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

November 4, 2013

Brady Antonetti
bradyantonetti@aol.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:

- *Everything in the file for LARRY FAINES, license numbers 125022116 and 036081591 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.*

Dr. Larry Faines is an Illinois Licensed Physician and Surgeon, license number 036. 036.081591. Dr. Faines is also the holder of a controlled substance license number 336. 043943. Dr. Faines is the sponsoring physician for Advance Practice Nurse, Hillarie Elizabeth Joehl.

Please find the attached documents in response to your request. Physician profiles are available on the Department's website, www.idfpr.com.

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

MAY 3 1989

PAGE ONE

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

APPLICATION FOR LICENSURE / EXAMINATION

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

1. Four page APPLICATION FOR LICENSURE/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 you may be required to submit with your application.

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

1. Type or print legibly with black ink only.
2. The licensure fee and application fee are NOT refundable.
3. Disclosure of Social Security number is not mandatory. It is used only to ensure identification, accuracy and to expedite processing of your application.
4. If the name shown on your supporting documents is different from that shown on your application, you must submit proof of legal name change—marriage license, divorce decree, affidavit or court order.
5. All documents in a foreign language that are required to be submitted with an application or for any other purpose in connection with licensure must be accompanied by an original, notarized translation that has been performed by a person, other than the applicant, who is fluent in both English and the language of the document(s). The translator shall certify to the above requirements as well as to the accuracy of the translation.

PART I: Application Category Information. (See REFERENCE SHEET, CHART I, prior to completing PART I.)

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
LARRY FAINES M.D			$

PART II: Applicant Identifying Information.

1. NAME LAST FIRST MIDDLE	2. TITLE	3. SOCIAL SECURITY NUMBER
FAINES LARRY	MR	[redacted]

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

[redacted]

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

MACNEAL HOSP. 3249 S OAK PARK AVE. IL/US 60402

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

7. PLACE OF BIRTH CITY STATE/COUNTRY | 8. DATE OF BIRTH | 9. AGE

[redacted]

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work [redacted] Area Code ... Area Code

IL486-1019 10/88 (LT-A)

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School — Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 (12) Graduated High School? [✓] Yes [ ] No Received G.E.D.? [ ] Yes [ ] No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
WEST SIDE HIGH SCHOOL	NEWARK, NJ	06 / 77 (Month / Year)

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

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

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	TO Month/Year	TYPE OF DEGREE EARNED
AMHERST COLLEGE	AMHERST, MASS	9/77	5/82	BA
SETON HALL UNIV.	SO. ORANGE, NJ	1/80	1/81	—

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	TO Month/Year	DID YOU COMPLETE TRAINING?
MACNEAL HOSPITAL	BERWYN, IL	6/88	6/89	[✓] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, complete the information requested below. 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 regarding possible fee). A certification of licensure from Illinois is not required. If you have ever held a temporary, trainee or apprenticeship license or a permit or related license, it must be listed here also. 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	LARRY FAINES M.D.	125-022116	6/27/88	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 written 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)
NBME PART I	NJ	6/86	PASSED
NBME PART II	IL	9/87	PASSED
NBME PART III	IL	3/89	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 ever been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a statement for each conviction including date and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed. Also include, where applicable, certified copies of order evidencing discharge from penalties imposed, or if such copies are not obtainable, a notarized statement explaining their unavailability.*		✓
2. Do you have any physical or mental impairment or disability that could interfere with your ability to practice your profession? *If yes, attach a detailed explanation.*		✓
3. Are you now addicted to or do you excessively use alcohol, narcotics, barbiturates or habit-forming drugs? *If yes, attach a detailed explanation.*		✓
4. Have you ever suffered from, been diagnosed as having, or been treated for any disease or condition that could interfere with your ability to practice your profession, including, but not limited to: 1) physical disease or conditions; 2) mental or emotional disease or condition; 3) alcohol or substance abuse? *If yes, attach a detailed explanation.*		✓
5. Have you ever been denied a license, permit, or privilege of taking an examination by any licensing authority? *If yes, attach a detailed explanation.*		✓
6. Have you ever had a license or permit encumbered in any way (revoked, suspended, surrendered, censured, restricted, limited, placed on probation)? *If yes, attach a detailed explanation.*		✓
7. 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.*		✓
8. Have you ever been declared incompetent by any court by reason of mental or physical defect or disease? *If yes, attach a detailed explanation.*		✓
9. Are you a U. S. citizen **OR** a lawfully admitted alien of the United States?	✓	

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. **TEST CODES** [ ] [ ] [ ] [ ] [ ] [ ]

b) CHART III – Select the examination site you desire and enter Test Center Code. **TEST CENTER CODE** [ ]

c) CHART IV – Find your School of Graduation and enter school code. **SCHOOL CODE** [ ]

d) Record the number of times you have taken this exam in Illinois or any other state. **EXAM ATTEMPTS** [ ]

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

PART VIII: 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

4-23-89 ____________________ Date

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

WORK HISTORY

SUPPORTING DOCUMENT

WH

APPLICANT: Complete Work History beginning with present employment and concluding with graduation. If never employed, complete items 1 through 8 as instructed and print N/A in the first box titled "Description of Duties Performed." You are authorized to photocopy this form if additional space is required.

1. NAME LAST FIRST MIDDLE: FAINES LARRY
2. DATE OF BIRTH: [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.
   LARRY FAINES M.D. — Profession Name
   Profession Code
6. MAIDEN OR GIVEN SURNAME
7. DATE FORM COMPLETED

8. RECORD WORK HISTORY CHRONOLOGICALLY – BEGIN WITH PRESENT EMPLOYMENT.

A. NAME OF BUSINESS/INSTITUTION: MACNEAL HOSPITAL

JOB TITLE: TRANSITIONAL INTERN

ADDRESS STREET, CITY, STATE, ZIP CODE: 3249 S. OAK PARK AVE. BERWYN IL, 60402

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME: DR FYRE, PROGAM DIRECTOR

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

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
[ ] Full-time [ ] Part-time

B. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

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

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
[ ] Full-time [ ] Part-time

C. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

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

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
[ ] Full-time [ ] Part-time

Complete the Reverse Side of this Form →

D. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ / __ / __ (Month / Day / Year)

To __ / __ / __ (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

E. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ / __ / __ (Month / Day / Year)

To __ / __ / __ (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

F. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ / __ / __ (Month / Day / Year)

To __ / __ / __ (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

G. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ / __ / __ (Month / Day / Year)

To __ / __ / __ (Month / Day / Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

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CERTIFICATE OF ACCEPTANCE FOR SPECIALTY / RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA - MED

0 0 9 6 7 1 0 0 2 5 9

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

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

1. NAME LAST / FIRST / MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
FAINES LARRY	[redacted] Month Day Year	[redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
[redacted]	LARRY FAINES M.D. (Profession Name) — 1 2 5 (Profession Code)
6. MAIDEN OR GIVEN SURNAME	

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	
COOK COUNTY HOSPITAL	07 / 01 / 89 (Month / Day / Year)	
C. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE	D. ENDING DATE	
1835 WEST HARRIOSN STREET CHICAGO, IL 60612	06 / 30 / 91 (Month / Day / Year)	
E. BUSINESS TELEPHONE NUMBER	F. SPECIALTY / RESIDENCY NAME	G. YEAR OF POSTGRADUATE TRAINING
Area Code (312) 633 - 6705	EMERGENCY MEDICINE	FIRST

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

[redacted] MD
Signature of Program Director

Robert Simon MD
Print Name of Program Director

SEAL

Chairman
Title

4-25-89
Date

IL486-0272 1.89 (MD)

Application No. 125 Prof. Code 147-52-0377 SSN/FEIN

LARRY FAINE 0 0 7 6 7 1 0 0 2 5

or Label Space

TEMPORARY APPLICATION REVIEW FINDINGS

AMF 4

1. DATE: 05/04/89
2. EMPLOYEE: 0307
3. STATUS: ___
4. DEFICIENCIES - ADD: ___

   CLEAR: ___
5. LAST CORRESPONDENCE RECEIVED DATE: __/__/__
6. LAST CORRESPONDENCE SENT DATE: __/__/__

EDUCATION INFORMATION:

7. School Name ___
8. School Code ___ 9. Foreign School ___ (Yes or No) 10. Date Graduated __/__/__
11. City/Country School Located ___ 12. State School Located ___

PROGRAM INFORMATION:

14. Facility Name COOK COUNTY HOSP
15. Facility Address
    - Line 1 C/O DEPT OF GRAD MED EDUC
    - Line 2 1835 W HARRISON
    - Line 3 ___
    - Line 4 ___
    - City/Country CHICAGO State IL Zip 60612
16. Start Training Date 06/22/83
17. Program Code 401
18. Start Program Date 07/01/85
19. Add ☒
20. Change ☐

IL486–1325 6/86 (EDP)

1 0 0 0 0 0 3 2 1 5 1

PAGE ONE

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APPLICATION FOR LICENSURE / EXAMINATION

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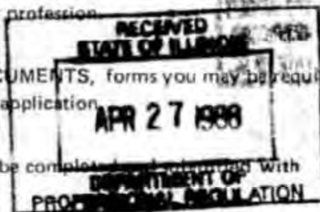
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms you may be required to submit with your application.
5. SCAN FORM, must be completed and submitted with your application.



