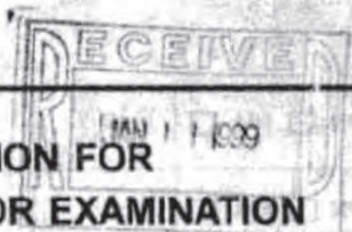
PAGE ONE



IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

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

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

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

A. Type or print legibly with black ink only.
B. The licensure and application fee are NOT refundable.
C. Disclosure of your U.S. social security number, if you have one, is mandatory. This disclosure is mandated by 5 Illinois Compiled Statutes 100/10-65. The social security number will be provided to the Department of Public Aid to assist in the identification of persons who are more than 30 days delinquent in complying with a child support order.
D. If the name shown on your supporting documents is different from that shown on your application, you must submit proof of legal name change - copy of marriage license, divorce decree, affidavit or court order.

PART I: Application Category Information

A. SEE REFERENCE SHEET, CHART I, 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	$ 435 65

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

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

PAID 435.65 MK 1-11-99

PART II: Applicant Identifying Information - You must notify the Department of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
GODFREY	EMILY	M	MD	[redacted]

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

[redacted]

COUNTY

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

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

[redacted]

10.

Wo

(Area Code) (Area Code)

IL486-1019 7/98 (LT)

PART III: Education Information

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

1 2 3 4 5 6 7 8 9 10 11 (12) — Graduated High School? ☒ Yes ☐ No — 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)
NEW TRIER HIGH SCHOOL	WINNETKA, IL	06 / 86

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
UNIV OF WISCONSIN - MADISON	MADISON, WI	9/87	12/91	BS
MEDICAL COLLEGE OF WISCONSIN	MILWAUKEE, WI	8/92	5/97	MD
COLORADO COLLEGE	COLORADO SPRINGS CO	8/86	6/87	None

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?
WEST SUBURBAN FAMILY PRACTICE RESIDENCY	RIVER FOREST, IL	6/97	PRES	☐ 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, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure Illinois	PHYSICIAN	125-035716	6/19/97	Active
State of Current Licensure where you most recently have been practicing:				
Other States of Licensure				
none				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
USMLE Step I	WI	06/95	PASSED
USMLE STEP II	WI	03/97	PASSED

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

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

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

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

a) CHART II - Select examination(s) you desire and enter Test Codes. 01

b) CHART III - Select the examination site you desire and enter Test Center Code: 3605

c) CHART IV - Find your School of Graduation and enter school code: N/A

d) Record the number of times you have taken this exam in Illinois or any other state: 00

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

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

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

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

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

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

☒ I am not currently under any child support order.

PART IX: Certifying Statement

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

[redacted] Signature of Applicant — 12/20/98 Date

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

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statues (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center	CERTIFICATION BY LICENSING AGENCY / BOARD	SUPPORTING DOCUMENT **CT**

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1. NAME LAST / FIRST / MIDDLE: GODFREY EMILY MARIA
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.
   PHYSICIAN (Profession Name) 0 3 6 (Profession Code)
6. MAIDEN OR GIVEN SURNAME
7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code ([redacted]

8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable): MEDICAL TEMPORARY
8b. LICENSE NUMBER (If applicable): 125-035716
8c. ISSUANCE DATE OF LICENSE (If applicable): 06/19/97

I hereby authorize STATE OF ILLINOIS PROFESSIONAL REGULATION (Name of Licensing Agency or Board) to furnish to the Illinois Department of Professional Regulation or its designated testing service, the information requested below.

Signature [redacted] Date 12/20/98

DO NOT RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS

A. The applicant ☐ has written ☐ is scheduled to write the following examination:

______ Name of Examination ______ Date of Examination

B. The applicant has or will have written the above-named examination _______ number of times.

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE	B. LICENSE NUMBER
C. ISSUANCE DATE OF LICENSE	D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD

- ☐ Examination (Administered in Your State)
  - ☐ National (Name) ______
  - ☐ State Constructed ______
  - ☐ Other (Name) ______
- ☐ Endorsement of License (State) ______
  Acceptance of Examination Results (Administered in Another State) ______
- ☐ Reciprocity with (State) ______
- ☐ Waiver/Grandfather
- ☐ Credentials
- ☐ Other (Describe) ______

F. CURRENT LICENSURE STATUS

- ☐ Active
- ☐ Inactive
- ☐ Lapsed
- ☐ Other (Explain) ______

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination	Score
Written	
Practical	
Other (Describe) ______	

Received no Grade Below ______

Examination Period _____ days _____ hours

IL486-0850 10/96 (LT-Front)

COMPLETE THE REVERSE SIDE OF THIS FORM

1-11-99

RECEIVED FEB 1 1999 SUPPORTING DOCUMENT TN-MED

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

(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: GODFREY FIRST: EMILY MIDDLE: MARIA
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: PHYSICIAN Profession Code: 0 3 6
6. MAIDEN OR GIVEN SURNAME:
7. ILLINOIS TEMPORARY LICENSE NUMBER (if applicable): 125-035716
8. ISSUANCE DATE: 06/19/97

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 12 months of postgraduate clinical training in West Suburban Family Practice Residency
(Name of Accredited Postgraduate Clinical Training Program)

from 07/01/97 to 06/30/98 at the following hospital:

Hospital: West Suburban Hospital Medical Center
Number and Street: 1 Erie Court
City, State and Zip Code: Oak Park IL 60302

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: Katherine A. Walsh, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: [redacted]

SEAL

Telephone No: [redacted]

IL486-1535 4/96 (MD)

testing

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

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: GODFREY FIRST: EMILY MIDDLE: MARIA
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.
   Profession Name: Physician Profession Code: 036
6. MAIDEN OR GIVEN SURNAME: —
7. ILLINOIS TEMPORARY LICENSE NUMBER (if applicable): 125-035716
8. ISSUANCE DATE: 06-19-97

RECEIVED AUG 17 1999 Licensing Unit

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR:
Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 62791

This is to certify that the above-named applicant satisfactorily completed 24 months of postgraduate clinical training in West Suburban Family Practice Residency Program
(Name of Accredited Postgraduate Clinical Training Program)

from 7/1/97 to 6/30/99 at the following hospital:

Hospital: West Suburban Hospital Medical Center

Number and Street: 3 ERIE COURT

City, State and Zip Code: Oak Park, IL 60302

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

RECEIVED AUG 16 1999 IDPR-MEDICAL UNIT

Name of Postgraduate Clinical Training Program Director: Katherine A. Walsh, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: [redacted]

SEAL

Telephone No: [redacted]

IL486-1535 4/94 (MD)

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WORK HISTORY

SUPPORTING DOCUMENT

WH

0 0 9 9 1 5 7 ...

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: GODFREY — FIRST: EMILY — MIDDLE: MARIA
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.
   - Profession Name: PHYSICIAN
   - Profession Code: 0 3 6
6. MAIDEN OR GIVEN SURNAME:
7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐
8. DATE FORM COMPLETED: 12/20/98

9. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS / INSTITUTION: WEST SUBURBAN HOSPITAL RESIDENCY

JOB TITLE: RESIDENT PHYSICIAN

ADDRESS — STREET, CITY, STATE, ZIP CODE: 7411 W. Lake St, Suite 1100, RIVER FOREST, IL 60305

DESCRIPTION OF DUTIES PERFORMED: As described in requirements for graduation from residency.

