APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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BY:.....

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 REFERENCE SHEET. In addition, note the following:

RECEIVED
BUSINESS SERVICES
NOV 07 2005

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 Illinois Compiled Statutes 20/10-65 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	0 3 6	Examination USMLE Step 3	$ 625 ET

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: _____

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NOV 14 2005
BY: 88758

- ☐ 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.
Brown	Jennifer	Marie	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

Loyola University Medical Center
Dept. of Anesthesiology 2160 S. First Ave. Maywood IL 60153-____ 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
(same as current)	Henry

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

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED	12. PREFERRED e-MAIL ADDRESS/ES (If available)
Work ([redacted]	
(Area Code) (Area Code)	

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

NAME (Last, First, MI): Brown, Jennifer M.

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
Pine Tree High School	Longview, TX	06/1995 (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	DATES OF ATTENDANCE TO	TYPE OF DEGREE EARNED
Texas Tech University	Lubbock, TX	Month/Year 08/95	Month/Year 05/99	B.S.

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM	DATES OF ATTENDANCE TO	Did You Complete Training?
University of Texas @ Houston (Medical School)	Houston, TX	Month/Year 08/99	Month/Year 06/03	☒ Yes ☐ No
Loyola University Medical Ctr. (Residency - Anesthesia)	Maywood, IL	7/04	Current	☐ Yes ☐ No (Currently in)
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Brown, Jennifer M.

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 IL temporary physician	Anesthesiology	125-071577	7/1/2004	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	TX	6/01	(Passed) Failed, Absent)
USMLE - Step 2	TX	11/02	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.*		✓
2. Have you been convicted of a felony?		✓
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		✓
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		✓
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		✓
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		✓

PART 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] 9/8/05

Signature of Applicant — 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): Brown, Jennifer M

SS#: [redacted]

Profession: Physician

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WORK HISTORY

SUPPORTING DOCUMENT

WH

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

1. NAME — LAST: Brown — FIRST: Jennifer — MIDDLE: Marie

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.
Physician (Profession Name) — 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: Jennifer Marie Brown

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

8. DATE FORM COMPLETED: 9/27/05

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: Loyola University Medical Center, Dept. of Anesthesia
JOB TITLE: House staff Resident
ADDRESS STREET, CITY, STATE, ZIP CODE: 2160 S. First Ave. Maywood, IL 60153
DESCRIPTION OF DUTIES PERFORMED: Patient care
SUPERVISOR NAME: Dany Murray M.D.
DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/2004 (Month/Day/Year) To Current
HOURS WORKED PER WEEK: 70
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month): > 1 year

B. NAME OF BUSINESS / INSTITUTION: NA
JOB TITLE: Vacation / Travel
ADDRESS STREET, CITY, STATE, ZIP CODE: 412 Narcissa St. Longview, TX 75604
DESCRIPTION OF DUTIES PERFORMED:
SUPERVISOR NAME: NA
DATE OF EMPLOYMENT/ATTENDANCE: From 12/01/2003 (Month/Day/Year) To 06/30/2004
HOURS WORKED PER WEEK: NA
TYPE OF EMPLOYMENT: ☐ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month):

NAME (Last, First, MI): Brown, Jennifer M

SS#: [redacted]

Profession: Physician

C. NAME OF BUSINESS / INSTITUTION: Salud Independent Study - Amerispan

JOB TITLE: Student / Physician Volunteer

ADDRESS STREET, CITY, STATE, ZIP CODE: P.O. Box 58129, Philadelphia, PA 19102-8129

DESCRIPTION OF DUTIES PERFORMED: I volunteered in a teaching hospital (patient care) in Cordoba, Argentina.

SUPERVISOR NAME: NA

DATE OF EMPLOYMENT/ATTENDANCE: From 08 / 01 / 2003 (Month / Day / Year) To 11 / 30 / 2003

HOURS WORKED PER WEEK: 20

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

TOTAL TIME WORKED (Year/Month): 4 Months

D. NAME OF BUSINESS / INSTITUTION: National Youth Leadership Forum on Medicine

JOB TITLE: Faculty Advisor

ADDRESS STREET, CITY, STATE, ZIP CODE: 1110 Vermont Ave. NW # 330, Washington, D.C. 20005

DESCRIPTION OF DUTIES PERFORMED: I helped to implement a curriculum introducing the field of medicine to high school students.