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

1. Type or print legibly with black ink only.
2. The licensure fee and application fee are NOT refundable.
3. Disclosure of Social Security number is not mandatory. It is used only to ensure identification, accuracy and to expedite processing of your application.
4. If the name shown on your supporting documents is different from that shown on your application, you must submit proof of legal name change—marriage license, divorce decree, affidavit or court order.
5. Any document in a foreign language must be accompanied by an original, notarized English translation. The translator must not be related to you by blood or marriage; must be fluent in both English and the foreign language; and must certify to these requirements as well as the accuracy of the translation.

PART I: Application Category Information. (See **REFERENCE SHEET, CHART I,** prior to completing **PART I.**)

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Licensure	1 2 5	nonexamination	$100.[00]

PART II: Applicant Identifying Information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE	3. SOCIAL SECURITY NUMBER
FAINES	LARRY		MR.	[redacted]

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

[redacted]

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

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

7. PLACE OF BIRTH CITY STATE/COUNTRY | 8. DATE OF BIRTH | 9. AGE

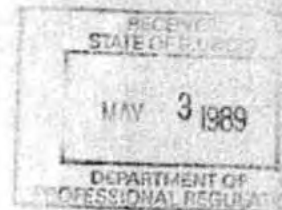
[redacted]

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (___) ___ - ____ Area Code   Home [redacted] Area Code

IL486-1019 10/87 (LT-A)

Cook County Hospital
1835 W. Harrison St., Chicago, Illinois 60612-9985. Telephone 312/633-6000



Date: 0 0 3 6 7 1 0 0 2 5 0307

Illinois Department of Professional Regulation
Medical Section, Third Floor
320 West Washington Street
Springfield, Illinois 62786

MAY 3 1989

Dear Sir/Madame:

The following items are attached to the Illinois Temporary/Permanent Medical License application for Dr. Larry Faikes.

Please return all original documents to Cook County Hospital, Department of Medical Education. If any additional material is needed, please do not hesitate to let me know.

____ $100.00 Check or Money Order

____ Verification of successful completion of either the ECFMG, VQE or FMGEMS

____ Official Medical School Transcripts

____ Photocopy of your Medical School Diploma

____ Official Transcripts from a two year course in Liberal Arts or Pre-Med

____ ED-Med Form

____ AF-Med Form

✓ Work History Form

____ CT Form (or photocopy if mailed directly to DPR from the licensing agency)

✓ CA-Med Form, Program Director Signature and Hospital Seal

____ Original, Nortarized Translation of MD Degree, Transcripts or Marriage Certificate.

✓ Original Temporary Medical License Certificate, #125-022116 for transfer to CCH, from Michael Hospital, Grad Med. Ed. Program to Emergency Medicine Program.

Sincerely yours,

[signature]

Linda Atkins
Department of Medical Education
Cook County Hospital
/mbm

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PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School — Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 (12) — Graduated High School? [✓] Yes [ ] No — Received G.E.D.? [ ] Yes [ ] No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION (Month / Year)
WEST SIDE HIGH SCHOOL	NEWARK, NEW JERSEY	06 / 77

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

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

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	TO Month/Year	TYPE OF DEGREE EARNED
RUTGERS UNIVERSITY	NEWARK/NJ/ESSEX	9/82	1/84	—
AMHERST COLLEGE	AMHERST/MASS.	9/77	5/82	BA
SETON HALL UNIVERSITY	SO ORANGE/NJ	1/79	1/80	—

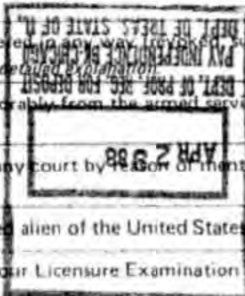
[stamp] ... DEPARTMENT OF ... APR 21 1988 ... OFFICE OF ... SECRETARY

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	TO Month/Year	DID YOU COMPLETE TRAINING?
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No

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

	YES	NO
1. Have you ever been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a statement for each conviction including date and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed. Also include, where applicable, certified copies of order evidencing discharge from penalties imposed, or if such copies are not obtainable, a notarized statement explaining their unavailability.*		✓
2. Do you have any physical or mental impairment or disability, or have you ever suffered from, been diagnosed as having, or been treated for any disease or condition which is generally regarded by the medical community as chronic, including physical disease or condition, that could interfere with your ability to practice your profession? *If yes, attach a detailed explanation*		✓
3. Are you now addicted to or do you excessively use alcohol, narcotics, barbiturates or habit-forming drugs? *If yes, attach a detailed explanation.*		✓
4. Have you ever suffered from, been diagnosed as having, or been treated for any (1) mental or emotional disease or condition; or (2) alcohol or substance abuse? *If yes, attach a detailed statement, including a statement whether or not you are currently under treatment and a signed statement regarding the disease or condition from your treating physician.*		✓
5. Have you ever been denied a license, permit, or privilege of taking an examination by any licensing authority? *If yes, attach a detailed explanation.*		✓
6. Have you ever had a license or permit encumbered in any way (revoked, suspended, surrendered, censured, restricted, limited, placed on probation)? *If yes, attach a detailed explanation.*		✓
7. 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.*		✓
8. Have you ever been declared incompetent by any court by reason of mental or physical defect or disease? *If yes, attach a detailed explanation.*		✓
9. Are you a U. S. citizen **OR** a lawfully admitted alien of the United States?	✓	
10. Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated?	✓	



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. — TEST CODES: N/A

b) CHART III – Select the examination site you desire and enter Test Center Code. — TEST CENTER CODE:

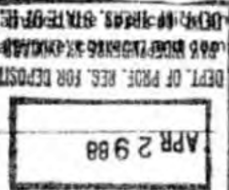
c) CHART IV – Find your School of Graduation and enter school code. — SCHOOL CODE:

d) Record the number of times you have taken this exam in Illinois or any other state. — EXAM ATTEMPTS:

PART VIII: Certifying Statement

Under penalties of perjury, I declare that I have examined this 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 — 4/15/88 Date



PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, complete the information requested below. 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. Enclosed in this application package are two Certification by Licensing Agency/Board forms for that purpose. If you have ever held a temporary, trainee or apprenticeship license or a permit or related license, it must be listed here also. 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 written 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)

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

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

CERTIFICATION OF EDUCATION

0 0 8 9 1 8 9 0 1 2 9

SUPPORTING DOCUMENT

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: FAINES, LARRY

4. ADDRESS STREET, CITY, STATE, ZIP CODE:

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

TEMPORARY LICENSURE — Profession Name; 1 2 5 — Profession Code

6. MAIDEN OR GIVEN SURNAME:

7. NAME OF INSTITUTION ATTENDED: UMDNJ - NJMS

8. DATE OF GRADUATION/COMPLETION: 05/25/88 (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.

4/15/88
Date

Signature of Applicant

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

A. NAME OF INSTITUTION: UMDNJ-New Jersey Medical School

B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE: 185 S. Orange Ave, Newark, N.J. 07103-2757

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

From (Month / Day / Year)	To (Month / Day / Year)
8 / 27 / 84	6 / 3 / 85
8 / 26 / 85	5 / 19 / 86
7 / 7 / 86	6 / 19 / 87
7 / 6 / 87	5 / 20 / 88
/ /	/ /
/ /	/ /

D. Total academic years attended: 4 Years / Months / Days
OR
Total calendar years attended: Years / Months / Days

E. TYPE OF DEGREE OR CERTIFICATE XXXXXXX expected to receive.

Doctor of Medicine

F. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS XXXXXX will be met.

