal Record

Exit | Find Anoth

License Number	336079859
Pin	[redacted]
Phone	[redacted]
Authorization	[redacted]
SSN	[redacted]
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	6/9/2011
Renewal Fee	$15.00
Fee Type	R
Service Fee	$1.50

Method | Credited:

User Responses

1	SSN		9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8					

Electronic Renewal Record

Exit | Find Anothe

License Number	336079859
Pin	[redacted]
Phone	[redacted]
Authorization	[redacted]
SSN	[redacted]
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	5/12/2008
Renewal Fee	$15.00
Fee Type	1
Service Fee	$1.50

Method | I | Credited:

User Responses

1	SSN		9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8					