SUPERVISOR NAME: DR. KATHIE WALSH

DATE OF EMPLOYMENT/ATTENDANCE: From 06/15/97 (Month/Day/Year) To 12/20/98 (Month/Day/Year)

HOURS WORKED PER WEEK: 80

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

TOTAL TIME WORKED (Year/Month): 18 months

A. NAME OF BUSINESS / INSTITUTION:

JOB TITLE:

ADDRESS — STREET, CITY, STATE, ZIP CODE:

DESCRIPTION OF DUTIES PERFORMED:

SUPERVISOR NAME:

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

HOURS WORKED PER WEEK:

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

TOTAL TIME WORKED (Year/Month):

IL486-1071 6/93 (LT-Front)

COMPLETE THE REVERSE SIDE OF THIS FORM

Family Practice Residency Program

An Affiliate of West Suburban Hospital Medical Center

Leading the Way to a Healthier Community

0 0 9 ...

January 29, 1999

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

To whom it may concern,

Please find attached one TN-MED form for the following West Suburban Family Practice Resident:

1. Emily Maria Godfrey, M.D.

Please call me at [redacted] if you have any questions.

Sincerely,

Wendy J. Urrutia, Program Coordinator
West Suburban Family Practice Residency Program

West Suburban Center For Primary Care

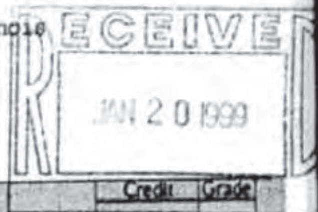
7411 W. Lake Street River Forest, Illinois 60305 (708) 488-2367 Fax (708) 763-2162

The Colorado College, Colorado Springs, Colorado

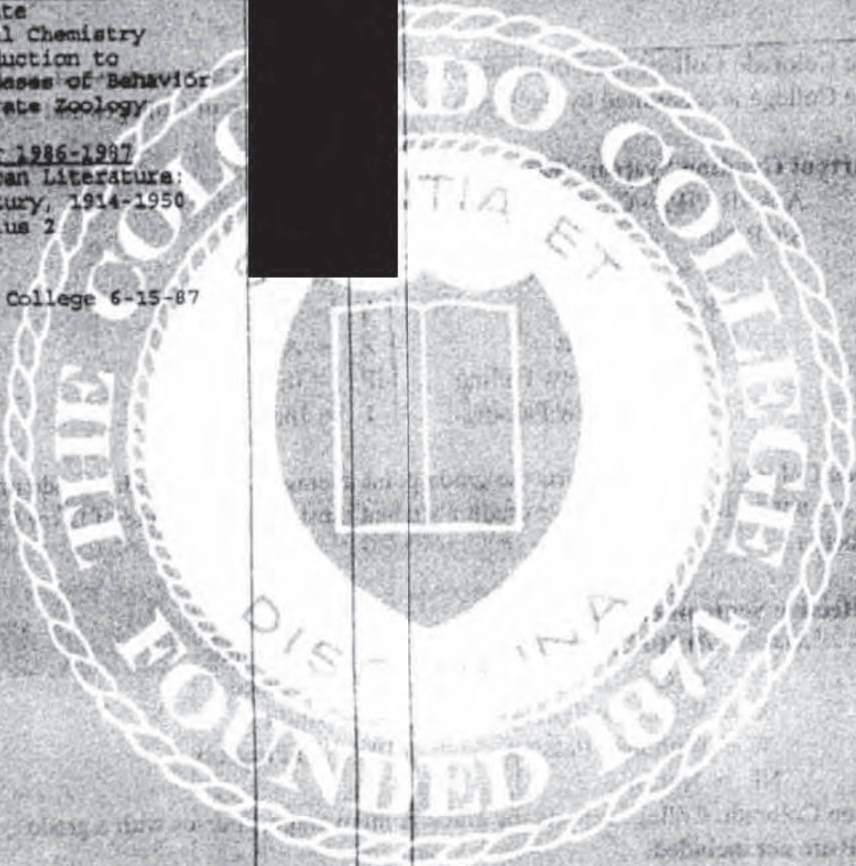
1/11/99

Godfrey, Emily Maria | Id Number: [redacted] | Entrance Date: 09-01-86

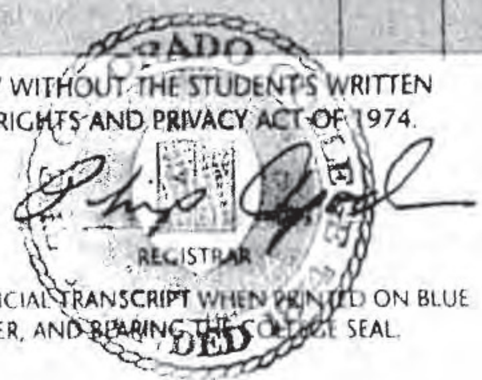
Date & Place of Birth: [redacted], Chicago, Illinois



	Credit	Grade
ADVANCED PLACEMENT		
Math Calc AB		
English Lit & Compositon		
First Semester 1986-1987		
F T 101 Watergate		
Chem 106 General Chemistry		
Psyc 100 Introduction to Psychology: Bases of Behavior		
Bio 109 Vertebrate Zoology		
Second Semester 1986-1987		
Engl 397 American Literature: The 20th Century, 1914-1950		
Math 128 Calculus 2		
Withdrew from College 6-15-87		



THIS INFORMATION IS NOT TO BE RELEASED TO A THIRD PARTY WITHOUT THE STUDENT'S WRITTEN CONSENT IN COMPLIANCE WITH THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974.



REGISTRAR

OFFICIAL TRANSCRIPT WHEN PRINTED ON BLUE PAPER, AND BEARING THE COLLEGE SEAL.

The Colorado College

Colorado Springs, Colorado

The Colorado College is an independent college of liberal arts established in 1874. The College is accredited by the North Central Association of Colleges and Schools.

Current Grading System: (Effective August 31, 1998)

A/A-/B+/B/B-/C+/C/C-/D+/D/NC
S/CR/NC

S = A through C-	NI = Not In
CR = D+/ D	Y = Excused
NC = No Credit	Z = Audit
X = Withdrew Failing	IP = In Progress
W = Withdrew Passing	I = Incomplete

When Colorado College reports the grade point average, courses with a grade of P, S or CR are not included. To receive credit a student must receive a grade of D (or CR) or better.

(Effective September 1, 1997)

A/A-/B+/B/B-/C+/C/C-/NC	I = Incomplete
P/NC	Y = Excused
X = Withdrew Failing	Z = Audit
W = Withdrew Passing	IP = In Progress
NI = Not In	

When Colorado College reports the grade point average, courses with a grade of P are not included.

Prior to September 1, 1997

A/A-/B+/B/B-/C+/C/C-/NC	I = Incomplete
P/NP	Y = Excused
X = Withdrew Failing	Z = Audit
W = Withdrew Passing	IP = In Progress
NI = Not In	

When Colorado College reports the grade point average, courses with a grade of P or NP are not included. To receive credit a student must receive a grade of C- (or P) or better.

Prior to August 31, 1988: A course credit of "one unit" is given as credit equivalent to 3.5 semester hours or 5.25 quarter hours.

Current Course Credit System: A course credit of "one unit" is given as a credit equivalent to 4.0 semester hours or 6.0 quarter hours.

- * Indicates courses in the Minor
- ** Indicates courses for the Liberal Arts & Sciences Major
- Ed. Indicates courses in the Teacher Education Program.

The Federation of State Medical Boards
of the United States, Inc.
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Telephone: (817) 571-2949
FAX (817) 868-4098

February 11, 1999

Continental Testing Center
ATTN: Deb Wyka
547 South LaGrange Road
La Grange, IL 60525

RE: Godfrey, Emily Maria 1-11-99
40391948

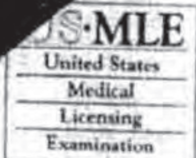
The enclosed Examination and Board Action History Report is being provided at the request of the above-referenced physician. This report must not be duplicated or forwarded to any other party.

