License Verification

Data As Of **11/14/2013**

VIJAY LAXMI GOYAL

LICENSE NUMBER: **ME93464**

Profession

MEDICAL DOCTOR

License/Activity Status

CLEAR/ACTIVE

Controlled Substance Prescriber

NO

License Expiration Date

1/31/2015

License Original Issue Date

06/17/2005

Discipline on File

NO

Public Complaint

NO

Address of Record

NOT PRACTICING IN FLORIDA

This practitioner has indicated that they are not currently practicing their profession in the State of Florida at this time. The practitioner may choose to begin practice at anytime provided that the license status is active. If the practitioner has resumed practice, the practitioner must update their practice location address. If you have any questions, please contact the department at 850-488-0595.

The information on this page is a secure, primary source for license verification provided by The Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

*** **AUTO** *** 018_023_07063 93464-27063

VIJAY LAXMI GOYAL
MICHELE SHIN
1640 N ARLINGTON HEIGHTS RD
SUITE 110
ARLINGTON HEIGHTS, IL 60004

:600043985357:

Your Medical Doctor License # **ME 93464** will expire at midnight, Eastern Standard Time (EST) on **Monday, January 31, 2011**.

Please log onto **www.FLHealthsource.com** and follow these steps:

1. Click **Renew My License** and log in.
2. Click **Renew License** and select your renewal option:
    a. Renew on-line
    b. Print your renewal notice to submit with your payment via mail

You will be prompted to complete the Physician Workforce Survey online.

Renewals by mail **MUST** include the renewal form, not this postcard.

Visit **www.cebroker.com/subscribe** to purchase your **optional** subscription and track your continuing education credits.

Section 456.0635, F.S., may affect your ability to renew your license. Please visit **http://www.doh.state.fl.us/mqa/laws.html** for more information.

Remember, all renewals MUST be submitted **no later than January 31, 2011** in order to avoid a delinquent fee. Questions? Contact the MQA Call Center at (850) 488-0595.

Florida Board of Medicine

COPY COPY COPY COPY COPY

Tallahassee, Florida

This is to Certify that **VIJAY LAXMI GOYAL** *is a*

Medical Doctor

Having furnished satisfactory evidence of attainments and qualifications, as required by law, in conformity with an Act of the Legislature of the State of Florida, creating and regulating the profession.

JEB BUSH
GOVERNOR OF FLORIDA

JOHN O. AGWUNOBI, M.D., M.P.H., M.B.A.
SECRETARY, DEPARTMENT OF HEALTH

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
06/18/2005	**ME 93464**	**158140**

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: ~~JANUARY 31, 2007~~

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS, IL 60004

COPY COPY COPY

AC# COPY
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
DATE | LICENSE NO. | CONTROL NO.
06/18/2005 | ME 93464 | 158140
The MEDICAL DOCTOR named below has met all requirements of the laws of Florida.
COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR DISPLAY IF REQUIRED BY LAW SECRETARY

EXPIRATION DATE: **JANUARY 31, 2007**

Your license number is **ME 93464**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to **www.DOH-MQAServices.com**
2. Choose one of the licensee services
3. Select your profession
4. Enter the account ID and password here **(Account ID and Password are case sensitiv**

Your opinion is important to us. To help us continue to improve our customer service, please take a moment to complete our online survey about the kind of service we provided you in obtaining your license. **http://www.doh.state.fl.us/mqa/Surveys/new-lic.htm** Thank you for helping us better serve you and our other customers.

To request a duplicate license, submit this form and a check or money order, payable to the **DEPARTMENT OF HEALTH**, in the amount of **$25.00**.
Now that you have your license, make sure you keep it. Go to **www.doh.state.fl.us/mqa/avoid.html** to find out more.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

☐ **PRACTICE LOCATION ADDRESS CHANGE**
(This address will be printed on your license and posted on the Internet.)

_____
_____
_____
CITY STATE ZIP

☐ **MAILING ADDRESS CHANGE**
(This address will be used when mailing your license and for all other correspondence from the Department.)

_____
_____
_____
CITY STATE ZIP

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-18
TALLAHASSEE, FLORIDA 32399-3258

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS, IL 60004

Jeb Bush
Governor

FLORIDA DEPARTMENT OF
HEALTH

John O. Agwunobi, M.D., M.B.A., M.P.H.
Secretary

August 19, 2004

Vijay Goyal, M.D.
1640 N Arlington Heights Rd
Apt 110
Arlington Heights, IL 60004

Dear Dr. Goyal:
File # 89558

Your application for medical licensure has been received and processed. Upon initial review, your application remains incomplete for the following deficiencies outlined in the attached letter.

Please be advised that previous malpractice, criminal charges, discipline, addictions/impairments, unfavorable evaluations, etc. may require you to appear before the Credentials Committee for determination of eligibility for licensure. If your appearance is required, you will be notified in writing once your file is complete. Any information received by this office may require additional explanation and/or documentation to be requested in order to further determine licensure eligibility. After all requested documentation is received, your file will be submitted for a standard supervisory review. Should additional information be required, you will be notified. Once your file is determined complete, it will be presented to the Board for consideration at the next scheduled meeting.

As documentation is received in our office, an updated list of deficiencies will be mailed to you. Your application will remain incomplete until all deficiencies are completed. In addition, notify the Board office immediately in writing of any occurence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If I can be of further assistance, contact me at (850) 245-4131 ext. 3531 or e-mail at Wendy_Alls@doh.state.fl.us.

Sincerely,

Wendy Alls
Regulatory Specialist I

Enclosure(s)

Name: Vijay Goyal, MD **Date: August 19, 2004**

General Information:

- We will consider no application complete for licensure until we receive all requested documentation by the board.
- The applicant must ensure that the Board receives all requested documentation. **Verbal responses are inadmissible.**
- We require copies to be legible, large/small documents to be reduced/enlarged to 8.5x11.
- You will be required to obtain certain continuing medical education courses, as part of the requirements for initial licensure. The courses are three (3) hours of HIV/AIDS, one (1) hour of Domestic Violence and two (2) hours of Prevention of Medical Errors. Please contact the Florida Medical Association at (850) 224-6496 or www.fmaonline.org for a list of CME providers who offer these courses. Other resources are the American Medical Association at (312) 464-4952 or Medical Education Group Learning Systems (MEGLAS) AT (800) 547-0308.
- To request your examination scores (NBME, FLEX, USMLE, or SPEX), contact the Federation of State Medical Boards at www.fsmb.org.
- **As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department. YOUR APPLICATION'S EXPIRATION DATE IS July 25, 2005.**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. We await the results of your criminal background check directly from the authorities. Processing of fingerprint card may take 4-6 weeks.