5 / 20 / 88 (Month / Day / Year)

G. DATE THAT DEGREE OR CERTIFICATE XXXXXXXXXXX will be conferred.

5 / 25 / 88 (Month / Day / Year)

H. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

[ ] Applicant has graduated on ___ / ___ / ___ (Month / Day / Year)

[X] Applicant will graduate on 5 / 25 / 88 (Month / Day / Year)

[ ] Applicant has completed program on ___ / ___ / ___ (Month / Day / Year)

[x] Applicant will complete program on 5 / 20 / 88 (Month / Day / Year)

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

Complete the Reverse Side of this Form →

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

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.

Joseph P. Tassoni, Ph.D. — X [redacted]
Print Name of School Official

Associate Dean of Student Affairs — April 19, 1988
Title — Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this ______ day of ______________________, 19 ____

Date of Expiration — Signature of Notary Public

RETURN THIS FORM TO APPLICANT

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY / RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA - MED

0 0 8 9 1 8 9 0 1 2 9

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: Faines Larry
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.
   Profession Name: Temporary Licensure — Profession Code: 1 2 5
6. MAIDEN OR GIVEN SURNAME:

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

A. HOSPITAL/INSTITUTION NAME: MacNeal Hospital

B. BEGINNING DATE: 06 / 27 / 88 (Month Day Year)

C. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: 3249 South Oak Park Avenue, Berwyn, IL 60402

D. ENDING DATE: 06 / 30 / 89 (Month Day Year)

E. BUSINESS TELEPHONE NUMBER: Area Code (312) 795-3400

F. SPECIALTY / RESIDENCY NAME: Transitional

G. YEAR OF POSTGRADUATE TRAINING: First

I do hereby declare that the above named applicant has been accepted for specialty/residency training as indicated above.

[redacted]
Signature of Administrator

Elizabeth B. Frye, M.D.
Print Name of Administrator

Acting Program Director
Title

April 25, 1988
Date

SEAL

IL486-0272 1/88 (MD)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

WORK HISTORY

SUPPORTING DOCUMENT

WH

APPLICANT: *Complete Work History beginning with present employment and concluding with graduation. If never employed, complete items 1 through 6 as instructed and print N/A in the first box titled "Description of Duties Performed." You are authorized to photocopy this form if additional space is required.*

1. NAME LAST FIRST MIDDLE: FAINES LARRY

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 LICENSURE — Profession Name

1 2 5 — Profession Code

6. MAIDEN OR GIVEN SURNAME

7. RECORD WORK HISTORY CHRONOLOGICALLY – BEGIN WITH PRESENT EMPLOYMENT.

A. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

N/A

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ __ / __ __ / __ __ (Month Day Year)

To __ __ / __ __ / __ __ (Month Day Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT [ ] Full-time [ ] Part-time

B. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ __ / __ __ / __ __ (Month Day Year)

To __ __ / __ __ / __ __ (Month Day Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT [ ] Full-time [ ] Part-time

C. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

From __ __ / __ __ / __ __ (Month Day Year)

To __ __ / __ __ / __ __ (Month Day Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT [ ] Full-time [ ] Part-time

IL486-1071 7/87 (LT-A)

Complete the Reverse Side of this Form →

D. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ATTENDANCE

From ___ / ___ / ___ (Month, Day, Year)

To ___ / ___ / ___ (Month, Day, Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

E. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ATTENDANCE

From ___ / ___ / ___ (Month, Day, Year)

To ___ / ___ / ___ (Month, Day, Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

F. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ATTENDANCE

From ___ / ___ / ___ (Month, Day, Year)

To ___ / ___ / ___ (Month, Day, Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

G. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ATTENDANCE

From ___ / ___ / ___ (Month, Day, Year)

To ___ / ___ / ___ (Month, Day, Year)

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

[ ] Full-time [ ] Part-time

Application No. Prof. Code SSN/FEIN

0 0 3 9 1 3 9 0 1 2 9

or Label Space

TEMPORARY APPLICATION REVIEW FINDINGS

AMF 4

1. DATE: / /

2. EMPLOYEE:

3. STATUS:

4. DEFICIENCIES ADD:

CLEAR:

5. LAST CORRESPONDENCE RECEIVED DATE: / /

6. LAST CORRESPONDENCE SENT DATE: / /

EDUCATION INFORMATION:

7. School Name New Jersey Med Sch.

8. School Code

9. Foreign School No (Yes or No)

10. Date Graduated 5/25/8

11. City/Country School Located Newark

12. State School Located N.J.

PROGRAM INFORMATION:

14. Facility Name

15. Facility Address

Line 1 c/o Dept of Grad. Med Ed.

Line 2 3249 South Oak Park Ave.

Line 3

Line 4

City/Country Berwyn State Il Zip 60402

16. Start Training Date 06/27/88

17. Program Code 45

18. Start Program Date 06/27/88

19. Add ☒

20. Change ☐

IL486-1325 6/86 (EDP)

Application No. ____ Prof. Code ____ SSN/FEIN or Label Space 0 0 8 9 1	8 9 0 1 2 9 APPLICATION DATA CHANGE	AMF 1

1. DATE: _/_/_
2. EMPLOYEE:
3. APPLICATION DATE: _/_/_
4. REAPPLICATION DATE: _/_/_

5. ASSIGN S.S.N.: No (Yes or No)

6. FELONY INDICATOR: No

7. LICENSURE METHOD:

8. DATE OF BIRTH: _/_/_

NAME:

9. Individual (Human) Last Fellows First Harry
M.I. — Title M.D.

10. Business (Non-human)

11. ADDRESS:

Line 1

Line 2

Line 3

Line 4

City/Country State Zip

County Foreign Address (Yes or No)

FINANCIAL/BATCH:

12. Payment Date _/_/_ 13. Batch No. 14. Fee Amount

15. Payment Type

16. Delete Financial (Yes or No)

17. ON CONTROL SLIP: (Yes or No)

18. Add ☐ 19. Change ☒

IL486-1322 6/86 (EDP)

DEPARTMENT OF REGISTRATION AND EDUCATION

MEDICAL TEMPORARY APPLICATION CHECK LIST

0 0 3 9 1 8 9 0 1 2 9

NAME: Larry Faines

DATE APPLICATION RECEIVED 4.29.88

1. FEE - AMOUNT RECEIVED OK
2. MED. EDUC. PROGRAM OK
3. PERSONAL HISTORY STATEMENT OK
4. SCAN FORM/STANDARD APPLICATION OK
5. CA-MED FORM OK
6. ED FORM OK
7. WORK HISTORY FORM (WH) OK

IN ADDITION TO THE ABOVE, FOREIGN MEDICAL GRADUATES MUST HAVE:

7. ECFMG CERTIFICATE ________
8. PRE-MEDICAL TRANSCRIPTS ________
9. MEDICAL TRANSCRIPTS ________
10. MEDICAL SCHOOL DIPLOMA ________

*NOTE - All foreign medical transcripts and original translations are to be returned to applicant via registered mail after having been copied and a notation made on the copies that the originals have been seen and returned.

A300 000 2227

PAGE ONE

RECEIVED STATE OF ILLINOIS

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter III of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

1091327009

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

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

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

A. Type or print legibly with black ink only.

B. The licensure fee and application fee are NOT refundable.

C. Disclosure of Social Security number is not mandatory. It is used only to ensure identification, accuracy and to expedite processing of your application.

D. If the name shown on your supporting documents is different from that shown on your application, you must submit proof of legal name change - marriage license, divorce decree, affidavit or court order.

CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION.