Your compliance with these requirements is appreciated.

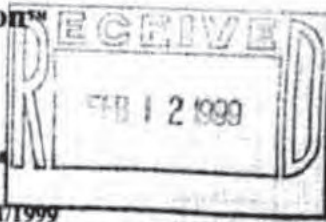
Thank you,

Examination Service Department

Enclosure



United States Medical Licensing Examination™
Certified Transcript of Scores



This Transcript was prepared by the Federation of State Medical Boards

0 0 9 9 2 5 7 ... Date of Certification: 02/11/1999

Continental Testing Center
ATTN: Deb Wyka
547 South LaGrange Road
La Grange, IL 60525

Examinee: Godfrey, Emily Maria
USMLE ID#:
DOB:
Alt Name(s):

STEP1 The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.

Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
6 /1995	PASS					

STEP2 The recommended minimum passing score on the three-digit scale, and the equivalent value on the two-digit scale is shown below.

Test Date	Pass/ Fail	Three-Digit Score	Three-Digit Passing	Two-Digit Score	Two-Digit Passing	Comments
3 /1997	PASS					

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

See reverse side for explanation of information reported above.

Authenticity of USMLE™ Transcripts
Original, certified transcripts of United States Medical Licensing Examination (USMLE) scores are printed on blue safety paper and are produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The embossed USMLE seal 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.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history, and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For recent administrations, the mean and standard deviation of scores on the three-digit scale for first-time examinees from medical schools in the United States are approximately 205 and 20, respectively, and most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 82 on the two-digit scale is equivalent to a score of 200 on the three-digit scale. A score of 75 on the two-digit scale is always the minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each Step of USMLE is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 6 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

NOTATION REGARDING FSMB BOARD ACTION DATA BANK

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 *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 assure 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.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Special circumstances in connection with the administration of an examination may result in one of the following annotations being listed next to the score for that examination:

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, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

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

Irregular Behavior - The USMLE 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*. To obtain information regarding the nature of the irregular behavior, the full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9600.

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.

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

ILLINOIS DEPARTMENT OF PROFESSIONAL REGULATION TESTING PROGRAM

CONTINENTAL TESTING SERVICES, INC. P. O. BOX 100 LaGrange, IL 60525-0100

EMILY M GODFREY

(036)Licensed Physician & Surgeon 0 9 9 2 5 7 1

DATE PRINTED ....:
LICENSURE FEE ....:
SCHOOL#/TEST DATE:
SITE #/SEAT # ....:
DPR ID # ....:
SOC SEC # ....:
EXAM RESULT ....: Pass

USMLE 82 Pass

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 Department 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 Department of Professional Regulation.

LICENSURE APPLICATION

EMILY M GODFREY

(036)Licensed Physician & Surgeon

DATE PRINTED ....:
LICENSURE FEE ....:
SCHOOL#/TEST DATE:
SITE #/SEAT # ....:
DPR ID # ....:
SOC SEC # ....:

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.

~~(APPLICATIONS MUST BE SIGNED)~~ APPLICANT SIGNATURE

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.

US·MLE
United States
Medical
Licensing
Examination

UNITED STATES MEDICAL LICENSING EXAMINATION™

Federation of State Medical Boards of the U.S., Inc.
400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855
Telephone: (817) 571-2949

IL-3

STEP 3 SCORE REPORT

*** MEDICAL BOARD FILE COPY ***

Godfrey, Emily Marie

USMLE ID:

Test Date: May 1999

The USMLE is a single examination program for all applicants for medical licensure in the United States; it replaced the Federation Licensing Examination (FLEX) and the certifying examinations of the National Board of Medical Examiners (NBME Parts I, II and III). The program consists of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. **Step 3** is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions. These scores represent your results for the administration of Step 3 on the test date shown above.

PASS	This result is based on the minimum passing score recommended by USMLE for Step 3. Individual licensing authorities may accept the USMLE-recommended pass/fail result or may establish a different passing score for their own jurisdictions.
	This score is determined by your overall performance on Step 3. For recent administrations, the mean and standard deviation for first-time examinees from U.S. and Canadian medical schools are approximately 207 and 18, respectively, with most scores falling between 140 and 260. A score of 177 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM)‡ for this scale is approximately five points.
	This score is also determined by your overall performance on the examination. A score of 82 on this scale is equivalent to a score of 200 on the scale described above. A score of 75 on this scale, which is equivalent to a score of 177 on the scale described above, is recommended by USMLE to pass Step 3. The SEM‡ for this scale is approximately one and a half points.

‡Your score is influenced both by your general understanding of clinical medicine and by the specific set of items selected for this Step 3 examination. The standard error of measurement (SEM) provides an estimate of the range within which your scores might be expected to vary by chance if you were tested repeatedly using similar tests.

NOTE: Original score report has copy-resistant watermark.

140VC202

ILLINOIS DEPARTMENT OF PROFESSIONAL REGULATION TESTING PROGRAM
CONTINENTAL TESTING SERVICES, INC. P. O. BOX 100 LaGrange, IL 60525-0100
ADMISSION NOTICE (036) Licensed Physician & Surgeon ADMISSION NOTICE

Your application has been received for the licensing examination.

Present this notice for admission to the examination.
Keep this notice on your person at all times during the examination process.

EMILY M GODFREY

EXAM DATE: SEE SCHEDULE BELOW
CANDIDATE NUMBER .:
SOCIAL SECURITY # :

If you change your name or address before the test date, notify Continental Testing Services by mail at the above address. If your name has changed, send a copy of the documentation for the change (marriage certificate, divorce decree, etc.) along with a copy of this notice. Bring a copy of your name change documentation to the test site.

You have been registered to take the examination at the following site:

SITE : DOLTON EXPO CENTER
14200 CHICAGO ROAD
DOLTON IL 60419

BUILDING ....:
ROOM ....: MAIN CONCOURSE
DAY 1 SEAT # : 275
DAY 2 SEAT # : 1143

Enter Side (Green Canopy)

Each book is 3 hours long.

The schedule for the exam is:

USMLE Day 1 MAY 11, 1999
08:00 REGISTRATION
NO CANDIDATE WILL BE ADMITTED
AFTER 8:15.
Instructions/BOOK A
Lunch break
Instructions/BOOK B

USMLE Day 2 MAY 12, 1999
08:00 REGISTRATION
NO CANDIDATE WILL BE ADMITTED
AFTER 8:15.
Instructions/BOOK C
Lunch break
Instructions/BOOK D

****

Bring the following materials to the examination:

1) This admission notice.
2) Photographic identification is required. The only acceptable photographic identification is a Driver's License, Secretary of State card or a current Passport. ** IF YOU DO NOT PRESENT ONE OF THESE, YOU WILL NOT BE ADMITTED TO THE EXAM. Illinois Department of Public Aid cards, Resident Alien cards, or Student Identification cards are NOT acceptable identification.
3) Three #2 sharpened pencils.

****

Friends and relatives are NOT permitted in the area near the testing room. Notepads, Books, Cameras, Beepers and Cellular Phones will not be allowed in the examination room.

If you have any questions concerning admission, please call: (708) 354-9911.
Hours: 8:00 - 4:30 (Monday - Friday)

04/21/99 R (136)

The Medical College of Wisconsin

has conferred on

Emily Maria Godfrey

the degree of

Doctor of Medicine

with all the rights and privileges thereunto appertaining.
In Witness Thereof, this diploma is granted by the
Board of Trustees upon recommendation of the Faculty.
Presented at Milwaukee, Wisconsin, this 17th day of May, 1997.