2. List all employment and non-employment activities, from 2/80 to 7/80, 6/83 to 8/83, and 1/92 to 1/94.

3. Submit copy of MBBS marksheets.

4. Submit copy of name change document. ? uncertain of document submitted

5. Submit a copy of medical school diploma.

6. We await verification of MD Degree, direct from medical school, which must be requested by the applicant.

7. We are awaiting response to our inquiry mailed to:

   Medical Staff Office, Access Health Center, verifying your staff privileges and good standing.

8. We await verification of licensure status, direct from the Illinois Board and Michigan Board, which must be requested by the applicant.

9. We are in receipt of NPDB self query. It indicates your date of birth as 8/27/55; whereas, your application states 8/24/55. Please explain and request that a corrected self query be forwarded to the Florida Board.

If I can be of any assistance, please contact me at (850) 245-4131, extension 3531, or email me at WENDY_ALLS@DOH.STATE.FL.US. I can also be reached via fax at 850-488-0596 and/or at 850-412-1282.

Name: Vijay Goyal, MD **Date: October 18, 2004**

General Information:

- ☐ We will consider no application complete for licensure until we receive all requested documentation by the board.
- ☐ The applicant must ensure that the Board receives all requested documentation. **Verbal responses are inadmissible.**
- ☐ We require copies to be legible, large/small documents to be reduced/enlarged to 8.5x11.
- ☐ You will be required to obtain certain continuing medical education courses, as part of the requirements for initial licensure. The courses are three (3) hours of HIV/AIDS, one (1) hour of Domestic Violence and two (2) hours of Prevention of Medical Errors. Please contact the Florida Medical Association at (850) 224-6496 or www.fmaonline.org for a list of CME providers who offer these courses. Other resources are the American Medical Association at (312) 464-4952 or Medical Education Group Learning Systems (MEGLAS) AT (800) 547-0308.
- ☐ To request your examination scores (NBME, FLEX, USMLE, or SPEX), contact the Federation of State Medical Boards at www.fsmb.org.
- ☐ **As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department. YOUR APPLICATION'S EXPIRATION DATE IS July 25, 2005.**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. List all employment and non-employment activities, from 2/80 to 7/80, 6/83 to 8/83, and 1/92 to 1/94.
2. Submit copy of MBBS marksheets.
3. Submit copy of legal name change document, such as a marriage certificate.
4. Submit a copy of medical school diploma.
5. We await verification of MD Degree, direct from medical school, which must be requested by the applicant.
6. We await verification of licensure status, direct from the Illinois Board, which must be requested by the applicant.
7. We are in receipt of NPDB self query. It indicates your date of birth as 8/27/55; whereas, your application states 8/24/55. Please explain and request that a corrected self query be forwarded to the Florida Board.

If I can be of any assistance, please contact me at (850) 245-4131, extension 3531, or email me at WENDY_ALLS@DOH.STATE.FL.US. I can also be reached via fax at 850-488-0596 and/or at 850-412-1282.

Name: Vijay Goyal, MD **Date: December 9, 2004**

General Information:

- ☐ We will consider no application complete for licensure until we receive all requested documentation by the board.
- ☐ The applicant must ensure that the Board receives all requested documentation. **Verbal responses are inadmissible.**
- ☐ We require copies to be legible, large/small documents to be reduced/enlarged to 8.5x11.
- ☐ You will be required to obtain certain continuing medical education courses, as part of the requirements for initial licensure. The courses are three (3) hours of HIV/AIDS, one (1) hour of Domestic Violence and two (2) hours of Prevention of Medical Errors. Please contact the Florida Medical Association at (850) 224-6496 or www.fmaonline.org for a list of CME providers who offer these courses. Other resources are the American Medical Association at (312) 464-4952 or Medical Education Group Learning Systems (MEGLAS) AT (800) 547-0308.
- ☐ To request your examination scores (NBME, FLEX, USMLE, or SPEX), contact the Federation of State Medical Boards at www.fsmb.org.
- ☐ **As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department. YOUR APPLICATION'S EXPIRATION DATE IS July 25, 2005.**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. We await verification of MD Degree, direct from medical school, which must be requested by the applicant.

2. We await verification of licensure status, direct from the Illinois Board, which must be requested by the applicant.

If I can be of any assistance, please contact me at (850) 245-4131, extension 3531, or email me at WENDY_ALLS@DOH.STATE.FL.US. I can also be reached via fax at 850-488-0596 and/or at 850-412-1282.

Name: Vijay Goyal, MD **Date: January 10, 2005**

General Information:

- We will consider no application complete for licensure until we receive all requested documentation by the board.
- The applicant must ensure that the Board receives all requested documentation. **Verbal responses are inadmissible.**
- We require copies to be legible, large/small documents to be reduced/enlarged to 8.5x11.
- You will be required to obtain certain continuing medical education courses, as part of the requirements for initial licensure. The courses are three (3) hours of HIV/AIDS, one (1) hour of Domestic Violence and two (2) hours of Prevention of Medical Errors. Please contact the Florida Medical Association at (850) 224-6496 or www.fmaonline.org for a list of CME providers who offer these courses. Other resources are the American Medical Association at (312) 464-4952 or Medical Education Group Learning Systems (MEGLAS) AT (800) 547-0308.
- To request your examination scores (NBME, FLEX, USMLE, or SPEX), contact the Federation of State Medical Boards at www.fsmb.org.
- **As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department. YOUR APPLICATION'S EXPIRATION DATE IS July 25, 2005.**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. We await verification of MD Degree, direct from medical school, which must be requested by the applicant.

2. We await verification of licensure status, direct from the Illinois Board, which must be requested by the applicant.

If I can be of any assistance, please contact me at (850) 245-4131, extension 3531, or email me at WENDY_ALLS@DOH.STATE.FL.US. I can also be reached via fax at 850-488-0596 and/or at 850-412-1282.

Name: Vijay Goyal, MD **Date: February 14, 2005**

General Information:

- We will consider no application complete for licensure until we receive all requested documentation by the board.
- The applicant must ensure that the Board receives all requested documentation. **Verbal responses are inadmissible.**
- We require copies to be legible, large/small documents to be reduced/enlarged to 8.5x11.
- You will be required to obtain certain continuing medical education courses, as part of the requirements for initial licensure. The courses are three (3) hours of HIV/AIDS, one (1) hour of Domestic Violence and two (2) hours of Prevention of Medical Errors. Please contact the Florida Medical Association at (850) 224-6496 or www.fmaonline.org for a list of CME providers who offer these courses. Other resources are the American Medical Association at (312) 464-4952 or Medical Education Group Learning Systems (MEGLAS) AT (800) 547-0308.
- To request your examination scores (NBME, FLEX, USMLE, or SPEX), contact the Federation of State Medical Boards at www.fsmb.org.
- **As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department. YOUR APPLICATION'S EXPIRATION DATE IS July 25, 2005.**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. We await verification of MD Degree, direct from medical school, which must be requested by the applicant.