SUPERVISOR NAME: Celia Olson

DATE OF EMPLOYMENT/ATTENDANCE: From 07 / 01 / 2003 (Month / Day / Year) To 07 / 31 / 2003

HOURS WORKED PER WEEK: >40

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

TOTAL TIME WORKED (Year/Month): 1 month

E. NAME OF BUSINESS / INSTITUTION: NA

JOB TITLE: Vacation / Travel

ADDRESS STREET, CITY, STATE, ZIP CODE: 412 Norcross St. Longview, Tx 75604 (Mailing Address)

DESCRIPTION OF DUTIES PERFORMED:

SUPERVISOR NAME: NA

DATE OF EMPLOYMENT/ATTENDANCE: From 06 / 09 / 2003 (Month / Day / Year) To 06 / 30 / 2003

HOURS WORKED PER WEEK:

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

TOTAL TIME WORKED (Year/Month): NA

F. UT-Houston Medical School, Houston, TX — Medical Student

From 08/01/1999
To 06/08/2003 (graduation)

TEXAS TECH UNIVERSITY

Office of the Registrar, Lubbock, Texas 79409

Jennifer Maria Brown
[redacted]

Official Undergraduate Academic Record

TSI Area ET - Exemption - TAAS Scores

Test Scores:
10-01-94 SAT
05-01-94 SAT
03-01-94 SAT
05-01-93 TAAS
[redacted]

Degrees Awarded:
Bachelor of Science May 15, 1999
College of Arts and Sciences
Major: Cell And Molecular Biology
Minor: Chemistry
Honors: Magna Cum Laude

Transfer Credit:
Kilgore College Aug 1994 - May 1995
School Total: 6.00

----------1995 Fall----------

Admitted Program:
College of Arts and Sciences
Bachelor of Arts
Major: Pre-Medicine

031	CHEM-1107	PRINS OF CHEM I (LAB)	[redacted]
030	CHEM-1307	PRINCIPLES OF CHEM I	
040	ENGL-2302	LITERATURE AFTER 1700	
020 021	MATH-1351	CALCULUS I	
	PF&W-1105	AQUA-BEG SCUBA	
080	SOC -1301	INTRO TO SOCIOLOGY	

President's List

	AHRS	EHRS	QHRS
Current	[redacted]		
Cumulative			

----------No Further Entries This Colu

----------1996 Spring----------

031	CHEM-1108	PRINS OF CHEM II (LAB)	[redacted]
030	CHEM-1308	PRINCIPLES OF CHEM II	
	CLAS-1310	LATIN/GREEK TERMINOLOGY	
011	HDFS-2320	BSC INTERPERSONAL SKILLS	
050	MUAP-1001	PIANO	
031	PHYS-1103	EXP GEN PHYSICS I (LAB)	
030	PHYS-1306	GENERAL PHYSICS	

President's List

	AHRS	EHRS	QHRS
Current	[redacted]		
Cumulative			

----------1996 Fall----------

030 031	BIOL-1403	BIOLOGY I	[redacted]
	CHEM-3105	ORGANIC CHEMISTRY LAB	
090	CHEM-3305	ORGANIC CHEMISTRY	
050	MUAP-1002	MUS APPL-GUITAR	
031	PHYS-1106	PRIN OF PHYSICS II (LAB)	
030	PHYS-2301	PRINCIPLES OF PHYSICS II	

Internal Transfer

	AHRS	EHRS	QHRS	QPTS	GPA
Current	[redacted]				
Cumulative					

No Further Entries This Column

[redacted]
Registrar

09-09-05

Jennifer Brown
[redacted]

ERN = Earned Hours QHR = Quality Hours QPTS = Quality Points
3 digit course numbers changed to 4 digit numbers effective September 1983
Honors in descriptive title indicates Honors Credit
Texas Technological College changed to Texas Tech University September 1, 1969

OFFICIAL TRANSCRIPTS BEAR REGISTRAR SIGNATURE WITH UNIVERSITY SEAL

A+ = Excellent
A = Excellent
A- = Excellent
B+ = Good
B = Good
B- = Good
C+ = Average
C = Average
C- = Average
D+ = Inferior
D = Inferior
D- = Inferior
F = Failure
I = Incomplete
CR. = Credit
NC = No Credit

PR = Progress
W = Withdraw or dropped passing
WF = Withdraw Failing
P = Pass
R = Repeated to remove incomplete
X = No grade reported
NP = Student did not pay fees (No grade)

	A+	B+	C+	D+											
	A	B	C	D											
	A -	B -	C -	D -	F	CR	NC	I	PR	W	WF	P	R	X	NP
4	+														
3		+													
2			+												
1				+											
0					+	*	+	*	*	*	+	*	*	*	*