Chairman, Board of Trustees

President and CEO

Michael A. Dunn MD
Dean and Executive Vice President

092492

SEE BACK FOR RECORD KEY

N15 1/6/99

THE MEDICAL COLLEGE OF WISCONSIN

ESTABLISHED IN 1913 AS THE MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

THE FACE OF THIS DOCUMENT HAS A C[illegible] -ITE PAPER

LAST NAME	FIRST NAME	MIDDLE NAME	SOC. SEC. NO.
GODFREY	EMILY	MARIA	[redacted]

NAME OF PARENT OR GUARDIAN: Thomas Godfrey and Judith Marinelli

ADDRESS OF PARENT OR GUARDIAN / CITY / STATE / ZIP: [redacted]

DATE OF ENTRANCE:

FIRST YEAR DATES OF ATTENDANCE: 8/11/92 to 5/21/93; 8/10/93 to 5/27/

SECOND YEAR DATES OF ATTENDANCE: 8/15/94 to 5/12/95

THIRD YEAR DATES OF ATTENDANCE: 6/26/95 to 6/28/96

FOURTH YEAR DATES OF ATTENDANCE: 7/01/96 to 5/15/97

DEGREE: Doctor of Medicine　DATE: May 17, 1997

RECORD KEY: H - Honors　HP - High Pass　P - Pass　LP - Low Pass　F - Fail　I - Incomplete　EX - Exempt

1/28/93: Entered into extended curriculum program.

ACADEMIC YEAR 1992/93

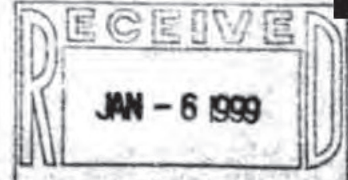
CLINICAL HUMAN ANATOMY
INTEGRATED MEDICAL NEUROSCIENCE
MICROANATOMY
HUMAN DEVELOPMENT
BIOSTATISTICS
PHYSIOLOGY
PSYCHIATRY
PROFESSION OF MEDICINE PROGRAM (POMP):
Human Values in Medicine/Medicine in Society
Medical Ethics

ACADEMIC YEAR 1993/94

BIOCHEMISTRY
PSYCHOPATHOLOGY
PROFESSION OF MEDICINE PROGRAM (POMP):
Medicine in Society
Palliative Medicine
Patient-Oriented Skills/Physical Diagnosis

ACADEMIC YEAR 1994/95

MICROBIOLOGY
PATHOLOGY
PHARMACOLOGY



THIS IS AN EIGHT AND ONE HALF INCH BY ELEVEN INCH DOCUMENT

THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW

OFFICIAL TRANSCRIPT ONLY IF REGISTRAR'S SIGNATURE, EMBOSSED SEAL AND DATE ARE AFFIXED.

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(Back of permanent record card)

NAME OF STUDENT GODFREY, EMILY MARIA

THE MEDICAL COLLEGE OF WISCONSIN

HONORS	

ACADEMIC YEAR 1995/96

SURGERY
AMBULATORY MEDICINE
PEDIATRICS
OBSTETRICS/GYNECOLOGY
ANESTHESIOLOGY
OPHTHALMOLOGY
PSYCHIATRY
WARD MEDICINE

ACADEMIC YEAR 1996/97

ENDOCRINOLOGY
AMBULATORY CARE
WARD MEDICINE
DIAGNOSTIC RADIOLOGY
SURGERY/ORTHOPAEDIC
REPRODUCTIVE HEALTH
ADVANCED CLINICAL SKILLS
PLASTIC SURGERY CLERKSHIP
MEDICAL SELECTIVE/CARDIOLOGY

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER

UNIVERSITY OF WISCONSIN - MADISON TRANSCRIPT

OFFICIAL COPY

GODFREY, EMILY MARIA
MATRICULATION DATE 09/02/87
COLLEGE ADMITTED: UNIV OF ILLINOIS AT CHICAGO CHICAGO, IL
COLLEGE(S) ATTENDED: CEEB ADVANCED PLACEMENT TEST PRINCETON NEW JERSEY
NORTHWESTERN UNIVERSITY EVANSTON, IL
COLORADO COLLEGE COLORADO SPRINGS, CO

```
                                                  CRS GR PTS
09/02/87 ENGLISH 101 OR BASIC COMPOSITION
         REQUIREMENT SATISFIED

 09/02/87     CEEB CREDIT
MATH      221 CALCULUS&ANALYTIC GEOMETRY
                    TOTAL DEGREE CREDITS

 09/02/87     TRANSFER CREDITS
CHEM      103 GENERAL CHEMISTRY
ENGLISH   XXX (AMER LIT 20TH CENT I)
ENGLISH   XXX (AMER LIT 20TH CENT II)
ITALIAN   XXX (ELEMENTARY ITALIAN)
MATH      XXX (CALCULUS 2)
POLI SCI  XXX (WATERGATE)
PSYCH     201 INTRODUCTION TO PSYCHOLOGY
ZOOLOGY   101 ANIMAL BIOLOGY
ZOOLOGY   102 ANIMAL BIOLOGY LABORATORY
                    TOTAL DEGREE CREDITS

 1-1987-88      BS  2  UNDERGRAD
CHEM      104 GEN CHEM & QUALITATIVE ANAL
ILS       205 W CULT:POL,ECON&SOC THGHT I
ZOOLOGY   430 COMPAR ANATOMY-VERTEBRATES
                COURSE DROPPED 10/15/87
ZOOLOGY   431 COMPARATIVE ANATOMY LAB
                COURSE DROPPED 10/15/87
 SUM: DEG CR    8  GPA CR   8  GPA 3.625

 2-1987-88      BS  2  UNDERGRAD
ENGLISH   699 DIRECTED STUDY
PE ELECT  208 ADVANCED LIFE SAVING
SOC       160 HUM SEXUALITY-SOC,PSYCH ISS
 SUM: DEG CR    7  GPA CR   7  GPA 3.214

 05/22/89     TRANSFER CREDITS
ENGLISH   203 INTRO TO CREATIVE WRITING
                    TOTAL DEGREE CREDITS

 SUMMER 1989    BS  2  UNDERGRAD
              SESSION HD: JUN 19 - AUG 13
CHEM      343 INTRO ORGANIC CHEMISTRY
PE ELECT  192 KAYAKING
PE ELECT  303 AQUATIC CONDITIONING
 SUM: DEG CR    3  GPA CR   5  GPA 3.600

 1-1989-90      BS  3  UNDERGRAD
CHEM      344 INTRO ORGANIC CHEMISTRY LAB
ED PSYCH  315 CREATIVITY
ENGLISH   215 ENGLISH LIT BEFORE 1800
ITALIAN   102 SECOND SEMESTER ITALIAN
PHYSICS   103 GENERAL PHYSICS
 SUM: DEG CR   14  GPA CR  14  GPA 3.571
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                                                  CRS GR PTS
 2-1989-90      BS  3  UNDERGRAD
CHEM      345 INTMED ORGANIC CHEMISTRY
ITALIAN   203 THIRD SEMESTER ITALIAN
MUSIC     114 MUSIC IN PERFORMANCE
PE ELECT  134 RELAXATION TECH & EXERCISE #>
PHYSICS   104 GENERAL PHYSICS
 SUM: DEG CR   12  GPA CR  12  GPA 3.833

05/20/90 DEANS LIST

 SUMMER 1990    BS  3  UNDERGRAD
              SESSION CA: MAY 29 - JUN 17
ENGLISH   251 STUDIES IN DRAMATIC LIT
              SESSION HD: JUN 18 - AUG 12
AFROAMER  672 JAMES BALDWIN & BLACK MUSIC
ENGLISH   418 SHAKESPEARE
 SUM: DEG CR    9  GPA CR   9  GPA 4.000

 1-1990-91      BS  4  UNDERGRAD
ENGLISH   216 ENGLISH LIT 1800-PRESENT
HISTORY   635 AFRO-AMER HISTORY TO 1900
ITALIAN   311 ADV COMPOSTN&CONVERSTN
MUSIC     113 MUSIC IN PERFORMANCE
PE DANCE  041 BALLROOM DANCING            #>
PHYSIOL   335 PHYSIOLOGY
 SUM: DEG CR   15  GPA CR  15  GPA 3.600

 2-1990-91      BS  4  UNDERGRAD
AFROAMER  362 AFRO-AM&AFRICA-LIT&FOLKLORE
BACT      102 GENERAL MICROBIOLOGY LAB
BACT      303 GENERAL MICROBIOLOGY
HIST MED  531 WOMEN & HEALTH-AMER HISTORY
PE ELECT  132 WEIGHT TRAINING
                COURSE DROPPED 02/27/91
PE PRO    350 INTRO TO SPORT PSYCHOLOGY
 SUM: DEG CR   15  GPA CR  15  GPA 3.533

 SUMMER 1991    BS  4  UNDERGRAD
              SESSION HD: JUN 17 - AUG 11
ENVIR ST  400 SPEC TOPICS-ENVIRON STUDIES
 SUM: DEG CR    3  GPA CR   3  GPA 4.000

          ADV STG CREDITS           36
          CUM DEGREE CREDITS       122
          CUM GPA CREDITS           88
          CUM GRADE POINTS       320.5
          UNDERGRAD GPA          3.642
```