2. We await verification of licensure status, direct from the Illinois Board, which must be requested by the applicant.

If I can be of any assistance, please contact me at (850) 245-4131, extension 3531, or email me at WENDY_ALLS@DOH.STATE.FL.US. I can also be reached via fax at 850-488-0596 and/or at 850-412-1282.

Name: Vijay Goyal, MD **Date: March 7, 2005**

General Information:

- ☐ We will consider no application complete for licensure until we receive all requested documentation by the board.
- ☐ The applicant must ensure that the Board receives all requested documentation. **Verbal responses are inadmissible.**
- ☐ We require copies to be legible, large/small documents to be reduced/enlarged to 8.5x11.
- ☐ You will be required to obtain certain continuing medical education courses, as part of the requirements for initial licensure. The courses are three (3) hours of HIV/AIDS, one (1) hour of Domestic Violence and two (2) hours of Prevention of Medical Errors. Please contact the Florida Medical Association at (850) 224-6496 or www.fmaonline.org for a list of CME providers who offer these courses. Other resources are the American Medical Association at (312) 464-4952 or Medical Education Group Learning Systems (MEGLAS) AT (800) 547-0308.
- ☐ To request your examination scores (NBME, FLEX, USMLE, or SPEX), contact the Federation of State Medical Boards at www.fsmb.org.
- ☐ **As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department. YOUR APPLICATION'S EXPIRATION DATE IS July 25, 2005.**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. We await verification of MD Degree, direct from medical school, which must be requested by the applicant.

2. ☑ We await verification of licensure status, direct from the Illinois Board, which must be requested by the applicant.

If I can be of any assistance, please contact me at (850) 245-4131, extension 3531, or email me at WENDY_ALLS@DOH.STATE.FL.US. I can also be reached via fax at 850-488-0596 and/or at 850-412-1282.

Name: Vijay Goyal, MD **Date: April 13, 2005**

General Information:

- ☐ We will consider no application complete for licensure until we receive all requested documentation by the board.
- ☐ The applicant must ensure that the Board receives all requested documentation. **Verbal responses are inadmissible.**
- ☐ We require copies to be legible, large/small documents to be reduced/enlarged to 8.5x11.
- ☐ You will be required to obtain certain continuing medical education courses, as part of the requirements for initial licensure. The courses are three (3) hours of HIV/AIDS, one (1) hour of Domestic Violence and two (2) hours of Prevention of Medical Errors. Please contact the Florida Medical Association at (850) 224-6496 or www.fmaonline.org for a list of CME providers who offer these courses. Other resources are the American Medical Association at (312) 464-4952 or Medical Education Group Learning Systems (MEGLAS) AT (800) 547-0308.
- ☐ To request your examination scores (NBME, FLEX, USMLE, or SPEX), contact the Federation of State Medical Boards at www.fsmb.org.
- ☐ **As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department. YOUR APPLICATION'S EXPIRATION DATE IS July 25, 2005.**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. We await verification of MD Degree, direct from medical school, which must be requested by the applicant.

If I can be of any assistance, please contact me at (850) 245-4131, extension 3531, or email me at WENDY_ALLS@DOH.STATE.FL.US. I can also be reached via fax at 850-488-0596 and/or at 850-412-1282.

MDverf 3/21/80
Appl 2/3/80

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # CO3
TALLAHASSEE, FLORIDA 32399
850/245-4131

Date: June 2, 2005

To: Vijay Goyal, MD
1640 N. Arlington Heights Road
#110
Arlington Heights, IL 60004

From: Wendy Alls - Regulatory Specialist I

YOUR APPLICATION HAS BEEN SUBMITTED FOR A STANDARD, SUPERVISORY REVIEW. HOWEVER, NO APPLICATION WILL BE CONSIDERED COMPLETE UNTIL ALL REQUESTED INFORMATION HAS BEEN RECEIVED IN THE BOARD OFFICE

✓ 1. We are in receipt of verification of medical degree. It indicates that you obtained your medical degree on 3/21/80; whereas your application, question #14, states 2/3/80. Please explain the date discrepancy.

PROVIDED NO ADDITIONAL CLARIFICATIONS OR SUPPLEMENTARY DOCUMENTATION IS NEEDED, WE WILL CONSIDER YOUR FILE FOR LICENSURE AT OUR JUNE MEETING. IF APPROVED, WE WILL NOT FORWARD YOUR ACTIVATION PACKET UNTIL ALL REQUESTED INFORMATION HAS BEEN RECEIVED IN THE BOARD OFFICE.

If I can be of any assistance, please contact me at 850/245-4131 ext. 3531.

/wa

BOARD OF MEDICINE
2005 JUN 16 PM 3:12

Vijay L. Goyal, M.D.
1640 N. Arlington Heights Rd, Suite 110
Arlington Heights, IL 60004

Tel: (847) 255-7400
Fax: (847) 398-4585

June 14, 2005

Via: Federal Express

Attn: Wendy Alls
Regulatory Specialist I
Department of Health
Division of Medical Quality Assurance
Florida Board of Medicine
4052 Bald Cypress Way, Bin #CO3
Tallahassee, FL 32399

Re: Application for Medical Doctor License

Dear Ms. Alls:

I have received your correspondence dated June 2, 2005 requesting explanation fro discrepancy regarding the date of obtaining my medical degree. The verification form states that the Medical School verified a degree date of 3/21/80 and my application reads 2/3/80.

I completed my graduation requirements around the end of January 1980. I was traveling to the United States around February 10, 1980, so I got my paperwork signed off at the school and traveled to the Tamil Nadu Medical Council in Madras to have my paperwork expedited. I received my medical registration "early" after completing my requirements and getting my provisional certificate on January 25, 1980. The class graduation was held in March 1980; after I had left for the United States.

Should you have any questions or require additional information, please contact me or my assistant, Tammy Stern, via telephone at 847-255-7400 or fax 847-398-4585.

Sincerely,

Vijay L. Goyal, M.D.

Enclosures

MEDICINE BOARD
2004 NOV 12 AM 10: 54

Vijay Goyal, M.D.
Suite 110
1640 N. Arlington Heights Road
Arlington Heights, IL 60004
Tel: (847) 255-7400
Fax: (847) 398-4585

November 8, 2004

Wendy Alls
Regulatory Specialist I
Florida Department of Health
Board of Medicine
4052 Bald Cypress Way, Bin #C03
Tallahassee, FL 32399-3253

Re: File #89558
Application for Licensure

Dear Ms. Alls:

Enclosed please find the following materials for completion of my application for medical licensure:

- Explanation of non-employment activities from 2/80 to 7/80, 6/83 to 8/83, and 1/92 to 1/94.
- MBBS Marksheets
- Copy of Marriage Certificate for Name Change Documentation (from India)
- Medical School Diploma
- The previous NPDB submitted contained the incorrect birthdate. My correct date of birth is 8/24/1955. It was just a typo error, a new report will be forwarded to you as soon as possible.