- [x] This is the first time I have made application for this profession in Illinois.
- [ ] I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- [ ] Other: ______
- [ ] My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- [ ] I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART I: Application Category Information (See REFERENCE SHEET, CHART 1, prior to completing PART I.)

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician/Surgeon	036	ACCEPTANCE of EXAMINATION	$300.00

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g. M.D., D.D.S., etc.)	3. SOCIAL SECURITY NUMBER
FAINES, LARRY	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

Cook County Hosp. EMERGENCY MEDICINE 1835 W. Harrison CHICAGO IL 60612 Cook

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

n/A

7. PLACE OF BIRTH CITY STATE/COUNTRY | 8. DATE OF BIRTH | 9. AGE

[redacted]

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (312) 633-6000 Home [redacted]

Area Code

IL486-1019 7/89 (I.T.-A)

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 (12) — Graduated High School? [x] Yes [ ] No OR Received G.E.D.? [ ] Yes [ ] No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION (Month / Year)
	Newark, NJ	06/77

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

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

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	TO (Month/Year)	TYPE OF DEGREE EARNED
Amherst College	Amherst, MA	9/77	6/82	BA
Univ. of Medicine + Dentistry - New Jersey Medical School	Newark, NJ	9/84	5/88	MD 033006
Rutgers University	Newark, NJ	9/82	9/84	--

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	TO (Month/Year)	Did You Complete Training?
MacNeal Hospital	Berwyn, IL	6/88	6/89	[x] Yes [ ] No
Cook County Hospital	Chicago, IL	7/89	Present	[ ] Yes [x] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No

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). A 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	FlEXIBLE	125-022116	6/27/88	(temporary) LapSED
State of Current Licensure where you most recently have been practicing ILLINOIS	EMERGENCY MEDICINE	125-022116	7/01/89	(temporary) ACTIVE
Other States of Licensure n/A				

(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)
N/B	IL	3/89	P

(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 statement for each conviction including date and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.*		X
2. Do you now suffer, have you suffered from, been diagnosed as having, or been treated for any disease or condition which is generally regarded by the medical community as chronic, 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
5. Are you a U.S. citizen **OR** a lawfully admitted alien of the United States?	X	

n/a **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. n/a

TEST CODES: [ ] [ ] [ ] [ ] [ ] [ ]

b) CHART III - Select the examination site you desire and enter Test Center Code. n/a

TEST CENTER CODE: [ ]

c) CHART IV - Find your School of Graduation and enter school code. n/a

SCHOOL CODE: [ ]

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

EXAM ATTEMPTS: 0 1

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

PART VIII: 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] D. — Signature of Applicant

7/17/90 — Date

AUG 07 '90

PRINTED BY THE AUTHORITY OF THE STATE OF ILLINOIS
[illegible] 02846

LARRY FAINES, M.D.

0091327009 8

RECEIVED
STATE OF ILLINOIS
AUG 13 1990
DEPARTMENT OF
PROFESSIONAL REGULATION

August 8, 1990

Illinois Department of
Professional Regulation
P. O. Box 7007
Springfield, Illinois 62791

Re: Larry Faines, M.D.

On or about July 30, 1990, I submitted an application to your office for a Physician's License through "Acceptance of Examination". In my application packet, I inadvertantly forgot to include a copy of my medical school diploma.

Please find a copy of my medical school diploma attached, and include it with the previously submitted materials. If you have any questions, please do not hesitate to contact me at the number or address listed above. Thank you for your attention to this matter.

Sincerely,

Larry Faines, M.D.

AUG 13 1990

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

WORK HISTORY

SUPPORTING DOCUMENT

WH

APPLICANT: *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. If never employed, complete Items 1 through 6 as instructed and print N/A in the first box titled "Description of Duties Performed." You are authorized to photocopy this form if additional space is required.*

1. NAME LAST FIRST MIDDLE: FAINES, LARRY
2. DATE OF BIRTH: [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 license application.
   Profession Name: Physician / Surgeon — Profession Code: 036
6. MAIDEN OR GIVEN SURNAME: n/A — DATE FORM COMPLETED: 7/16/90

II. RECORD WORK HISTORY CHRONOLOGICALLY – BEGIN WITH PRESENT EMPLOYMENT

A. NAME OF BUSINESS/INSTITUTION: COOK COUNTY HOSPITAL

JOB TITLE: RESIDENT Physician – EMERGENCY MED.

ADDRESS STREET, CITY, STATE, ZIP CODE: 1835 W. HARRISON, Chicago, IL 60612

SUPERVISOR NAME: CONSTANCE S. GREENE, M.D.

DATES OF EMPLOYMENT/ATTENDANCE: From 07/01/89 (Month/Day/Year) To __/__/__

TOTAL TIME WORKED (Yr./Mo.): 1yr. 1mo.

HOURS WORKED PER WEEK: 60+

TYPE OF EMPLOYMENT: [✓] Full-time [ ] Part-time

DESCRIPTION OF DUTIES PERFORMED: CURRENTLY SERVING AS A PGY-III Resident in a four Year (incl. Transition yr.) EMERGENCY MEDICINE TRAINING PROGRAM.

B. NAME OF BUSINESS/INSTITUTION: MACNEAL HOSPITAL

JOB TITLE: RESIDENT Physician – TRANSITIONAL

ADDRESS STREET, CITY, STATE, ZIP CODE: 3249 S. Oak Park Avenue, BERWYN, IL 60402

SUPERVISOR NAME: ELIZABETH B. FRYE, MD

DATES OF EMPLOYMENT/ATTENDANCE: From 06/27/88 To 06/30/89

TOTAL TIME WORKED (Yr./Mo.): 12 mo

HOURS WORKED PER WEEK: 70+

TYPE OF EMPLOYMENT: [✓] Full-time [ ] Part-time

DESCRIPTION OF DUTIES PERFORMED: COMPLETED PGY-I TRANSITIONAL YEAR AS PART OF RESIDENCY TRAINING.

C. NAME OF BUSINESS/INSTITUTION:

JOB TITLE:

ADDRESS STREET, CITY, STATE, ZIP CODE:

SUPERVISOR NAME:

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

TOTAL TIME WORKED (Yr./Mo.):

HOURS WORKED PER WEEK:

TYPE OF EMPLOYMENT: [ ] Full-time [ ] Part-time

DESCRIPTION OF DUTIES PERFORMED:

IL486-1071 1/89 (LT-A)

Complete the Reverse Side of this Form

D. NAME OF BUSINESS/INSTITUTION		JOB TITLE
ADDRESS — STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME		
DATES OF EMPLOYMENT/ ATTENDANCE	TOTAL TIME WORKED (Yr./Mo.)	
From ___ / ___ / ___ Month Day Year	HOURS WORKED PER WEEK	
To ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT [ ] Full-time [ ] Part-time	

E. NAME OF BUSINESS/INSTITUTION		JOB TITLE
ADDRESS — STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME		
DATES OF EMPLOYMENT/ ATTENDANCE	TOTAL TIME WORKED (Yr./Mo.)	
From ___ / ___ / ___ Month Day Year	HOURS WORKED PER WEEK	
To ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT [ ] Full-time [ ] Part-time	

F. NAME OF BUSINESS/INSTITUTION		JOB TITLE
ADDRESS — STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME		
DATES OF EMPLOYMENT/ ATTENDANCE	TOTAL TIME WORKED (Yr./Mo.)	
From ___ / ___ / ___ Month Day Year	HOURS WORKED PER WEEK	
To ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT [ ] Full-time [ ] Part-time	

G. NAME OF BUSINESS/INSTITUTION		JOB TITLE
ADDRESS — STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME		
DATES OF EMPLOYMENT/ ATTENDANCE	TOTAL TIME WORKED (Yr./Mo.)	
From ___ / ___ / ___ Month Day Year	HOURS WORKED PER WEEK	
To ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT [ ] Full-time [ ] Part-time	

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

CERTIFICATION OF TRAINING

SUPPORTING DOCUMENT

TN

APPLICANT: *Complete the applicant section of this form. Forward the form to the individual who will certify your training. Return the completed form with your Application for Licensure/Examination.*