Grade Point Value

* Not included in hours Attempted for computing GPA
Four Grade-Points System effective September 1962

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- Effective February 1, 2003 design modifications include new Double T, University Seal and Registrar signature

SECURITY FEATURES

Alteration Prevention/Deterrence:
- Linelock™ (Artificial)
- Chemical-Reactive Stains (Evidence of Alteration)
- High Polarity Solvents
- Low Polarity Solvents
- Oxidants
- TonerFuse® Coating

Duplication Prevention/Deterrence:
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TEXAS TECH UNIVERSITY

Office of the Registrar, Lubbock, Texas 79409

Jennifer Marie Brown
[redacted]

---1997 Spring---

Program Changed To:
Bachelor of Science
Major: Cell And Molecular Biology

030	031	BIOL-1404	BIOLOGY II
		CHEM-3106	ORGANIC CHEMISTRY LAB
		CHEM-3306	ORGANIC CHEMISTRY
020	021	MATH-2300	STATISTICAL METHODS
		PF&W-1102	DUAL ACT-SELF DEFENSE
040		SPAN-1507	COMPREHENSIVE REVIEW: 1ST YEAR

Dean's List

	AHRS	EHRS	QHRS
Current	[redacted]		
Cumulative			

---1997 First Summer---

060		HIST-2300	HIST OF U.S. TO 1877
070		POLS-1301	AMER GOVT, ORGANIZATION

Dean's List

	AHRS	EHRS	QHRS
Current	[redacted]		
Cumulative			

---1997 Second Summer---

060		HIST-2301	HIST OF U.S. SINCE 1877
070		POLS-2302	AMERICAN PUBLIC POLICY

	AHRS	EHRS	QHRS
Current	[redacted]		
Cumulative			

---No Further Entries This Colu

---1997 Fall---

		BIOL-3320	CELL BIOLOGY
		CHEM-3311	BIOLOGICAL CHEMISTRY I
		MBIO-3401	PRINS OF MICROBIOLOGY
040		SPAN-2301	SECOND COURSE-SPANISH I

Dean's List

	AHRS	EHRS	QHRS
Current	[redacted]		
Cumulative			

---1998 Spring---

		BIOL-3301	GENETICS
		CHEM-3312	BIOLOGICAL CHEMISTRY II
040		PHIL-2300	BEGINNING PHILOSOPHY - HONORS
040		SPAN-2302	SECOND COURSE IN SPANISH II

Dean's List

	AHRS	EHRS	QHRS
Current	[redacted]		
Cumulative			

---1998 First Summer---

		BIOL-4300	UNDERGRADUATE RESEARCH I

	AHRS	EHRS	QHRS
Current	[redacted]		
Cumulative			

No Further Entries This Colum

Don Wiehardt
Registrar

09-09-05

Jennifer Brown
[redacted]

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CR. = Credit
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WF = Withdraw Failing
P = Pass
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X = No grade reported
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	A+	B+	C+	D+											
	A	B	C	D											
	A -	B -	C -	D -	F	CR	NC	I	PR	W	WF	P	R	X	NP
4	+														
3		+													
2			+												
1				+											
0					+	•	+	•	•	•	+	•	•	•	•

Grade Point Value

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Four Grade-Points System effective September 1962

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- Chemical-Reactant Stains: (Evidence of Alteration)
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TEXAS TECH UNIVERSITY

Office of the Registrar, Lubbock, Texas 79409

Jennifer Marie Brown
[redacted]

----------1998 Second Summer----------

BIOL-4300	UNDERGRADUATE RESEARCH I	A	3.00	12.00

	AHRS	EHRS	QHRS	QPTS	GPA
Current					
Cumulative	[redacted]				

----------1998 Fall----------

Program Changed To:
Major: Cell And Molecular Biology
Minor: Chemistry

BIOL-2120	INTRO CELL/MOLECULAR BIO			
BIOL-3120	CELL BIOLOGY LABORATORY			
MBIO-4404	PATHOGENIC MICROBIOLOGY			
PHIL-4000	PHILOSOPHICAL PROBLEMS			
040 SPAN-3303	SPANISH CONVERSATION			

	AHRS	EHRS	QHRS
Current			
Cumulative	[redacted]		