Please feel free to contact me or my assistant, Tammy Schroeder, should you have any questions via telephone at (847) 255-7400 or fax (847) 398-4585.

Sincerely,

V. Goyal MS

Vijay Goyal, M.D.

Employment and Non-employment activities:

2/80 to 7/80 – Moved to the United States and Prepared to take the Flex examination. Started my residency in 7/80.

6/83 to 8/83 - Finished residency and took two months off before starting in private practice to spend time with my children and travel.

1/92 – 1/94 – After my youngest child was born I decided to be home with my children during this time period.

Hindu ellOarriage Register.

(Rule 12).

Serial number of marriage 6 of year 1979.

1. (a) Full Name of Husband	Vinod Kumar Goyal.	
(b) Caste	Hindu.	
(c) Age (Date of birth)	30 years 7.8.1948.	
(d) Occupation and address before marriage,	Doctor. C/o Shri Jagat Ram Goyal Delhi Gate Malerkotla. Punjab	
2. (a) Full names of parents of the husband	Father	Mother
	Jagaram Goyal	Padma Vati
(b) Caste	Hindu	Hindu.
(c) Their age	56.	48.
(d) Occupation and address.	Nil. Delhi Gate Malerkotla.	Same
3. (a) Full name of wife	Vijay Laxmi Sood.	
(b) Caste	Hindu.	
(c) Age (Date of birth)	23 years. 24.8.1955.	
(d) Occupation and address before marriage	Doctor C II Jipmer Pondy 6.	
4. (a) Full names of parents or guardian in marriage if any of the wife	Father	Mother.
	Dr. Gian Chand Sood	Vimala Sood.
(b) Caste	Hindu	Hindu.
(c) Their age	56.	49.
(d) Occupation and address.	Doctor C II III Jipmer Pondicherry.	Same.
5. Name and address of the person who Solemnized the marriage	Vedankar Prasad Aurobindo Ashram Pondicherry.	
6. Whether the marriage was solemnized under customary rights and ceremonies of either parties to the marriage as required under sub sections (1) and (2) of Section 7 of the Act.	According to the Hindu right under Section 1 and 2 of Section 7 of the Hindu ellarriage Act.	

Signed: [signature]

Date: 6-9-04

Subscribed to and sworn before me this 9 day of June, 2004.

Notary Public [signature]

OFFICIAL SEAL
CATHERINE RAMIREZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11-4-2006

Hindu ellarriage Register.

(Rule 12).

Serial number of marriage 6 of Year 1979.

1. (a) Full Name of Husband	Vinod Kumar Goyal.	
(b) Caste	Hindu.	
(c) Age (Date of birth)	30 years 7.8.1948.	
(d) Occupation and address before marriage,	Doctor. C/o Shri Jagat Ram Goyal Delhi Gate ellalerkotla. Punjab	
2. (a) Full names of parents of the husband	Father	ellother
	Jagaram Goyal	Padma Vati
(b) Caste	Hindu	Hindu.
(c) Their age	56.	48.
(d) Occupation and address.	Nil. Delhi Gate ellalerkotla.	Same
3. (a) Full name of wife	Vijay Laxmi Sood.	
(b) caste	Hindu.	
(c) Age (Date of birth)	23 years. 24.8.1955.	
(d) Occupation and address before marriage	Doctor C II Jipmer Pondy 6.	
4. (a) Full names of parents or guardian in marriage if any of the wife	Father	ellother.
	Dr. Gian Chand Sood	Veniala Sood.
(b) caste	Hindu	Hindu.
(c) Their age	56.	49.
(d) Occupation and address.	Doctor C II III Jipmer Pondicherry.	Same.
5. Name and address of the person who Solemnized the marriage	Vedankar Prasad Awrobindo Ashram Pondicherry.	
6. Whether the marriage was solemnized under customary rights and ceremonies of either parties to the marriage as required under sub sections (1) and (2) of Section 7 of the Act.	According to the Hindu right under section 1 and 2 of Section 7 of the Hindu ellarriage Act.	

Signed: [signature]

Date: 6-9-04

Subscribed to and sworn before me this 9 day of June, 2004.

[signature]

Notary Public

OFFICIAL SEAL
CATHERINE RAMIREZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11-4-2005

Access HEALTH CENTER, LTD.

(630) 964-0000
(800) 403-3033
Fax (630) 964-0047

1700 75th Street • Downers Grove, IL 60516

June 9, 2004

Florida Board of Medicine
Department of Health
4052 Bald Cypress Way, Bin #C03
Tallahassee, FL 32399

RE: Vijay Goyal, M.D.

Dear Board:

I have been asked to provide reference of Dr. Vijay Goyal to you.

I have worked closely with Dr. Vijay Goyal, and have gotten to know Dr. Goyal in both a personal and professional manner. I find her to be an honorable person in all areas.

Dr. Goyal is a committed physician. This is reflected not only in her work, but in her personal life as well. She is dedicated and really takes pride in what she does.

I give my highest recommendation of Dr. Vijay Goyal to your state.

Sincerely,

Dinah Lindsay-Ahomka, M.D.

AMERICAN HEALTH
CENTER, LTD

1640 North Arlington Heights Road • Suite 210
Arlington Heights, IL • 60004
847-255-7474 • FAX 847-506-8927

June 10, 2004

Florida Board of Medicine
Department of Health
4052 Bald Cypress Way, Bin #C03
Tallahassee, FL 32399

RE: Vijay Goyal, M.D.

Dear Board:

I have had the opportunity to work with Dr. Vijay Goyal over the past year. I find her to be a very skilled physician, and a kind and caring person. She looks at each patient with the compassion and detail of a true professional.

It is my pleasure to recommend ~~Dr. Vijay Goyal~~ to you.

Sincerely,

Debjani Roy, M.D.

57. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

$5,000	$250	$0	AMOUNT ENCLOSED
Participating	Non-participating	Exempt	$ 250.00 ✓

IMPORTANT: **If an exemption is claimed, appropriate documentation must be provided to the Board of Osteopathic Medicine and to NICA. See attachment for explanation.**

I HAVE READ THE EXPLANATORY INFORMATION PROVIDED BY NICA, AND I CHOOSE THE OPTION ABOVE.

signature date

Vijay L. Goyal, M.D.
PRINTED name

1640 N. Arlington Heights Rd. #110
street address

Arlington Heights, IL 60004
city, state, zip

Return this completed, signed, and dated portion with payment (made payable to the Department of Health) to:

Department of Health
Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3256

IMG Processor 8/19/04
Application fee (400) ✓ Bkgd (52) ✓
Init lic fee (390) ✓ Reduced (205) ✓
NICA (250) ✓ Exempt ___
CME's: HIV ✓ DV ✓ ME ___
Fin Resp form ___ NICA form ___

Appl Ave End Trans# ___
Photo ✓ POA ___ FCVS ___
Complete Bkgd: FDLE ___ FBI ___ BKGNCCK

Issue(s) ___

Unaccounted Time 2/80-7/80 ✓
6/83-8/83 1/92-1/94 ✓
Name chg/variance ✓ translation ✓
Military Honorable Discharge doc ___
Undergrad transcript ___ translation ___
Med School transcript ✓ translation ___
Medical Degree ✓ translation ___
Medical School Inquiry ___

ECFMG
ECFMG certificate ✓
Certification status report ✓

SCORES:
ST BD *score* ___ *date* ___
NBME *score* ___ *date* ___
USMLE *score* ___ *date* ___
FLEX *score* ___ *date* 1980 ✓
SPEX *score* ___ *date* ___

TRAINING:

Internship certificate(s) ___
INQUIRY(S)

Residency certificate(s) Verified 3yrs
INQUIRY(S)
- Cook County Hospital 7/80-8/83 ✓

Fellowship certificate(s) ___
INQUIRY(S)

American Board Certificate(s) ___

2 Original Letters of Recommendation
(1) Ahonkay ✓
(2) Roy ✓

Current staff privileges
- Access Health Center ✓

State license(s) IL, MI, IN ✓

Nat'l Prac Data Bank ✓ AMA ___

Initial application process for Vijay L. Goyal, M. D. by Connie Clayton

******** *Fill in Dates* ********
**Complete At Intake*

Appl received* 7/26
Fingerprint card submitted* 7/28
FL licensure file requested* ___
Inquiries mailed* 8/10
Application processed 8/04 (1st review)
Last Document received 8/5
PRAES: Basic Data ___ Exam/Date ___
Supp Docs ___ Educ History ___
Submitted for 2nd Review 5/13
Next Board meeting ___
2nd Review ___

DOB
NPDB-8/27/55
Appl. 8/24/55

6/1/05

- bkgnccck
- 2/80-7/80
  6/83-8/83
  1/92-1/94
- Name Chng ?
- marksheets
- diploma
- MDverf
- ~~Exam Scores~~
- staffing
  - IL MI
- NPDB discrep
- Gottlieb ~~staff privileges~~?

1. Diploma listed Diploma rec'd 3/21/80; Application lists 2/80

Rev 6/23/03

FLORIDA
DEPARTMENT OF HEALTH
BOARD OF MEDICINE
4052 Bald Cypress Way, Bin #C03
Tallahassee, Florida 32399-3253
(850) 245-4131

RECEIVED
JUL 26 2004
DEPARTMENT OF HEALTH
BOARD OF MEDICINE

Received Date : 07/26/2004
Deposit Date : 07/27/2004
Deposit # : 167976
Batch Number : 001576
Validation # : 904015187
Check Amount : $500.00
Validation # : 904015188
Check Amount : $390.00
Validation # : 904015189
Check Amount : $250.00
Validation # : 904015190
Check Amount : $52.00
PRO_CDE : 1501

1501 MEDICAL DOCTOR APPLICATION FOR LICENSURE

READ INSTRUCTIONS FOR IMPORTANT INFORMATION

1. APPLICATION CATEGORY/APPLICABLE FEES: CLIENT 1501
(TYPE OR PRINT LEGIBLY IN BLACK INK– CHECK APPROPRIATE LICENSURE AVENUE)

[X]ENDORSEMENT (1021) [ ]C-SPEX (1022) [ ]STATE BOARD EXAM (1022) [ ] EXAMINATION (1024)

2. U.S. SOCIAL SECURITY NUMBER: _____

3a. NAME: Goyal (Last) Vijay (First) Laxmi (Middle)

3b. Have you ever changed your name through marriage or through action of a court? [X] YES [ ] NO

Vijay Laxmi Sood - 7/12/1979
If 'yes', list name(s) (Last, First, Middle) and Date(s) of changes

FD3526864
JUL 21 2004
6-0-0-4

3c. Have you ever been known by any other name (aliases)? [ ] YES [X] NO

If 'yes', list name(s) (Last, First, Middle, and Suffix)

4. MAILING ADDRESS (where you receive mail):

1640 N. Arlington Heights Rd. #110, Arlington Heights, IL 60004 USA
(Street and number or PO Box) (City) (State/Province) (Zip/Postal Code) (Country)

5. PRIMARY PRACTICE/PHYSICAL ADDRESS (where you can be located):

1640 N. Arlington Heights Rd. #110, Arlington Heights, IL 60004 USA
(Street and number) (City) (State/Province) (Zip/Postal Code) (Country)

6. TELEPHONE: (847) 334-7474 Home: Area Code/Phone Number (847) 255-7400 Work: Area Code/Phone Number,

7. E-MAIL ADDRESS: _____

8. PERSONAL DATA:
HEIGHT: 5'5" WEIGHT: 140

EYE COLOR: Brown HAIR COLOR: Black

We are required to ask that you furnish the following information as part of your voluntary compliance Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This info gathered for statistical and reporting purposes only and does not in any way affect your candidacy for

RACE: Caucasian [ ] Black [ ] Hispanic [ ] Asian [X] Native American [ ] Other [ ]
SEX: Male [ ] Female [X]

As a Florida licensed physician, are you willing to provide health care services in special need shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?
[X] Yes [ ] No

9. Are you a citizen of the U.S.? [X] YES [ ] NO
(Please provide your date and place of birth regardless of citizenship below)

Birth Date: 08/24/1955 (Month/Day/Year) Birth Place: Nepal (City)(State/Province)(Country)

a. If you are a Naturalized citizen please provide date and place of Naturalization:

02/10/1980 (Month/Day/Year) & Chicago, IL, USA (City/State/Province/Country)

b. If you are not a U.S. citizen, please provide alien number: _____

10. Have you ever been in the United States Military and/or Public Health Service? [ ] YES [X] NO

_____
If 'yes' list branch of service, rank, dates of service (Enclose copy of discharge form)

10a. Have charges, now or ever, been brought against you by any branch of the United States Military and/or Public Health Service? [ ] YES [X] NO
If 'yes' explain on a separate sheet, providing accurate details.

11. Do you hold or have you ever held a license to practice Medicine in any state in the US, Canada, Guam, Puerto Rico, Virgin Islands? [X] YES [ ] NO
If 'yes' list State or Country/Profession/License Number (provide an attachment for additional information)
Verification of each license must be received directly from the licensing authority, regardless of status of license.