1. NAME LAST FIRST MIDDLE: FAINES, LARRY
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.
   Profession Name: PHYSICIAN / SURGEON — Profession Code: 0 3 6
6. MAIDEN OR GIVEN SURNAME: n/A
7. DATES OF TRAINING: FROM __ / __ / __ TO __ / __ / __ (Month Day Year)
8. ILLINOIS TEMPORARY CERTIFICATE OF REGISTRATION NUMBER (If Applicable): 125-022116 — ISSUANCE DATE (If Applicable): 07/01/89
9. SPECIFIC NAME OF TRAINING RECEIVED: EMERGENCY MEDICINE
10. SUPERVISOR/INSTRUCTOR NAME:

CERTIFYING OFFICIAL: *Complete the remainder of this form. Return the completed form to the applicant.*

A. SUPERVISOR/INSTRUCTOR NAME: Russell M. Petrak, M.D.
B. INSTITUTION/BUSINESS NAME: MacNeal Hospital
C. SUPERVISOR/INSTRUCTOR JOB TITLE/PROFESSION NAME: Academic Director Internal Medicine
D. INSTITUTION/BUSINESS STREET ADDRESS: 3249 S. Oak Park Avenue
E. SUPERVISOR/INSTRUCTOR LICENSE OR CERTIFICATE NUMBER: 036-063-551
F. INSTITUTION/BUSINESS CITY, STATE, ZIP CODE: Berwyn, Illinois 60402
G. SUPERVISOR/INSTRUCTOR STATE OF LICENSURE OR CERTIFYING ASSOCIATION NAME: Illinois — OK
H. INSTITUTION/BUSINESS TELEPHONE NUMBER: AREA CODE (708) 795-3400
I. APPLICANT'S TRAINING DATES: FROM 06 / 27 / 88 TO 06 / 30 / 89 (Month Day Year)
J. TRAINING CLOCK HOURS APPLICANT COMPLETED:
K. SPECIALIZATION NAME IN WHICH APPLICANT TRAINED: Transitional
L. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE? [X] Yes [ ] No
M. IF TRAINING WAS OBTAINED OUTSIDE OF AN INSTITUTIONAL FACILITY, INDICATE THE SETTING (S) IN WHICH TRAINING WAS OBTAINED.

N. RECORD ANY ADDITIONAL COMMENTS YOU WISH TO MAKE REGARDING THE APPLICANT'S TRAINING.

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

Russell M. Petrak, M.D.
Print Name of School Official

Signature of School Official

Academic Director Internal Medicine
Title

5-24-90
Date

INSTITUTION SEAL OR NOTARY SEAL

NOTE: If the institution does not have a seal, this form must be notarized.

Subscribed and sworn before me this ______ day of ______________________, 19 ____

Date of Expiration

Signature of Notary Public

RETURN THIS FORM TO APPLICANT

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

CERTIFICATION OF TRAINING

09 13 70098

SUPPORTING DOCUMENT

TN

APPLICANT: *Complete the applicant section of this form. Forward the form to the individual who will certify your training. Return the completed form with your Application for Licensure/Examination.*

1. NAME (LAST, FIRST, MIDDLE): FAINES, LARRY	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.
6. MAIDEN OR GIVEN SURNAME: n/A	Profession Name: PHYSICIAN / SURGEON — Profession Code: 036
7. DATES OF TRAINING: FROM 07, 01, 89 TO 06, 30, 90 (Month Day Year)	8. ILLINOIS TEMPORARY CERTIFICATE OF REGISTRATION NUMBER (If Applicable): 125-022116 — ISSUANCE DATE (If Applicable): 07/01/89
9. SPECIFIC NAME OF TRAINING RECEIVED: EMERGENCY MEDICINE	10. SUPERVISOR/INSTRUCTOR NAME: CONSTANCE GREENE, MD

CERTIFYING OFFICIAL: *Complete the remainder of this form. Return the completed form to the applicant.*

A. SUPERVISOR/INSTRUCTOR NAME (OR): Constance S. Greene	B. INSTITUTION/BUSINESS NAME: COOK County HOSPITAL
C. SUPERVISOR/INSTRUCTOR JOB TITLE/PROFESSION NAME: Residency Director / Medicine	D. INSTITUTION/BUSINESS STREET ADDRESS: 1900 W Polk Street
E. SUPERVISOR/INSTRUCTOR LICENSE OR CERTIFICATE NUMBER: 036-059850	F. INSTITUTION/BUSINESS CITY, STATE, ZIP CODE: Chicago IL 60612
G. SUPERVISOR/INSTRUCTOR STATE OF LICENSURE OR CERTIFYING ASSOCIATION NAME: ILLINOIS	H. INSTITUTION/BUSINESS TELEPHONE NUMBER: AREA CODE (312) 633-3226
I. APPLICANT'S TRAINING DATES: FROM 07, 01, 89 TO 06, 30, 90 (Month Day Year)	J. TRAINING CLOCK HOURS APPLICANT COMPLETED: 2,920
K. SPECIALIZATION NAME IN WHICH APPLICANT TRAINED: Emergency Medicine	L. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE? [ ] Yes [X] No not until 1992

M. IF TRAINING WAS OBTAINED OUTSIDE OF AN INSTITUTIONAL FACILITY, INDICATE THE SETTING (S) IN WHICH TRAINING WAS OBTAINED.

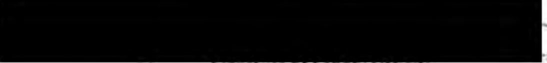
IL486-1341 1/89 (LT-A)

Complete the Reverse Side of this Form

N. RECORD ANY ADDITIONAL COMMENTS YOU WISH TO MAKE REGARDING THE APPLICANT'S TRAINING.

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

Cook County Hospital
Print Name of School Official


Signature of School Official

Associate Medical Director
Title

7/27/90
Date

INSTITUTION SEAL OR NOTARY SEAL

NOTE: If the institution does not have a seal, this form must be notarized.

Subscribed and sworn before me this ______ day of ____________________, 19 ____

Date of Expiration

Signature of Notary Public

RETURN THIS FORM TO APPLICANT

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Larry Faines, M.D.

0 0 9 1 3 2 7 0 0 9 8

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest L. THOMPSON BOWLES, M.D., Ph.D.
Chairman of the Board

SEAL ROBERT L. VOLLE, Ph.D.
President of the Board

Philadelphia, Pa
07/31/89

Certificate # 300717

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above who graduated from UMDNJ-NEW JERSEY MED SCH in MAY 1988 and whose birth date is 01/23/1959. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/86		
Anatomy	400	75
Physiology	455	75
Biochemistry	500	80
Pathology	450	76
Microbiology	545	83
Pharmacology	490	80
Behavioral Sciences	375	75
TOTAL TEST (Minimum Passing Score 380/75)	470	79
PART II passed 09/87		
Medicine	415	76
Surgery	465	81
Obstetrics and Gynecology	395	77
Public Health and Preventive Medicine	380	76
Pediatrics	295	72
Psychiatry	525	83
TOTAL TEST (Minimum Passing Score 290/75)	395	78
PART III passed 03/89		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	345	75
GENERAL AVERAGE (Parts, I, II, and III Scale Score)	77	

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Secretary for Certification

SEAL

07/30/90
Date

AMHERST COLLEGE Amherst, Massachusetts 01002

STUDENT TRANSCRIPT

Larry Faines

Birthdate [redacted] Class 1982 ~~1981~~

Degree Bachelor of Arts

Date Awarded May 30, 1982 Major Psychology

Parent or Guardian Mr. Clarence Faines, Jr.