PAGE 2 FOLLOWS

REGISTRAR

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UW (25)-30 REV. 7/90

GRADING SYSTEM

All credits are based on semester hours. A 4.000 grading system is used. Prior to 1954-55 a 3.00 grading system was used. Intermediate grades of AB and BC were instituted as of September 1973.

Grades With Associated Grade Points Per Credit

GRADE	GRADE POINTS
A (Excellent)	4
AB (Intermediate Grade)	3.5
B (Good)	3
BC (Intermediate Grade)	2.5
C (Fair)	2
D (Poor)	1
F (Failure)	0
NR (No Report)	0

Grades Which Do Not Have Associated Grade Points

S	(Satisfactory)
U	(Unsatisfactory)
CR	(Credit)
N	(No Credit)
I	(Incomplete)
IN	(Incomplete in Credit/No Credit Course)
P	(Progress)
EI	(Extended Incomplete)
PI	(Permanent Incomplete)
DEF	(Deferred)
PE	(Permanently Excused)
EX	(Excused)
R	(Registered)
DR	(Dropped)
W	(Withdrew)

ABBREVIATIONS AND SYMBOLS

CRS	Number of Credits
GR	Grade Received
PTS	Grade Points
#	Course Taken On a Pass/Fail Basis
•	Grades of Failure Or No Report-Credits Do Not Count Toward Degree
!	Credit/No Credit Course in Progress
®	Repeat Of A Failed Course
>	Course Does Not Count Toward Degree
H	Course Taken For Honor Credit
AU	Course Taken For Audit Credit
—	Failed Course That Has Been Repeated. These Credits Have Been Removed From Cumulative GPA Calculation
GPA	Grade Point Average
GPA CR	Number of Credits Included In Grade Point Average Calculation
DEG CR	Number of Credits Applicable To Current Degree Program
ADV ST CRS	Credits Applicable To Degree Program, But Not Earned On UW-Madison Campus
SEM	Semesterly Totals
CUM	Cumulative Totals
? On Credits	Question on Credits
• Following Name	Full Name At Bottom Right

YEAR LEVEL DEFINITIONS

1	– FRESHMAN	– Less than 24 credits or 48 grade points
2	– SOPHOMORE	– 24 credits and 48 grade points
3	– JUNIOR	– 54 credits and 108 grade points
4	– SENIOR	– 86 credits and 172 grade points
5	– GRADUATE	– A student pursuing a graduate degree
9	– SPECIAL	– A student not pursuing a degree program
9	– GUEST	– A student authorized to audit courses only

COURSE NUMBERING SYSTEM

000 - 099 Special Purpose Courses
100 - 299 Undergraduate Courses Not Open To Graduate Students
300 - 699 Courses Open To Either Undergraduates Or Graduates
700 - 999 Graduate And Professional Courses Including Seminars

A middle digit of 8 (i.e. 181) indicates an honors course. Honors courses are also shown by an H immediately preceding course credit.

A middle digit of 9 (i.e. 999) indicates courses such as independent study, research, or thesis.

INCOMPLETES

The undergraduate student in Letters and Science must remove the grade of I (Incomplete) by the end of the fourth week of classes in the next semester (excluding summer) the student is in attendance. All other undergraduate students and most special students must remove the Incomplete by the end of the next semester they are in attendance. Incompletes that are not removed by the deadline dates lapse into a grade of F (Failure). The deadlines for removal of Incompletes may be extended with approval of the Associate Dean. Graduate students are not subject to the above Incomplete deadlines. Students who are not in attendance for a five year period after an Incomplete is received may not remove the Incomplete without permission from the Associate Dean. These Incompletes remain on the record as permanent Incompletes and do not lapse into failures.

LAW SCHOOL STUDENTS

To be eligible to continue a student must maintain a weighted average of 77 on completion of two or more semesters of Law School residence work. A weighted average of 77 on 90 credits is required for graduation. Beginning September 1970, the Law School has related numerical grades to typical letter grades in accordance with the following table:

87 – 100	A	
82 – 86	B	
77 – 81	C	
70 – 76	D	
0 – 69	F	

For interpretation of Law School grades prior to September 1970, please consult the UW-Madison Law School or the Registrar's Office.

NON-LAW SCHOOL STUDENTS

Non-Law School students who take a Law School course have their numerical grades converted in accordance with the following table:

85 –	100	A
83 –	84	AB
77 –	82	B
75 –	76	BC
72 –	74	C
64 –	71	D
0 –	63	F

MEDICAL SCHOOL GRADES

Detailed information concerning a student's grades, relative class standing and clinical performance is available upon request of the student from the UW-Madison Medical School Registrar's Office. The grade of IF is available to medical students in Medical School Courses.

THE HONORS PROGRAM

The College of Letters and Science, The College of Agricultural and Life Sciences, The School of Business, and The School of Family Resources and Consumer Sciences have developed special Honors programs that replace or supplement the designation of awards based on grade point average alone. These programs encourage and recognize work of greater depth, scope and originality by undergraduates whose abilities and interests make them eligible. The content and pace of honors courses are adapted to students who have chosen to do intensive work (either of an accelerated or enriched nature) in the subjects. The programs are entirely voluntary. To enroll in an Honors Program a student must have a strong B average and must maintain an overall B average. Only grades of B or better in Honors courses carry specific Honors credit.

TRANSCRIPTS FROM OTHER INSTITUTIONS

The University of Wisconsin-Madison does not issue copies of transcripts or other documents received from other institutions, including the University of Wisconsin-Extension.

RECORDING OF UW WORK PRIOR TO JANUARY 1972

Prior to January 1972 all courses and grades for work taken within the former University of Wisconsin System (UW-Madison, UW-Milwaukee, UW-Green Bay, UW-Parkside, UW-Centers, and UW-Extension) were recorded on one record and may appear on this transcript.