Illinois/036-062651/07/27/81 (State or Country/License Number/Issue Date)
Indiana/01058843A/3/19/2004 (State or Country/License Number/Issue Date)

Michigan/4301083202/3/11/2004 (State or Country/License Number/Issue Date)
_____ (State or Country/License Number/Issue Date)

12. List the year and state/province/country where you legally first began to practice medicine?

1980 (Year) India (State/Province/Country)

13. EDUCATION: UNDERGRADUATE/GRADUATE MEDICAL EDUCATION (includes medical school) – Starting with undergraduate education, list all schools, colleges and universities attended, whether completed or not, in chronological order. Submit a separate sheet of paper if needed.

College/University Name/Address	Major/Minor Course of Study	From: MM/YY	To: MM/YY	Degree Received
Government College Simla, India	Pre-med	07/1971	06/1973	BS
Jawaharlal Institute of post-graduate Medical Education & Research / Pondicherry, India	Medicine	07/1973	02/1980	MBBS

14. Doctor of Medicine Degree was obtained from:

Jawaharlal Insitute of Post-graduate Medical Education & Research MBBS on 02/03/1980

(Name of School/Institution) (Degree Title) (Month, Day, Year)

15. Have you ever been dropped, suspended, placed on probation, expelled or requested to resign from any school, college or university? [ ] YES [x] NO
(If 'yes', explain on a separate sheet providing accurate details.)

16. Was attendance in Medical school for a period other than the normal curriculum or were you required to repeat any of your medical education? [ ] YES [x] NO
(If 'yes', explain on a separate sheet providing accurate details.)

17. Did you take a leave of absence during medical school? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

18. Have you ever taken the National Board Medical Examination, FLEX, and/or USMLE? [X] YES [ ] NO

FLEX - 06/1980
(list the examination and date taken)

18a. If you are using a combination of National Boards, FLEX, and/or USMLE completed prior to the year 2000, please list which examinations and dates on the line listed below:

19. PROFESSIONAL/POSTGRADUATE EDUCATION: List in chronological order from date of graduation from Medical school, to present, all professional/postgraduate training (Internship/Residency/Fellowship). If you are an International Graduate, please complete #19a and #19b on page #4.

Program Name and full mailing address required	Specialty Area	From: MM/YY	To: MM/YY	Did you receive credit? Yes or No
Cook County Hospital John H. Stroger Jr. Hospital 27 S. Wood Street. Chicago, IL	Pediatrics	07/1980	06/1983	yes

ONLY INTERNATIONAL MEDICAL GRADUATES NEED TO COMPLETE #19a AND #19b

19a. INTERNATIONAL MEDICAL GRADUATES PROVIDE THE FOLLOWING: CLERKSHIP(S) Be specific: Account for each clerkship. List specific date(s), type of rotation, and name and location of hospital, institution or individual where clerkship was performed or supervised. List affiliate University/College.

Medical School Rotation; Institution/Individual	Address/City/State/Country	Affiliate Program	From: MM/YY	To: MM/YY
General Medicine / 12 Weeks	Pondicherry India 605006	Jawaharlal Institute	01/79	02/80
General Surgery / 12 Weeks	Pondicherry India 605006	Jawaharlal Institute	01/79	02/80
Preventative & Social Medicine 12 Weeks	Pondicherry India 605006	Jawaharlal Institute	01/79	02/80
Obstetrics & Gynecology 12 Weeks	Pondicherry India	Jawaharlal Institute	01/70	02/80
E.N.T. (elective) 4 Weeks	Pondicherry India	Jawaharlal Institute	01/79	02/80

19b. ECFMG standard certificate or results letter number (list number) 309-839-9

(issue date) 2/20/1981

20. Have you ever been dropped, suspended, placed on probation, expelled or requested to resign from any postgraduate training program? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

21. Was attendance in a postgraduate training program for a period other than the established timeframe or were you required to repeat any of your postgraduate training? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

22. Did you take a leave of absence during a postgraduate training? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

23. PRACTICE/EMPLOYMENT: List in chronological order from date of graduation from medical school to present, all employment, non-employment and/or any unaccounted period of time. (If needed, continue on back of page or a separate page)

Name and full mailing address of employment	Type of Employment	From: MM/YY	To: MM/YY
Cook County Hospital 1835 W. Harrison Chicago, IL	3-year residency in pediatrics	07/1980	06/1983
self employment PO Box 95510 Hoffman Estates, IL	self-employment	08/1983	01/92
AH Employee Company 1640 N. Arlington Heights Rd Arlington Heights, IL 60004	Physician FT	01/94	Presen

24. Have you had responsibility for graduate medical education within the last 10 years? [ ] YES [X] NO

25. Do you currently hold a faculty appointment at a Medical/health-related institution of higher learning? [ ] YES [X] NO
(If 'yes', complete section #28)

26. List any hospital/health institution/clinic or medical facility where you have faculty appointment:

Name of Institution	Full mailing address	Title of Appointment

27. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? (If 'yes' complete section 30) [X] YES [ ] NO

28. List any hospital/health institution/clinic or medical facility where you hold staff privileges (Do Not List Training Privileges).

Name/mailing address of Facility	Chief of Staff	Type of Privileges	From: MM/YY	To: MM/YY
Access Health Center, Ltd 1640 N. Arlington Hts Rd Arlington Heights, IL 60004	Exec. Director Lisa Shyne	Active	01/94	present

29. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, placed on probation, asked to resign or asked to take a temporary leave of absence or otherwise acted against by any facility? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Name of Institution	Date: MM/DD/YY	Violation	Final Action	Under Appeal? Y/N

30. Have you ever been asked, or allowed to resign from any facility in lieu of disciplinary action or during any pending investigations into your practice? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Name/Address of Facility	Date: MM/DD/YY	Violation/Investigation	Reason for Resignation

31. Have you ever had any staff privileges restricted or not renewed by any facility in lieu of disciplinary action? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Name/Address of Facility	Date: MM/DD/YY	Circumstances	Final Action

32. CERTIFICATION: Are you certified by any Specialty Board recognized by the American Board of Medical Specialties, or specialty board approved by the Florida Board of Medicine? [ ] YES [X] NO
(If 'yes', list below and enclose a copy of each certification or letter of verification)

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification MM/YY

33. Have you ever applied for, taken an examination for, or failed to receive specialty board certification or recertification for any reason? [ ] YES [X] NO
(If 'yes', explain on a separate sheet, providing full details.)