0 0 9 1 3 2 7 0 0 9 3

Entered September 9, 1977 from: West Side High School, Newark, New Jersey

Course No. and Title		Grade
	1977 Fall	
Biol 23	Ecology	
BlkSt 47	Sociology African Family	
Engl 11	Intro English: Reading	
FrSem 5	Blacks and Women	
	1978 Spring	
Math 11	Introductory Calculus	
Relig 34	Religion in America	
Hampshire Coll.: HA 150 - Still Photography Workshop		
Univ. of Mass.: Chem 110 - General Chemistry		
	1978 Fall	
Chem 11	Introductory Chemistry	
Phil 13	Introduction to Logic	
Smith Coll.: Biol 100 - Principles of Biological Science		
Univ. of Mass.: Engl 150 - Expository Writing		
12/21/78: Academic Dismissal		
2/2/81: Returned to college		
Credit granted for work as follows:		
Glassboro State College		
1979 Summer		
Inorganic Chem I		
Struct/Funct Body II		
Inorganic Chem II		
(Equivalent to three full courses)		

Course No. and Title		Grade
Seton Hall University		
1979 Fall		
Ch 031	Organic Chemistry I	
1980 Spring		
Ch 032	Organic Chemistry II	
Cl 208	Scientific Terminology	
So 091	Principles of Sociology	
Py 072	General Physics II	
Py 078	Physics Laboratory II	
1980 Fall		
Ps 001	Introduction to Psychology	
Cl 214	Mythology of Greece & Rome	
Bl 286	Psych Testing & the Bl Chld	
Bl 296	Mass Media & Minorities	
(Equivalent to eight full courses)		
	1981 Spring	
Biol 22	Developmental Biology	
Psych 12	Psych as Natural Science	
Psych 40	Sex Role Socialization	
Mount Holyoke: Art 346 - Advanced Sculpture		
	1981 Fall	
PolSc 21	American Government	
Psych 22	Stat & Exper Design	
Psych 26	Physiological Psychology	
Psych 27	Developmental Psychology	

See page 2 for continuation of Record

This record without an authorized signature and imprint of the College Seal is only a statement of the student's progress to date and is not an official transcript.

[redacted] Validating Signature

SEP 12 1990 Date

Year	1977	1978	1978			1981	1981	1982		
Semester	Fall	Spring	Fall	Spring	Fall	Spring	Fall	Spring		
Semester Courses										
Semester Average										
Transferred Courses										
Cumulative Courses										
Cumulative Average										

Number of Physical Education Courses Completed

See attached Transcript Regulations for explanation of grades and course credits.

Faines, Larry

*Withdrawal (Freshman Rule) -- 3/9/78

AMHERST COLLEGE Amherst, Massachusetts 01002

STUDENT TRANSCRIPT

Larry Faines

Birthdate [redacted]

Class 1982 (1981 struck through)

Degree Bachelor of Arts

Date Awarded May 30, 1982

Major Psychology

Parent or Guardian Mr. Clarence Faines, Jr.

1 3 9 1 3 2 7 0 0 9 9

Entered September 9, 1977 from: West Side High School, Newark, New Jersey

Course No. and Title		Grade		Course No. and Title	Grade	
Record continued from page 1						
	1982 Spring					
Anthr 36	Culture and Personality					
BlkSt 22	Intro to Afro-Amer Music					
Psych 29	Human Sexuality					
Psych 98	Erotic Orientation Devel					
April 1982: Comprehensive Examination in Psychology						

This record *without* an authorized signature and imprint of the College Seal is only a statement of the student's progress to date and is *not* an official transcript.

Validating Signature [redacted]

Date SEP 12 1990

Year										
Semester	Fall	Spring	Fall	Spring	Fall	Spring	Fall	Spring		
Semester Courses										
Semester Average										
Transferred Courses										
Cumulative Courses										
Cumulative Average										

Number of Physical Education Courses Completed

See attached Transcript Regulations for explanation of grades and course credits.

Faines, Larry

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY
NEW JERSEY MEDICAL SCHOOL
100 Bergen Street, Newark, New Jersey, 07103

RECEIVED STATE OF ILL... JUL 10 1990

PERMANENT RECORD

Name: Faines, Larry   Address: [redacted]

Date of birth: [redacted]   Admitted from: ______   Degree: ______

Date of matriculation: 8/27/84   M.D. degree granted: May 25, 1988   Status: Graduated

Course Title	Grade
1984-1985	
Microanatomy	[redacted]
Gross Anatomy	[redacted]
Neurosciences	[redacted]
Psychiatry	[redacted]
Preventive Medicine	[redacted]
Physiology	[redacted]
Biochemistry	[redacted]
PROMOTION COMMITTEE ACTION: Promoted	
Non-credit Elective: "1985 Student Research"	
1985-1986	
Pathology	[redacted]
Microbiology	[redacted]
Psychiatry	[redacted]
Preventive Medicine	[redacted]
Pharmacology	[redacted]
Introduction to Clinical Sciences	[redacted]
PROMOTION COMMITTEE ACTION: Promoted	
1986-1987	
Ob/Gyn	[redacted]
Pediatrics	[redacted]
Psychiatry	[redacted]
Medicine	[redacted]
Ophthalmology	[redacted]
Surgery	[redacted]
PROMOTION COMMITTEE ACTION: Promoted	

Course Title	Grade
1987-1988	
Emergency Medicine	[redacted]
Acting Intern in Medicine	[redacted]
Neurology	[redacted]
Practice of Medicine	[redacted]
Electives:	
Surgical anesthesia	[redacted]
Emergency Medicine	[redacted]
Intensive Review of Internal Medicine	[redacted]
Coronary Care Unit	[redacted]
Radiology	[redacted]

THIS IS AN OFFICIAL TRANSCRIPT OF THE STUDENT ABOVE ONLY IF IT BEARS THE SIGNATURE OF THE REGISTRAR AND IS IMPRESSED WITH THE SEAL OF THE UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY.

EXPLANATION OF GRADES (To be stamped on)   EFFECTIVE SEPTEMBER 1974 H=HONORS HP=HIGH PASS P=PASS F=FAIL

[signature redacted]
SIGNATURE OF REGISTRAR   JUL 26 1990
DATE

MARY F. MANSEY
Assistant Registrar
UMDNJ-NJMS

UMDNJ-NJM-6703
OCT., 82

University of Medicine and Dentistry of New Jersey

0091327098

New Jersey Medical School

Be it known that upon the recommendation of the Faculty and by the authority of the Board of Trustees, the University of Medicine and Dentistry of New Jersey hereby confers upon

Larry Faines

the degree of

Doctor of Medicine

with all the rights and privileges thereto.

In witness whereof we have hereunto affixed our signatures and the seal of the University in the State of New Jersey this twenty-fifth day of May, 1988.

LARRY FAINES

3 0 9 1 3 ? 7 0 0 ? 8

APPLICATION REVIEW FINDINGS	AMF 2

1. DATE: 10/2/90

3. PERSONAL HISTORY ______ (Y or N)

2. EMPLOYEE: 0305

4. STATUS: 6

5. DEFICIENCIES - ADD ______

6. LAST CORRESPONDENCE RECEIVED DATE: 2/16/90

CLEAR: 093

7. LAST CORRESPONDENCE SENT DATE: 10/2/90

8. IL APPRENTICE TRAINING LICENSE NO. ______

EDUCATION INFO:

9. School Name ______

10. School Code ______ 11. Foreign School ______ (Yes or No) 12. Date Graduated __/__/__

13. City/Country School Located ______ 14. State School Located ______

RECIPROCITY INFO:

15. Original Licensure State ______ 16. Licensure Date __/__ Month Year

17. Current Licensure State ______ 18. Licensure Date __/__ Month Year

19. No. of States Licensed in ______

ACCEPTANCE OF EXAM INFO:

20. Who Gave Exam: ______ 21. Examination Date __/__/__

22. Grades: 23. No. of Times Exam Taken ______

1. ______ 2. ______ 3. ______ 4. ______ 5. ______ 6. ______

7. ______ 8. ______ 9. ______ 10. ______ 11. ______ 12. ______

13. ______ 14. ______ 15. ______ 16. ______ 17. ______ 18. ______

MISC. INFO:

24. Related License No.:

1. ______ D __ 2. ______ D __ 3. ______ D __ 4. ______ D __

25. License Specialty Code ______ 26. Bond Insurance Expire Date __/__/__

27. Agency Manager Name ______ 28. Telephone No. ______

LICENSE ASSIGNMENT INFO:

29. Original IL License No. ______ 30. Issuance Date __/__/__

IL 486-1323 7/69 (L&T)

AMHERST COLLEGE
OFFICE OF THE REGISTRAR
AMHERST, MASSACHUSETTS 01002
TELEPHONE: 413-542-2225

0 0 9 1 3 2 7 0 0 SEPTEMBER 12, 1990

ILLINOIS DEPARTMENT OF PROFESSIONAL
REGULATION
P.O. BOX 7007
SPRINGFIELD, IL 62791

ENCLOSED IS AN OFFICIAL TRANSCRIPT OF THE ACADEMIC RECORD OF:

LARRY FAINES MD, CLASS OF '82.