----------1999 Spring----------

BIOL-3302	DEVELOPMENTAL BIOLOGY			
BIOL-4320	MOLECULAR BIOLOGY			
PSY -3306	PERSONALITY			
ZOOL-4304	GEN ENDOCRINOLOGY			

Dean's List

	AHRS	EHRS	QHRS
Current			
Cumulative	[redacted]		

Requirements completed for Bachelor of Science
Core Curriculum Completed

----------End of Undergraduate Academic Record----------

Don Wiehardt
Registrar

09-09-05

Jennifer Brown
[redacted]

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	A+	B+	C+	D+											
	A	B	C	D											
	A-	B-	C-	D-	F	CR	NC	I	PR	W	WF	P	R	X	NP
4	+														
3		+													
2			+												
1				+											
0					+	*	+	*	*	*	+	*	*	*	*

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- Invisible Fluorescent Fibers

The University of Texas Health Science Center at Houston
P.O. Box 20036, Houston, Texas 77225

NAME: JENNIFER MARIE BROWN
SID: [redacted]
BIRTH:

SEPTEMBER 12, 2005

ISSUED TO STUDENT

DEGREES AWARDED:

DOCTOR OF MEDICINE
CONFERRED 2003/06/07

COURSE	DESCRIPTION	GRADE	HOURS
	MEDICAL YEAR 1999 - 2000		
	MEDICAL SCHL MDMED		
BSCI 1001	BIOCHEMISTRY		
BSCI 1002	GROSS ANATOMY		
BSCI 1003	DEVELOPMENTAL ANATOMY		
BSCI 1004	HISTOLOGY		
BSCI 1005	MICROBIOLOGY		
BSCI 1006	NEUROSCIENCE		
BSCI 1007	PHYSIOLOGY		
BSCI 1010	IMMUNOLOGY		
BSCI 1011	INTRO CLINICAL MEDICINE		
	MEDICAL YEAR 2000 - 2001		
	MEDICAL SCHL MDMED		
BSCI 2001	BEHAVIORAL SCIENCES		
BSCI 2004	PATHOLOGY		
BSCI 2005	PHARMACOLOGY		
BSCI 2007	GENETICS		
BSCI 2008	PHYSICAL DIAGNOSIS		
BSCI 2009	FUNDAMENTAL CLIN MEDICINE		
BSCI 2025	REPRODUCTIVE BIOLOGY		
RAD 2000	RADIOLOGY (P,F ONLY)		
TSKI 2001	TECH SKILLS (PASS/FAIL)		
	MEDICAL YEAR 2001 - 2002		
	MEDICAL SCHL MDMED		
FAPR 3001	FAMILY PRACTICE		
INTM 3001	MEDICINE		
OBGY 3001	OBSTETRICS/GYNECOLOGY		
PED 3001	PEDIATRICS		
PSYC 3001	PSYCHIATRY		
	NO FURTHER ENTRIES IN THIS COLUMN		

COURSE	DESCRIPTION	GRADE	HOURS
	MEDICAL YEAR 2001 - 2002 (CONTINUED)		
	MEDICAL SCHL MDMED		
SURG 3001	SURGERY		
	MEDICAL YEAR 2002 - 2003		
	MEDICAL SCHL MDMED		
ANES 4001	ANESTHESIOLOGY		
FAPR 4000	REQUIRED FAMILY PRACTICE		
FAPR 4006	CARDIO SUBINTERNSHIP		
INDP 4005	REQUIRED SURGERY		
INTM 4000	REQUIRED MEDICINE		
INTM 4001	INT MED ACTING INTERNSHIP		
JURI 4001	MED JURISPRUDENCE		
NEUR 4000	REQUIRED NEUROLOGY		
RAD 4001	DIAGNOSTIC RADIOLOGY		
SPEC 4000	SPECIAL ELECTIVE		
TSKI 4001	TECH SKILLS (PASS/FAIL)		

END OF ACADEMIC RECORD

** - INDICATES "IN PROGRESS" DURING THIS ACADEMIC PERIOD

In accordance with the Family Rights and Privacy Act of 1974, this information is being released on the condition that you will not permit any other party to have access to this transcript without written consent of individual involved.

This official university transcript is printed on secured paper and does not require a raised seal.

Robert L. Jenkins

Robert L. Jenkins, Registrar

The Federation of State Medical Boards
of the United States, Inc.
P O Box 619850
Dallas, TX 75261-9850
Telephone: (817) 571-2949
FAX (817) 868-4098

September 9, 2005

Continental Testing Center
ATTN: Lisa Albury
P.O. Box 100
547 S. LaGrange Rd
La Grange, IL 60525

RE: Brown, Jennifer
[redacted]

The enclosed Examination and Board Action History Report is being provided at the request of the above-referenced physician. This report must not be duplicated or forwarded to any other party.