34. Have you ever had any sanctions taken against you by a specialty board or other similar national organization? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Name of Specialty Board	Date: MM/DD/YY	Circumstances	Final Action	Under Appeal? Y/N

ALL AFFIRMATIVE ANSWERS FOR QUESTIONS 20-34 MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

35. Have you had any application for professional license or any application to practice Medicine denied by any state board or other governmental agency of any state, territory, or country? [ ] YES [X] NO

36. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Medical practice act, unprofessional or unethical conduct? [ ] YES [X] NO

37. Have you ever had any professional license or license to practice Medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? [ ] YES [X] NO

Name of Agency	Date: MM/DD/YY	Circumstances	Final Action	Under Appeal? Y/N

38. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? you must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. (If 'yes', list below and see application instructions for required documentation to submit) [ ] YES [X] NO

Offense	Date: MM/DD/YY	Jurisdiction	Final Action	Under Appeal? Y/N

39. Have you ever been criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances? [ ] YES [X] NO

40. Have you ever had employment terminated for cause? [ ] YES [X] NO

41. Have you ever been warned or called before the United States Drug Enforcement Agency (DEA)? [ ] YES [X] NO

42. Have you ever been made an offer to compromise or entered into any other arrangement or other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? [ ] YES [X] NO

43. Have you ever been denied, or surrendered a DEA Registration? [ ] YES [X] NO

44. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?

45. In the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or impairment?

46. In the last five years, have you been treated for or had a recurrence of a diagnosed physical impairment?

47. In the last five years, have you been treated for or had a recurrence of a diagnosed addictive disorder?

48. MALPRACTICE/LIABILITY CLAIMS:
Within the previous ten years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? [ ] YES [X] NO
(If "yes", complete Exhibit 1 on the next page for each occurrence)

49. Have you ever been the subject of a lawsuit or insurance claim, settled or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, or employee? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Date of Occurance	Location	Claimant	Amount	Date of Final Disposition

50. List all Medical/Professional Society or Association Memberships:

Name of Society/Association	Mailing Address	Dates of Affiliation: From/To

51. Have you ever had an application for membership denied by a Medical Society or Association or had a Medical Society or Association Membership suspended? [ ] YES [X] NO
(If 'yes', see application instructions for required documentation to submit)

52. Have you ever been notified to appear before a Medical Society or Association regarding charges/complaints filed against you? [ ] YES [X] NO
(If 'yes', see application instructions for required documentation to submit)

53. Affidavit for completion of the HIV/AIDS, Domestic Violence Course and Prevention of Medical Errors or request for extensions.

HIV/AIDS Affidavit OR Request for Extension:

[X] I hereby certify that subsequent to January 1, 1988, I have completed a minimum of three hours HIV/AIDS, AMA Category I, American Medical Association, Continuing Medical Education which meets Florida requirements.

[ ] I hereby certify that subsequent to January 1, 1988, I have **not** completed a minimum of three hours, HIV/AIDS AMA Category I, American Medical Association, Continuing Medical Education. As I have not completed the required course for initial licensure, **I understand that the six months extension is based on the date the Board of Medicine approved/certified my application for licensure** and I request an extension of up to 6 months to complete this requirement.

Domestic Violence Affidavit or Request for Extension:

[X] I hereby certify that subsequent to July 1, 1995, I have completed a minimum of one hour of Domestic Violence, Continuing Medical Education, as defined in s. 456.01, Florida Statutes.

[ ] I hereby certify that subsequent to July 1, 1995, I have **not** completed a minimum of one hour, Continuing Medical Education, in domestic violence. As I have not completed the required course for initial licensure, **I understand that the six months extension is based on the date the Board of Medicine approved/certified my application for licensure** and I request an extension of up to 6 months to complete this requirement.

Prevention of Medical Errors:

[X] I hereby certify that subsequent to June 1, 2002, I have completed a minimum of two (2) hours of Prevention of Medical Errors, Continuing Medical Education, as defined by s. 456.013(7), Florida Statutes.

[ ] I hereby certify that subsequent to June 1, 2002, I have **not** completed a minimum of two (2) hours of Prevention of Medical Errors, Continuing Medical Education, as defined by s. 456.013(7), Florida Statutes. As I have not completed the required course for initial licensure, I understand that the six months extension is based on the date the Board of Medicine approved/certified my application for licensure and I request an extension of up to 6 months to complete this requirement.

54. Dispensing Practitioner Registration: This is optional and for physicians whose primary practice is in the State of Florida.
Dispensing relates to physicians who maintain a "mini-pharmacy" in their private office for profit.

Section 465.0276, F.S., requires that licensees of the Board of Medicine who dispense medicinal drugs pay a fee of $100.00 at the time of such registration and upon each renewal of the practitioner's license. It is unlawful for any person to sell samples or complimentary packages of drug products. A practitioner who confines his/her activities to dispensing complimentary packages of medicinal drugs to patients in the regular course of his/her practice shall **not** be required to register.

[ ] I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register pursuant to Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 OVER AND ABOVE the required initial license fee.

55. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only ONE option of the ten provided pursuant to s.458.320, Florida Statutes.

CATEGORY I: FINANCIAL RESPONSIBILITY COVERAGE

☐ **1.** I do not have hospital staff privileges and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ **2.** I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ **3.** I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F.S.

☐ **4.** I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s.627.357, F .S.

☒ **5** I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgements up to the minimum amounts pursuant to s. 458.320(5)(g) 1 or 459.008S(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.0085(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐ **6.** I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;

☐ **7.** I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;

☐ **8.** I do not practice medicine in the State of Florida;

☐ **9.** I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.; and

(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that I have decided not to carry medical malpractice insurance.

☐ **10.** I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

56. OPTIONAL INFORMATION:

a. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature within the previous ten years.

(Title) (Publication) (Date)

(Title) (Publication) (Date)

(Title) (Publication) (Date)

(Title) (Publication) (Date)

b. DO YOU PARTICIPATE IN THE MEDICAID PROGRAM? [ ] YES [ ] NO
If yes list:

(Type of Provider) (state)

(Type of Provider) (state)

c. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES, HONORS OR AWARDS:

(Activity/Honor/Award) (Organization)

(Activity/Honor/Award) (Organization)

(Activity/Honor/Award) (Organization)

(Activity/Honor/Award) (Organization)

d. LANGUAGES OTHER THAN ENGLISH: Indicate languages other than English used by you to communicate with patients and any translation service available for patients at your primary place of practice.

e. COMMENTS/ADDITIONAL INFORMATION: Any comments/information you want the board to be aware of.

58. AFFIDAVIT OF APPLICANT:

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.083 and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Medicine in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

12/31/2005

(Specification of date, event or condition upon which this content expires)

Vijay L. Goyal, M.D.