For questions concerning this transcript contact

Office of the Registrar
Transcript Department
University of Wisconsin-Madison
750 University Avenue
Madison, Wisconsin 53706

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER

UNIVERSITY OF WISCONSIN - MADISON TRANSCRIPT

OFFICIAL COPY

GODFREY, EMILY MARIA

CRS GR PTS

BACHELOR OF SCIENCE
DEGREE CONFERRED AUGUST 25, 1991
GRADUATED WITH DISTINCTION

MAJOR: ENGLISH
UNDERGRADUATE DEGREE GPA 3.642

1-1991-92 UNRS 9 SPECIAL
BIOCHEM 501 INTRODUCTION-BIOCHEMISTRY
BIOCHEM 588 BIOCHEMISTRY HONORS
ZOOLOGY 570 CELLULAR BIOLOGY
SUM: DEG CR 0 GPA CR 7 GPA 4.000

END OF RECORD

0099257

JUL 19 1994

REGISTRAR

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UW (25)-30 REV. 7/90

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IN	(Incomplete in Credit/No Credit Course)
P	(Progress)
EI	(Extended Incomplete)
PI	(Permanent Incomplete)
DEF	(Deferred)
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EX	(Excused)
R	(Registered)
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W	(Withdrew)

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=	Credit/No Credit Course in Progress
≡	Repeat Of A Failed Course
>	Course Does Not Count Toward Degree
H	Course Taken For Honors Credit
AU	Course Taken For Audit Credit
–	Failed Course That Has Been Repeated. These Credits Have Been Removed From Cumulative GPA Calculation.
GPA	Grade Point Average
GPA CR	Number of Credits Included In Grade Point Average Calculation
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? On Credits	Question on Credits
• Following Name	Full Name At Bottom Right

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9	= SPECIAL	— A student not pursuing a degree program
9	= GUEST	— A student authorized to audit courses only

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700 - 999 Graduate And Professional Courses Including Seminars

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A middle digit of 9 (i.e. 999) indicates courses such as independent study, research, or thesis.

INCOMPLETES

The undergraduate student in Letters and Science must remove the grade of I (Incomplete) by the end of the fourth week of classes in the next semester (excluding summer) the student is in attendance. All other undergraduate students and most special students must remove the Incomplete by the end of the next semester they are in attendance. Incompletes that are not removed by the deadline dates lapse into a grade of F (Failure). The deadlines for removal of Incompletes may be extended with approval of the Associate Dean. Graduate students are not subject to the above Incomplete deadlines. Students who are not in attendance for a five year period after an Incomplete is received may not remove the Incomplete without permission from the Associate Dean. These Incompletes remain on the record as permanent Incompletes and do not lapse into failures.

LAW SCHOOL STUDENTS

To be eligible to continue a student must maintain a weighted average of 77 on completion of two or more semesters of Law School residence work. A weighted average of 77 on 90 credits is required for graduation. Beginning September 1970, the Law School has related numerical grades to typical letter grades in accordance with the following table:

87 – 100	A	77 – 81	C
82 – 86	B	70 – 76	D
		0 – 69	F

For interpretation of Law School grades prior to September 1970, please consult the UW-Madison Law School or the Registrar's Office.

NON-LAW SCHOOL STUDENTS

Non-Law School students who take a Law School course have their numerical grades converted in accordance with the following table:

85 – 100	A
83 – 84	AB
77 – 82	B
75 – 76	BC
72 – 74	C
64 – 71	D
0 – 63	F

MEDICAL SCHOOL GRADES

Detailed information concerning a student's grades, relative class standing and clinical performance is available upon request of the student from the UW-Madison Medical School Registrar's Office. The grade of IF is available to medical students in Medical School Courses.

THE HONORS PROGRAM

The College of Letters and Science, The College of Agricultural and Life Sciences, The School of Business, and The School of Family Resources and Consumer Sciences have developed special Honors programs that replace or supplement the designation of awards based on grade point average alone. These programs encourage and recognize work of greater depth, scope and originality by undergraduates whose abilities and interests make them eligible. The content and pace of honors courses are adapted to students who have chosen to do intensive work (either of an accelerated or enriched nature) in the subjects. The programs are entirely voluntary. To enroll in an Honors Program a student must have a strong B average and must maintain an overall B average. Only grades of B or better in Honors courses carry specific Honors credit.

TRANSCRIPTS FROM OTHER INSTITUTIONS

The University of Wisconsin-Madison does not issue copies of transcripts or other documents received from other institutions, including the University of Wisconsin-Extension.

RECORDING OF UW WORK PRIOR TO JANUARY 1972

Prior to January 1972 all courses and grades for work taken within the former University of Wisconsin System (UW-Madison, UW-Milwaukee, UW-Green Bay, UW-Parkside, UW-Centers, and UW-Extension) were recorded on one record and may appear on this transcript.

For questions concerning this transcript contact:

Office of the Registrar
Transcript Department
University of Wisconsin-Madison
750 University Avenue
Madison, Wisconsin 53706

0011176.00178

01000002712

125-035716

PAGE ONE

RECEIVED CASH SECTION
APR - 8 1997
DEPARTMENT OF PROFESSIONAL REGULATION

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

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

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

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

A. Type or print legibly with black ink only.

B. The licensure and application fee are NOT refundable.

C. Disclosure of Social Security number and gender information 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 - copy of marriage license, divorce decree, affidavit or court order.

PART I: Application Category Information

050010 97

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician License	1 2 5	Nonexamination	$ 100 00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

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

PART II: Applicant Identifying Information - You must notify the Department of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g. M.D. D.D.S. etc.)	3. SOCIAL SECURITY NUMBER
GODFREY	EMILY	MARIA	M.D.	[redacted]

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

[redacted]

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

(None)

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

[redacted]

10

Wo

IL 486-1019 10/95 (LT)

PART III: Education Information

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

1 2 3 4 5 6 7 8 9 10 11 12 Graduated High School? ☑ Yes ☐ No OR Received GED? ☐ Yes ☑ No

2 NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3 LAST PRELIMINARY SCHOOL LOCATION (City and State)	4 DATE OF GRADUATION
NEW TRIER HIGH SCHOOL	WINNETKA, IL	0 6 / 8 6 (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
University of Wisconsin	Madison, WI	9/87	5/91	B.S.
Medical College of Wisconsin	Milwaukee, WI	8/92	5/97	M.D.

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	TO Month/Year	Did You Complete Training?
West Suburban Family Practice Residency Program	River Forest, IL	07/97	07/2000	☐ Yes ☑ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

2272

PART IV: Record of Licensure Information

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing				
Other States of Licensure				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
USMLE Step I	WI	06/95	Passed
USMLE Step II	WI	03/97	Pending

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

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

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

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

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

Signature of Applicant ______________________ Date 3/31/97

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

IL486-1019 10/95 (LT)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

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

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

1. NAME (LAST / FIRST / MIDDLE)	2. DATE OF BIRTH (Month / Day / Year)	3. SOCIAL SECURITY NUMBER
Godfrey Emily M.	[redacted]	[redacted]

4. ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
[redacted]	Profession Name: Temporary Physician; Profession Code: 125
6. MAIDEN OR GIVEN SURNAME: N/A	

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE (Month / Day / Year)	C. ENDING DATE (Month / Day / Year)
West Suburban Hospital Medical Center Family Practice Residency Program	06/19/97	06/30/00

D. BUSINESS ADDRESS: STREET, CITY, STATE, ZIP CODE	E. SPECIALTY / RESIDENCY NAME
7411 West Lake Street, Suite 1100 River Forest, IL 60305	Family Practice
F. BUSINESS TELEPHONE NUMBER	G. YEAR OF POSTGRADUATE TRAINING
Area Code (708) 488-2369	One