THIS INFORMATION IS BEING PROVIDED AT THE REQUEST OF THE STUDENT.

GERALD M. MAGER
REGISTRAR

AMHERST COLLEGE
Amherst, Massachusetts 01002
Office of the Registrar

DISTRIBUTION OF STUDENT CUMULATIVE AVERAGES
Combined 1979-80, 1980-81, and 1981-82 Data

To assist the interpretation of current Amherst College transcripts, listed below are the proportions of different classes obtaining certain averages. Details of the Amherst College grading system are described in the Catalog and in the transcript guide. The present marking system was introduced beginning with the academic year 1967-68. Please do not use this table for classes prior to 1980.

	PERCENTAGES				
Cumulative Average	SENIORS Classes of 1980,1981,1982 N = 1059	JUNIORS Classes of 1981,1982,1983 N = 1043	SOPHOMORES Classes of 1982,1983,1984 N = 1164	FRESHMEN Classes of 1983,1984,1985 N = 1196	TOTAL N = 4462
14 (A+)					
13 (A)	3%	2%	2%	3%	2%
12 (A-)	21%	18%	16%	15%	17%
11 (B+)	39%	35%	33%	30%	34%
10 (B)	23%	26%	28%	30%	27%
9 (B-)	10%	13%	13%	15%	13%
8 (C+)	3%	5%	5%	5%	5%
7 (C)	1%	1%	2%	2%	2%
6 (C-)	*	*	1%	*	*
5			*	*	*
4 (D)				*	*
3				-	-
2				*	*
1 (F)					
	100%	100%	100%	100%	100%

*Less than ½ of one per cent.

FIVE-COLLEGE INTERCHANGE COURSE GRADES

Beginning with 1976-77, the following conversion values are those being used for the inclusion of grades from Five-College interchange courses in Amherst College student averages. (The Five-College grades are recorded on the transcript as given by the institution offering the course.)

VALUE FOR AMHERST AVERAGE	HAMPSHIRE COLLEGE	MOUNT HOLYOKE COLLEGE	SMITH COLLEGE	UNIVERSITY OF MASSACHUSETTS
14	A+		A+	
13	A	A, 4	A	A
12	A-		A-	
11	B+	AB	B+	AB
10	B	B, 3	B	B
9	B-		B-	
8	C+	BC	C+	BC
7	C	C, 2	C	C
6	C-		C-	
5	D+	CD	D+	CD
4	D	D, 1	D	D
3	D-		D-	
2				
1	Fail	F, NP	E (F)	F
Pass**	Pass**	Pass**	Pass**	Pass**

**Does not affect average.

Registrar's Office
GMM 7/12/82

TRANSCRIPT GUIDE

AMHERST COLLEGE, AMHERST, MASSACHUSETTS 01002

Release Of Information

In accordance with the Family Educational Rights and Privacy Act of 1974, the attached information is released to you with the condition that it will not be made available to any other party without the written consent of the student.

Student records are confidential and information is released only at the request of the student. Partial transcripts are not issued; each transcript must include the student's complete record at Amherst College to date. An official transcript carries an authorized signature as well as the embossed Amherst College seal. (If a transcript is given to a student, it will contain a notation to that effect.)

Grading System

	Honor Grades						Pass Grades				Fail
Course Grades	A+	A	A-	B+	B	B-	C+	C	C-	D	F
Conversion Values	14	13	12	11	10	9	8	7	6	4	1

Semester and cumulative averages are calculated on a 14-point scale rounded to the nearest whole number or are given in comparable letters, plus and minus. A grade of PASS is not included in the student's average, although a FAILURE (F) is treated as any other grade.

A cumulative average of 12 (A−) is the usual level for eligibility for graduation *summa cum laude*; an average of 11 (B+) for *magna cum laude*; an average of 9 (B−) for *cum laude*; and an average of 6 (C−) for graduation with the Bachelor of Arts degree, *rite*. The reporting of specific rank in class has been discontinued. (A distribution of averages for the several classes accompanies each transcript.)

Abbreviations: N = Grade not yet available and W = Withdrew with permission. Neither course credit nor a grade is given for Physical Education, although completion of such activities is noted.

Five College Program

In the Five College Cooperative Program, courses may be taken at Hampshire College, Mount Holyoke College, Smith College and the University of Massachusetts and are given full credit. Grades and credit in these courses are included in a student's transcript, and an explanation of the grade conversion values is attached. (The official transcript for all Five College courses is maintained at the *student's home institution.*) Grades for courses that were transferred from institutions other than the Five Colleges are not recorded; credit only is listed on the transcript.

Credit

In 1966-67, a curriculum was introduced which requires all students to carry 4 full courses each semester with 32 courses normally required for graduation. Students may elect an additional half course in a semester, but require special permission to elect more than 4 and one-half courses.

The Freshman Rule enables a freshman to withdraw from a course before the eighth week of either his first or second semester. No prejudice is attached to such a withdrawal, and the student may graduate with 31 courses. Furthermore, a student who has failed a course in the freshman or sophomore year may graduate having satisfactorily completed only 31 courses.

All courses unless indexed with D for Double or H for Half are full courses. Full courses are equivalent to 4 semester-hours credit each; half courses (H) to 2 semester-hours credit; and double courses (D) in the Senior Honors Program are equivalent to 8 semester-hours credit.

Course Numbering

Senior Honors courses, usually open only to candidates for the degree with honors, are numbered 77 and 78, and special topics reading courses are numbered 97 and 98. Odd-numbered courses are offered in the first semester unless followed by the designation "S" (Second), and even-numbered courses are offered in the second semester unless followed by the designation "F" (First).

Status Of Student

Good Standing signifies that the student is eligible to continue, return, or transfer. It implies satisfactory academic standing and citizenship. *The student is in good standing unless otherwise indicated on the transcript.* Suspension or dismissal for academic or disciplinary cause will be shown on the transcript.

OFFICE OF THE REGISTRAR 9-80-RN

Profession 036

Date 8-16-90

Initial AB

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786

NOTICE CONCERNING YOUR APPLICATION WITH THE DEPARTMENT

9091327009 8

TO:

YOUR APPLICATION CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES.
MAKE THE CORRECTIONS OR ADDITIONS MARKED BELOW AND RESUBMIT.
PLEASE RETURN THIS FORM WITH THE REQUESTED MATERIALS.