Your compliance with these requirements is appreciated.

Thank you.

Examination Service Department

Enclosure

CDS v5.00.001 16125180

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 – Telephone (817) 868-4041

Date: 09/09/2005

Recipient:

Continental Testing Center
ATTN: Lisa Albury
P.O. Box 100
547 S. LaGrange Rd
La Grange, IL 60525

Examinee: Brown, Jennifer
Alt Name(s): Brown, Jennifer Marie

Examinee ID#: [redacted]
Date of Birth:

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
06/13/2001	[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
11/25/2002	[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.

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".

-9K

The University of Texas
Health Science Center at Houston
Medical School

Be it known that

Jennifer Marie Brown

having completed the prescribed course of study has been admitted to the degree of

Doctor of Medicine

with all the rights, privileges, and responsibilities pertaining to that degree
Issued by the Board of Regents upon recommendation of the Faculty

Witness the seal of the University and the signatures the seventh day of June, A. D., two thousand and three.

Charles Miller
Chairman, Board of Regents

Chancellor, The University of Texas System

Jim T. Willerson, M.D.
President

L. Maximilian Buja, M.D.
Dean

APPLICATION TRANSMITTAL - Physician

(This transmittal must accompany the application.)

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Brown	Jennifer	Marie	[redacted]	

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).

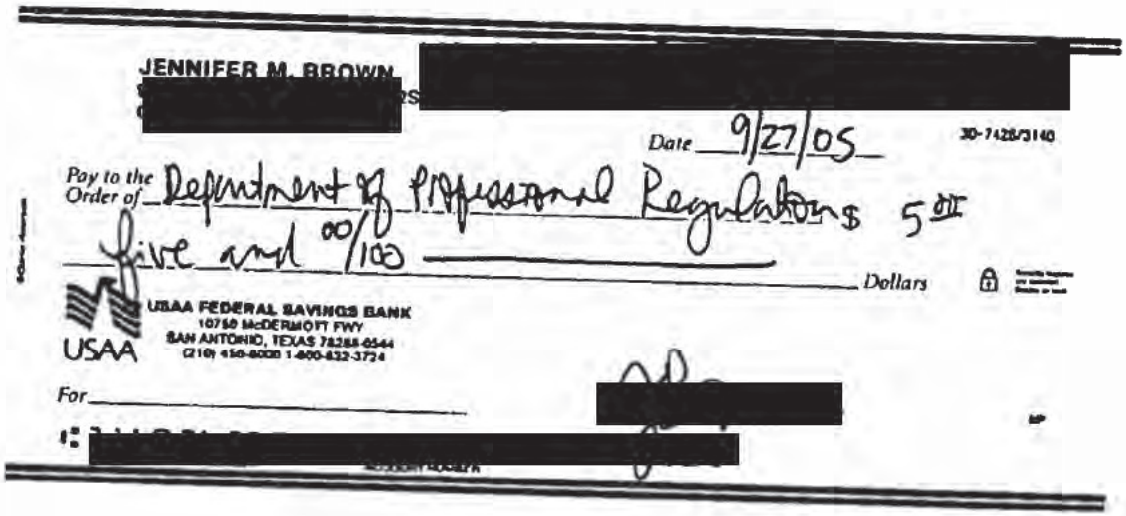
Enclosed	Requested	Description
✓		4-page Application for Licensure and/or Examination
✓		Application Fee
✓		Form WH (required for all applicants)
[redacted]		FCVS Physician Profile
		TN-MED Form
N/A		ECFMG Certificate (Copy)
✓		Medical School Diploma (Copy)
✓		Proof of Pre-Medical and Medical Education (Official transcript of grades issued by medical college or university with school seal affixed] from: _____
N/A		AF-MED
N/A		ED-NON
N/A		5th Pathway/Social Service
[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: _____

_____

_____


JENNIFER M. BROWN
[redacted]

Date 9/27/05

30-7428/3140

Pay to the Order of Department of Professional Regulations $ 5.00

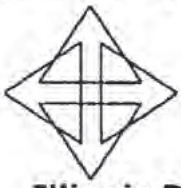
five and 00/100 Dollars

USAA FEDERAL SAVINGS BANK
10750 McDERMOTT FWY
SAN ANTONIO, TEXAS 78288-0544
(210) 498-8000 1-800-832-3724

USAA

For [redacted]