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

SEAL

[redacted]
Signature of Program Director

Kenneth M. Blair, M.D
Print Name of Program Director

Program Director
Title

3/27/97
Date

IL 486-0272 12/93 (MD)

125
4-15-97
UNS

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statues). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATION OF EDUCATION

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
GODFREY EMILY MARIA

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
Temporary Physician License — Profession Name
1 2 5 — Profession Code

6 MAIDEN OR GIVEN SURNAME

7 NAME OF INSTITUTION ATTENDED
MEDICAL COLLEGE OF WISCONSIN

8 DATE OF GRADUATION / COMPLETION
05 / 17 / 97 (Month / Day / Year)

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

3/31/97 — Date
[redacted] — Signature

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

A NAME OF INSTITUTION
The Medical College of Wisconsin

B ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE
8701 Watertown Plank Road
Milwaukee, WI 53226

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 / 10 / 93	5 / 27 / 94
8 / 15 / 94	5 / 12 / 95
6 / 26 / 95	6 / 28 / 96
7 / 1 / 96	Present
__ / __ / __	__ / __ / __
__ / __ / __	__ / __ / __

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

E TYPE OF DEGREE OR CERTIFICATE AWARDED/will be awared
M.D.

F DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET
__ / __ / __ (Month / Day / Year)

G DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED
__ / __ / __ (Month / Day / Year)

H CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

[ ] Applicant has graduated on __ / __ / __ (Month / Day / Year)
[ ] Applicant has completed program on __ / __ / __ (Month / Day / Year)
[X] Applicant will graduate on 5 / 17 / 97 (Month / Day / Year)
[X] Applicant will complete program on 5 / 15 / 97 (Month / Day / Year)

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

IL486-1425 5/94 (L&T)

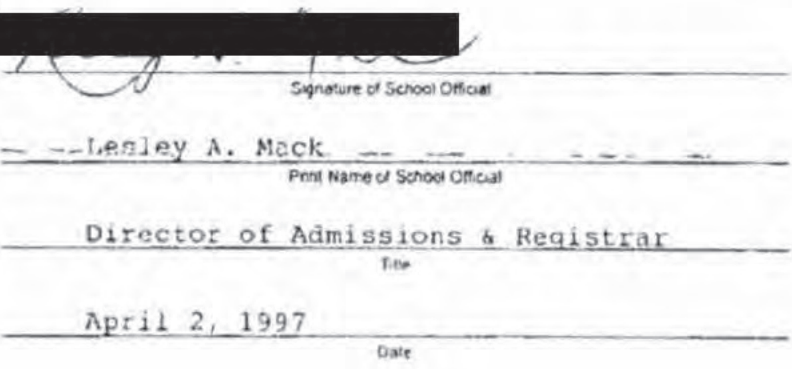
Complete the Reverse Side of this Form

APR 17 1997

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



Signature of School Official

Lesley A. Mack

Print Name of School Official

Director of Admissions & Registrar

Title

April 2, 1997

Date

RETURN THIS FORM TO APPLICANT

IL486-1426 Back (L&T)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.	**WORK HISTORY**	SUPPORTING DOCUMENT **WH**

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

1. NAME LAST / FIRST / MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
GODFREY EMILY MARIA	[redacted]	[redacted]
4. ADDRESS STREET CITY STATE ZIP CODE: [redacted]	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application: Temporary Physician License (Profession Name) 1 2 5 (Profession Code)	
6. MAIDEN OR GIVEN SURNAME	7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☑	8. DATE FORM COMPLETED 03/31/97

9. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS / INSTITUTION	JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME	
DATE OF EMPLOYMENT/ATTENDANCE From __/__/__ (Month Day Year) To __/__/__ (Month Day Year)	HOURS WORKED PER WEEK; TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month)	

B. NAME OF BUSINESS / INSTITUTION	JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME	
DATE OF EMPLOYMENT/ATTENDANCE From __/__/__ (Month Day Year) To __/__/__ (Month Day Year)	HOURS WORKED PER WEEK; TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month)	

COMPLETE THE REVERSE SIDE OF THIS FORM

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

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

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

00111176.00178

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION
NIKKI M. ZOLLAR
DIRECTOR

APRIL 29, 1997

EMILY M GODFREY MD

DEAR EMILY M GODFREY MD

Your application for temporary licensure in Illinois has been approved and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 06/19/97. Assuming you remain in the training program listed below, this license will be valid until 06/18/00.

PROGRAM: FAMILY PRACTICE TRAINING
TRAINING FACILITY: WEST SUBURBAN HOSP MED CTR

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

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

Please be aware that the Medical Practice Act sets forth the appropriate use of the temporary license and any violation of that Act may result in disciplinary action by this Department.

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

Sincerely,

Pat Eubanks, Manager
Medical Unit

0011176.00178

Application No. ______ ______
Prof. Code SSN/FEIN

or Label Space

TEMPORARY APPLICATION REVIEW FINDINGS

AMF 4

1. DATE: 04/25/97

2. EMPLOYEE: 0303

3. STATUS: 6

4. DEFICIENCIES - ADD: ______

CLEAR: ______

5. LAST CORRESPONDENCE RECEIVED DATE: 04/17/97

6. LAST CORRESPONDENCE SENT DATE: 04/25/97

EDUCATION INFORMATION:

7. School Name: MEDICAL College of Wisconsin

8. School Code: ______ 9. Foreign School: No (Yes or No) 10. Date Graduated: 05/17/97

11. City/Country School Located: Milwaukee 12. State School Located: WI

PROGRAM INFORMATION:

14. Facility Name: West Suburban Hosp MED CtR

15. Facility Address

Line 1: FAmily PrAC Residency Prog

Line 2: 7411 W LAke St, Ste 1100

Line 3: ______

Line 4: ______

City/Country: River Forest State: IL Zip: 60305

16. Start Training Date: 06/19/97 17. Start Program Date: 06/19/97 18. Expiration Date: 06/18/00

19. Program Code: 15 fam prac

20. Original: Y 21. Extension: ______ 22. Transfer: ______

23. Add [X] 24. Change [ ]

IL486-1325 4/89 (L&T)

0011176.00178

Northwestern University Medical School

Graduate Medical Education

Ward Building 9-332
303 East Chicago Avenue
Chicago, Illinois 60611-3008
(312) 503-7975
Fax (312) 503-5230

Robert M. Vanecko, MD
Associate Dean

James Mathews, MD
Assistant Dean

April 16, 1997

Patricia Eubanks
Illinois Department of Professional Regulation
320 W. Washington Street
3rd Floor, Medical Unit #1
Springfield, IL 62786

Re: Emily M. Godfrey, MD
SSN# [redacted]

To Whom It May Concern:

The enclosed ED-Med form is submitted for the issuance of Dr. Godfrey's temporary Illinois medical license. If you have any questions, please call (312) 503-7947 or fax (312) 503-5230. Thank you for your assistance in this matter.

Sincerely,

[redacted signature]

Mary Ann Page
Program Assistant

APR 17 1997

00111126.00128

Family Practice Residency Program

An Affiliate of West Suburban Hospital Medical Center

Leading the Way to a Healthier Community

April 4, 1997

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

To Whom It May Concern,

Enclosed is the licensure application packet for **Emily Godfrey,**. The contents include:

_X_ The four page application.

_X_ The **WH** Work History form.

_X_ The **CT** Certificate of Licensure form. (She has never been licensed before.)

_X_ The **CA-MED** Certification of Acceptance for Specialty/Residency Training form.