1. Submit the required fee of $ ______ made payable to the Department of Professional Regulation. This fee is not refundable.
2. Your application is illegible. Please type or print all information on the enclosed application and submit it.
3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: ______ to ______
4. The enclosed documents 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) and is not related to you by blood or marriage.
5. The enclosed application must be completed in the areas circled below:
   PART I — 1 2 3 4
   PART II — 1 2 3 4 5 6 7 8 9 10
   PART III — 1 2 3 4 5 6 7
   PART IV
   PART V
   PART VI — 1 2 3 4 5 6 7 8 9 10
   PART VII — a b c d
   PART VIII
6. The application you completed is obsolete, you must complete the enclosed revised application and submit it to this Department.
7. Submit ( ) 1 ( ) 2 recent photograph(s), no larger than 2½ by 2½ inches.
8. Sign form(s) where indicated.
9. Signature(s) must be witnessed by a notary public where indicated.
10. ✓ Submit proof of Pre-medical education or its equivalent. (# 12)
11. School seal must be affixed to form. (If school does not have a seal, form must be notarized.)
12. ✓ Submit an official transcript bearing the school seal of ~~[illegible]~~ Amherst or Rutgers Univ from ______ at dates of attendance
13. Submit completed college certification form. (Supporting Document ______.)
14. Submit certification of original/current licensure (Supporting Document ______.)
15. Submit certification of licensure from each state in which you are or have ever been licensed.
16. Submit verification of out-of-state examination. (Supporting Document ______.)
17. Please have your ______ scores forwarded directly from ______
18. Please submit a list of your work experience from ______ to present. (Indicate N/A on form if not applicable.) (Supporting Document ______.)
19. Submit ______ reference(s). (Supporting Document ______.) The following reference form(s) have been received:
20. Submit a certificate of health verified by your physician. (Supporting Document ______.)
21. Submit completed supporting document ______
22. Submit certification of ______
23. Submit proof of successful completion of ______
24. The information on your application does not concur with the information provided on ______ by ______. Please advise.
25. When your application is complete the ______ will review your qualifications.
26. Submit evidence of retraining after ______ failures on the examination.
27. Submit evidence of ______ hours of continuing education.
28. Submit restoration questionnaire. (Supporting Document ______.)
29. Submit copy of DD214 if restoring after military service.
30. Submit Request for Waiver of Continuing Education. (Supporting Document ______.)
31. Submit your mini application for licensure.
32. Records of the Department indicate you previously submitted the required licensure fee. Therefore, we are returning your recent remittance.
33. A copy of your assumed name certificate which may be obtained from the Office of the County Clerk.
34.

Other Instructions: Forwarding address should include "12 Hudson Court"

IL486-1385 11/87 (LT)

Application No. 036 147-52-0309
Prof. Code SSN/FEIN

L FAINES

or Label Space 0 0 9 1 3 2 7 0 0 9 8

APPLICATION REVIEW FINDINGS

AMF 2

1. DATE: 02/26/90
2. EMPLOYEE: 0305 AB
3. PERSONAL HISTORY N (Y or N)
4. STATUS: /
5. DEFICIENCIES - ADD: 093
CLEAR:
6. LAST CORRESPONDENCE RECEIVED DATE: 02/12/90
7. LAST CORRESPONDENCE SENT DATE: 02/26/90
8. IL APPRENTICE TRAINING LICENSE NO.:

EDUCATION INFO:

9. School Name Univ of Medicine & Dentistry of New Jersey
10. School Code
11. Foreign School No (Yes or No)
12. Date Graduated 05/25/88
13. City/Country School Located Newark
14. State School Located NJ

RECIPROCITY INFO:

15. Original Licensure State
16. Licensure Date Month / Year
17. Current Licensure State
18. Licensure Date Month / Year
19. No. of States Licensed in

ACCEPTANCE OF EXAM INFO:

20. Who Gave Exam:
21. Examination Date / /
22. Grades:
23. No. of Times Exam Taken

1. 2. 3. 4. 5. 6.
7. 8. 9. 10. 11. 12.
13. 14. 15. 16. 17. 18.

MISC. INFO:

24. Related License No.:
1. D 2. D 3. D 4. D
25. License Specialty Code
26. Bond Insurance Expire Date / /
27. Agency Manager Name
28. Telephone No.

LICENSE ASSIGNMENT INFO:

29. Original IL License No.
30. Issuance Date / /

IL486-1323 7/89 (L&T)

American Heart Association. Fighting Heart Disease and Stroke

scientific sessions 2002

CME Credit Statement

CME Credit Statement Is for Registrant's Record

American Heart Association CME Validation

The American Heart Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education activities for physicians.

LARRY FAINES MD

Attended Scientific Sessions 2002, November 17 - 20, 2002, in Chicago, Illinois.

The American Heart Association designates this continuing medical education activity for up to 42.75 hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Diane Porter
Director, Professional Education Operation

	Sunday Nov. 17, 2002	Monday Nov. 18, 2002	Tuesday Nov. 19, 2002	Wednesday Nov. 20, 2002
7:00				
8:00				
9:00	Sunday Morning Programs 9:00 - 12:00	Scientific Sessions 8:30 - 1:00	Scientific Sessions 8:30 - 1:00	Scientific Sessions 8:30 - 1:00
10:00				
11:00				
12:00				
1:00		Ask Expert & How-To 12:30 - 1:30	Ask Expert & How-To 12:30 - 1:30	Ask Expert & How-To 12:30 - 1:30
2:00	Opening Session 1:15 - 3:15	Scientific Sessions 1:00 - 6:00	Scientific Sessions 1:00 - 6:00	Scientific Sessions 2:00 - 5:00
3:00	Scientific Sessions 3:00 - 6:00			
4:00				
5:00				
6:00	Cardiovascular Seminars 5:30 - 7:00	Cardiovascular Seminars 5:30 - 7:00		
7:00				

Sunday	Monday	Tuesday	Wednesday	Scientific Sessions 2002
Up to 11.25 hrs. may be claimed +	Up to 13.75 hrs. may be claimed +	Up to 9.5 hrs. may be claimed +	Up to 8.25 hrs. may be claimed =	Grand Total
11.25	13.75	9.5	8.25	42.75 hr

Indicate hours claimed above. This copy is your official record of attendance. Please retain for your records. We recommend that you save the entire Scientific Sessions 2002 Final Program for your records should information be requested from you. Reporting is done on an honor basis.

AMA PRA CATEGORY 1 CERTIFICATE

AMERICAN MEDICAL SEMINARS CERTIFIES THAT

Larry Faines, M.D.

HAS PARTICIPATED IN THE EDUCATIONAL ACTIVITY TITLED

EMERGENCY MEDICINE: A PRACTICAL APPROACH TO COMMON PROBLEMS

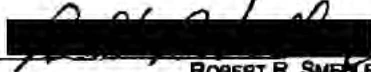
AT CHICAGO, ILLINOIS ON NOVEMBER 25, 2002 AND IS AWARDED 25 HOURS OF CATEGORY 1 CREDIT TOWARD THE PHYSICIAN'S RECOGNITION AWARD.

AMERICAN MEDICAL SEMINARS

D. REECE PIERCE
President and Director of CME

1000 Boulevard of the Arts • Sarasota • Florida • 34236
1-866-ams-4cme • FAX 941-365-7073 • www.ams4cme.com

TEMPLE
UNIVERSITY
SCHOOL OF MEDICINE



ROBERT R. SMEDLEY, ED.D.
Associate Dean for CME
Temple University School of Medicine

3400 North Broad Street, Philadelphia, Pennsylvania 19140

CERTIFICATE NUMBER: T24682

Continuing Medical Education Compliance
For Illinois Department of Professional Regulation

Name:	**Larry Faines, MD**
IL license #:	036081591
Employment:	Northwestern University / Northwestern Medical Faculty Foundation Department of Medicine Division of Emergency Medicine
Full Time Position:	July 1, 1993 - present Assistant Professor Clinical Attending Physician Emergency Medicine Northwestern Memorial Hospital

As a full time faculty member and clinical instructor of Emergency Medicine at Northwestern University Medical School and Northwestern Memorial Hospital, I am constantly providing and participating in Continuing Medical Education associated with the practice of Emergency Medicine.

I provide over 1400 hours annually of clinical instruction to residents and students who rotate through Northwestern Memorial Hospital's emergency department. Approximately 80% of these hours would qualify as Category 2 Continuing Medical Education hours.

In addition to the clinical instruction noted above, I also as a faculty member of the NU Department of Emergency Medicine provide and participate in academic teaching each year. Outlined below are examples of activities that would qualify as Category I Continuing Medical Education activities since my last license renewal in July, 1999:

1) Participate in Board Certification Examination Preparation for residents through the "Mock Oral Board Examinations" at Cook County Hospital; Department of Emergency Medicine (16 hours/year for 2 years = 32 hours in 2000 and 2001)
2) Prepare content examinations for Emergency Medicine Residents (20 hours in 2001)
3) Participate in NUMS Emergency Medicine department sponsored journal club activities (6 hours per year=18-20 hours)
4) Prepared and presented lecture on Acute Ischemic Coronary Syndrome to residents of Emergency Medicine; Fall 1999. (25 hours)

Signed ______________________ Dated 11/5/02

Verified by ______________________ Dated 11/5/02

James Adams, MD
Medical Director
Division of Emergency Medicine
Northwestern University Medical School