[redacted]



CONTINENTAL TESTING SERVICES, INC.
P.O. Box 100 · LaGrange, Illinois 60525
800-359-1313 · 708-354-9911 · fax 708-354-9922
www.continentaltesting.net

Print this Listing

11/16/2005 **Illinois Division of Professional Regulation** 10:24:35 AM

You requested license number: 125-047377

Licensee's Name	DBA / AKA	License Number	License Status	City, State	Program Name	Program Start Date	Issuance Date	Current Exprtn	Ever Discpined
JENNIFER MARIE BROWN MD		125047377	ACTIVE	MAYWOOD, IL	Anesthesiology	07/01/2004	07/01/2004	06/30/2007	N

Page 1

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

(DPR)

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

1. NAME — LAST: Brown — FIRST: Jennifer — MIDDLE: Marie

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

8. (same)

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

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable): 125-047377

8. ISSUANCE DATE: 7/1/04

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed 32 months of postgraduate clinical training in ANESTHESIOLOGY (Name of Specialty Program)

from 07/01/2004 (MM/DD/YYYY) to 02/23/07 (MM/DD/YYYY) at the following hospital:

Hospital: LOYOLA UNIVERSITY MEDICAL CENTER

Number and Street: 2160 SOUTH FIRST AVE

City, State and Zip Code: MAYWOOD, IL 60153

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

- [x] the ACGME
- [ ] the AOA
- [ ] the CFPC, RCPSC or FMLAC (Canadian Programs)
- [ ] not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: AMY MURRAY, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 2-23-07

University/Hospital SEAL

Telephone No: 708-216-9169

(If no seal, attach letter on letterhead stating no seal exists.)

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

Jennifer Marie Brown
[redacted]

DATE PRINTED: 03/09/2006
LICENSURE FEE: $300.00
SCHOOL #/TEST DATE: 036925 02/13/2006

Licensed Physician & Surgeon

SOC SEC #: [redacted]

OVERALL EXAM RESULT: Pass

USMLE 88 Pass 02/13/2006

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

Jennifer Marie Brown
[redacted]

DATE PRINTED: 03/09/2006
LICENSURE FEE: $300.00
SCHOOL #/TEST DATE: 036925 02/13/2006

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.

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	3. SOCIAL SECURITY NUMBER
Brown	Jennifer	Marie	[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
Jennifer Marie Brown

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)
125-047377

8. ISSUANCE DATE
07/01/2004

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 14 months of postgraduate clinical training in ANESTHESIOLOGY
(Name of Accredited Postgraduate Clinical Training Program)

from 7-1-04 to 9-27-05 at the following hospital:

Hospital: LOYOLA UNIVERSITY MEDICAL CENTER
Number and Street: 2160 SOUTH FIRST AVENUE
City, State and Zip Code: MAYWOOD, IL 60153

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: AMY MURRAY, MD
Signature of Postgraduate Clinical Training Program Director: [redacted]
Date of this Certification: 9-27-05
Telephone No: 708-216-9169

SEAL

November 17, 2005

USMLE - STEP 3

NO.	LAST	FIRST	SOCIAL SECURITY #	FEE
1	[redacted]			
2	BROWN	JENNIFER		
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

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

USMLE CHECKLIST- 036 – Licensed Physician Surgeon

Date of Screening: 11-16-05

Name: Jennifer Marie Brown

[redacted]

✓ 1. USMLE APPLICATION Fee 635—

✓ 2. 4 page Application Jacket CTS Fee 8.8.75

✓ 3. TN-Med form (✓14 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 #: 1250473777

___ 11. Fifth Pathway Active ✓ Expired ___

___ 12. AF-Med

___ 13. ED-Non

___ # 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 lo System" Chapter (Pg. 14.104E).

Electronic Renewal Record

Exit | Find Another

License Number	036117814
Pin	[redacted]
Phone	[redacted]
Authorization	[redacted]
SSN	[redacted]
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	6/18/2011
Renewal Fee	$300.00
Fee Type	R
Service Fee	$5.00

Method | Credited:

User Responses

1	SSN		9	MD2	N
2	IA1	N	10	MD3	N
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 Another

License Number	036117814
Pin	[redacted]
Phone	[redacted]
Authorization	[redacted]
SSN	[redacted]
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	5/29/2008
Renewal Fee	$300.00
Fee Type	3
Service Fee	$5.00

Method | I | 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					