___ The **ED-MED** form.

- ___ The applicant's Certification of Education will be submitted by the medical school via a computer list of their graduates.
- ___ The ED-MED form is enclosed in a sealed envelope from the medical school attended.
- _X_ The ED-MED form will be mailed directly form the medical school's dean or registrar office.
- ___ This applicant currently holds an active Illinois State Temporary Physician License. Certification of Education previously verified upon applying for the current license.

Requests of additional information can be made via phone contact (708) 488-2369, or fax communications (708) 763-2162 to Ms. Elizabeth Ryan, Program Coordinator of the West Suburban Family Practice Residency Program.

Sincerely,

Elizabeth Ryan
Program Coordinator

West Suburban Center For Primary Care
7411 W. Lake Street River Forest, Illinois 60305 (708) 488-2367 Fax (708) 488-2394

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1 NAME LAST FIRST MIDDLE

GODFREY EMILY MARIA

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.

Temporary Physician License — Profession Name

1 2 5 — Profession Code

6 MAIDEN OR GIVEN SURNAME

7 APPLICANT TELEPHONE NUMBER (Daytime)

Area Code (414) 906-0438

8a RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED (If applicable)

N/A

8b LICENSE NUMBER (If applicable)

N/A

8c ISSUANCE DATE OF LICENSE (If applicable)

N/A

I hereby authorize ______________________ (Name of Licensing Agency or Board) to furnish to the Illinois Department of Professional Regulation or its designated testing service, the information requested below.

Signature ______________________ Date ______________________

DO NOT RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS

A. The applicant ☐ has written ☐ is scheduled to write the following examination

______________________ (Name of Examination) ______________________ (Date of Examination)

B. The applicant has or will have written the above-named examination _______ number of times

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE

B. LICENSE NUMBER

C. ISSUANCE DATE OF LICENSE

D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD

- ☐ Examination (Administered in Your State)
  - ☐ National (Name) ______________
  - ☐ State Constructed ______________
  - ☐ Other (Name) ______________
- ☐ Endorsement of License (State) ______________
  - Acceptance of Examination Results (Administered in Another State) ______________
- ☐ Reciprocity with (State) ______________
- ☐ Waiver/Grandfather
- ☐ Credentials
- ☐ Other (Describe) ______________

F. CURRENT LICENSURE STATUS

- ☐ Active
- ☐ Inactive
- ☐ Lapsed
- ☐ Other (Explain) ______________

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination	Score
Written	______
Practical	______
Other (Describe) ______________	
Received no Grade Below	
Examination Period _____ days _____ hours	______

COMPLETE THE REVERSE SIDE OF THIS FORM

PART III - CERTIFICATION OF EXAMINATION SCORES

A1 National or other Profession Specific Examination (*Record all available information*) Date of Examination ____________

Scaled Score ____________ Raw Score ____________

Standard Deviation ____________ Corrected Score ____________

National Mean ____________ Percent Score ____________

A2

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

A Is there now or has there ever been any formal action commenced against the applicant? ☐ Yes ☐ No

B Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? **(If yes, attach a certified copy of disciplinary action.)** ☐ Yes ☐ No

PART V - RECIPROCAL REGISTRATION

This state ☐ does ☐ does not grant the same privilege of reciprocal registration to Illinois registrants

I certify that the information contained herein is true and correct according to the official records of the State

SEAL

____________ Print Name

____________ Title ____________ Signature

____________ Agency/Board Street Address ____________ Date

____________ City, State, ZIP Code Area Code ( ) ____________ Telephone Number

IL486-0850 10/95 (LT-Back)

RETURN TO: **Department of Professional Regulation**
320 West Washington, L & T
Springfield, Illinois 62786

336-063066

000500 00105

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

IMPORTANT NOTICE: Completion of this form is required by 720 of the Illinois Compiled Statutes (Chap. 56 1/2, of the Ill. Rev. Stat. 1985). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application. This form has been approved by the Forms Management Center.

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

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

1. Every person who prescribes or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Professional Regulation in accordance with the Illinois Controlled Substances Act.
2. A separate controlled substances registration is required for each place of professional practice or business where controlled substances are stored or located.
3. A State Controlled Substances Registration is prerequisite to a Federal Controlled Substances Registration.

A. Type or print legibly with black ink only.

B. The fee is $5 - Make check payable to the Department of Professional Regulation. THIS FEE IS NOT REFUNDABLE! (Separate application/fee is required for each registration.)

C. Disclosure of your U.S. social security number, if you have one, is mandatory. This disclosure is mandated by 5 Illinois Compiled Statutes 100 1-65. The social security number will be provided to the Department of Public Aid to assist in the ... days delinquent in comp...

D. Submit application and f...
Department of Profes...
320 West Washingto...
Springfield, Illinois 62...

GODFREY, EMILY M MD

[REDACTED]

CHECK A BOX INDICATING THE APPROPRIATE INFORMATION REG...
(Do not use this form to renew existing Regist...)

☑ First Time Applicant ☐ Additional Location (separate ...

336063066

PART I: Application Category Information

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

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. D.D.S., M.D., ETC.	3. UNITED STATES SOCIAL SECURITY NO.
GODFREY	EMILY	M	M.D.	[REDACTED]

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

5. NAME OF BUSINESS AND LOCATION (STREET/CITY/ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED

Salud Family Health Center
5359 W. Fullerton Ave
Chicago IL 60639+____

6. MAIDEN OR GIVEN SURNAME ... NAMES

7. TELEPHONE NUMBER WHERE ... MAY BE REACHED DURING THE DAY
Work [REDACTED]
Home [REDACTED]

PART III: Professional Activity

Practitioner - CHECK AND COMPLETE ONE OF THE FOLLOWING

		Professional License Number
☐Dentist	019 -	
☑Physician	036 -	101057
☐Podiatrist	016 -	
☐Veterinarian	090 -	

DRUG SCHEDULES ...

(II) (IIN) (III) (IIIN) (IV) (V)

FOR OFFICIAL USE ONLY FEE $5

BNDD Number: ________ **Type:** ☐ **Suffix:** ☐

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

Issuance Date (Month/Day/Year)

IL486-0500 2/99 (LT)

REVERSE SIDE MUST BE COMPLETED

PART IV: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you ever been charged or convicted of any drug related criminal offense in any state or in federal court? *If yes, attach a statement for each conviction including dates and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.*		✓
2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		✓
3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		✓
4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		✓
5. Has any previous registration held by the applicant under the Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? *If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.*		✓

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

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

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

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

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

☑ I am not currently under any child support order

PART VI: Certifying Statement

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

Emily M. Godfrey, M.D.
Print Name of Applicant

[redacted]
Signature of Applicant

5/20/00
Date of Application

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 hereun**der, but** in no event shall such reduction be made in an amount greater than $50.

IL486-0500 2/99 ILT

Application must be completed in its entirety.

If not completed, it will be returned to the address noted on front of application.

Electronic Renewal Record

Exit | Find Another

License Number	036101057
Pin	[redacted]
Phone	[redacted]
Authorization	[redacted]
SSN	[redacted]
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	4/29/2008
Renewal Fee	$300.00
Fee Type	3
Service Fee	$5.00
Memo	

Method I

Credited:

User Responses

#	Question	Response	#	Question	Response
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	CE1	Y			

Print Record

Next Record

Electronic Renewal Record

Exit | Find Another

Field	Value
License Number	036086852
Pin	[redacted]
Phone	[redacted]
Authorization	[redacted]
SSN	[redacted]
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	7/1/2008
Renewal Fee	$300.00
Fee Type	R
Service Fee	$5.00
Memo	

Method | Credited:

User Responses

#	Code	Response	#	Code	Response
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	CE1	Y			

Print Record

Next Record