(Please Print Your Name)

7/16/2004

(Signature of Applicant required) (Date Signed required)

Form # DH MQA1000-10/03

Vijay Goyal, M.D.
Suite 110
1640 N. Arlington Heights Road
Arlington Heights, IL 60004
Tel: (847) 255-7400
Fax: (847) 398-4585

MEDICINE BOARD
2004 NOV 19 PM 2:18

November 16, 2004

Wendy Alls
Regulatory Specialist I
Florida Department of Health
Board of Medicine
4052 Bald Cypress Way, Bin #C03
Tallahassee, FL 32399-3253

Re: File #89558
Application for Licensure

Dear Ms. Alls:

Enclosed please find the following materials for completion of my application for medical licensure:

- The previous NPDB submitted contained the incorrect birth date. My correct date of birth is 8/24/1955. It was just a typo error. The "new report" with corrected birth date is attached.

Please feel free to contact me or my assistant, Tammy Schroeder, should you have any questions via telephone at (847) 255-7400 or fax (847) 398-4585.

Sincerely,

Vijay Goyal, M.D.

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

MEDICINE BOARD
2004 JUL 30 AM 11:25

AMA Physician Profile

Name and Mailing Address:

VIJAY LAXMI GOYAL MD
PO BOX 95510
HOFFMAN ESTS IL 60195-0510

Primary Office Address:

STE 210
1640 N ARLINGTON HEGHTS RD
ARLINGTON HTS IL 60004-3985

Phone: UNKNOWN

Birthdate: 08/24/1955
Birthplace: INDIA UNKNOWN

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: PEDIATRICS

Secondary Specialty: GENERAL PRACTICE

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

JAWAHARLAL INST OF MED EDUC & RES, PONDICHERRY UNIV, PONDICHERRY, INDIA

Degree Awarded: Yes

Reported Year of Graduation 1980

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Chicago, Illinois 60610
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AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: JOHN H STROGER JR HOSP OF COOK CO
Specialty : PEDIATRICS

State: ILLINOIS
07/1980 - 06/1983
(VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
INDIANA	MD	03/19/2004	06/30/2005	ACTIVE	UNLIMITED	06/14/2004
MICHIGAN	MD	03/11/2004	01/31/2005	ACTIVE	UNLIMITED	07/07/2004
ILLINOIS	MD	07/27/1981	07/31/2005	ACTIVE	UNLIMITED	06/17/2004

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

ECFMG Certfication:

Applicant Number: 03098399

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

Federal Drug Enforcement Administration:

FEDERAL DEA REGISTRATION INFORMATION WAS LAST REPORTED TO THE AMA ON 06/02/2004.
DEA REGISTRATION IS VALID THROUGH 09/30/2005.

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

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515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an official "display agent" of the ABMS Specialty Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and National Committee for Quality Assurance (NCQA).

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:

Duration	Effective	Expiration	Occurrence	Last Reported

Note: **For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.**

***This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties. Copyright 2004 American Board of Medical Specialties. All right reserved.**

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

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Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please mark them on a copy of the profile and mail or fax to:

Division of Survey and Data Resources
Attn: Physician Profile Unit
515 N. State Street
Chicago, IL 60610
312 464-5199
312 464-5900 (fax)

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[redacted]

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

ROD R. BLAGOJEVICH
Governor

FERNANDO E. GRILLO
Secretary

DANIEL E. BLUTHARDT
Acting Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

THE DEPARTMENT OF HEALTH
MQA/BOARD OF MEDICINE
4052 BALD CYPRESS WAY BIN # C03
TALLAHASSEE, FL 32399-3253

Licensee:	VIJAY L GOYAL
License Number:	036-062651
Profession:	PHYSICIAN AND SURGEON
Date of Issuance:	07/27/1981
Expiration Date:	07/31/2005
License Status:	ACTIVE
License Method:	ENDORSEMENT - FLEX
Disciplinary History:	NONE

2005 MAR 15 AM 8:04 MEDICINE BOARD

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

ILL. DEPT. OF FINANCIAL & PROFESSIONAL REGULATION DIV. OF PROFESSIONAL REGULATION

Daniel E. Bluthardt
Acting Director
Division of Professional Regulation

3/9/2005
Date

Refer to the Department's Web Site at www.dpr.state.il.us to verify professional licenses via License Look-Up.

WA

Health Professions Bureau

402 West Washington Street, Room W066
Indianapolis, Indiana 46204

Telephone (317) 232-2960
Fax (317) 233-4236
http://www.ai.org/hpb

July 26, 2004

Florida Board of Medicine/Medical Quality Assurance
HMQAM
4052 Bald Cypress Way BIN #C03
Tallahassee FL 32399

MEDICINE BOARD
2004 AUG -2 PM 4:19

To Whom It May Concern:

THIS IS TO CERTIFY THAT:	Vijay Goyal
BECAME A LICENSED:	Physician
NUMBER ISSUED:	01058843A
ISSUANCE DATE:	03/19/2004
EXPIRATION DATE:	06/30/2005
STATUS:	Active
BASIS OF LICENSURE:	Endorsement
SCHOOL/GRADUATION DATE: 02/03/1980	Jawaharlal Institute Of PostGraduate Medical-India

Unless otherwise indicated, the State of Indiana has not disciplined this license. If other information is needed, you can email us at hpb3@hpb.state.in.us or phone us at (317) 234-2060.

Meredith Shirley

Meredith Shirley
Case Manager

GOVERNMENT OF INDIA

JAWAHARLAL INSTITUTE OF POSTGRADUATE MEDICAL EDUCATION AND RESEARCH, PONDICHERRY-605006

(Directorate General of Health Services)

32

CERTIFICATE

This is to certify that ~~Mr./~~Miss/~~Mrs.~~ VIJAY LAXMI SOOD was a bonafide student of this Institute from 25 JULY 1973 to 3 FEB 1980 while pursuing M. B. B. S. Course. ~~He~~/She passed the Final M. B. B. S. (Annual/~~Supplementary~~) Examination of the University of MADRAS held in DECEMBER 1978 and satisfactorily completed the compulsory Rotatory Internship (one year programme) as a Resident Intern from 27 JAN 1979 to 3 FEB 1980 as detailed below with Provisional Registration No. 129

Discipline	Period spent
1. General Medicine	12 Weeks
2. General Surgery	12 Weeks
3. Preventive & Social Medicine	12 Weeks
4. Obstetrics & Gynaecology	12 Weeks.
5. Elective Subject (if any) (E.N.T.)	4 Weeks.

~~He~~/She is eligible for the award of the M. B. B. S. degree of the University of Madras.

~~His~~/Her work, character and conduct during the stay in this Institution were found to be satisfactory as per records.

Date : 4th Feb, 1980.

DIRECTOR

DIRECTOR,
JAWAHARLAL INSTITUTE OF
POSTGRADUATE MEDICAL EDUCATION
AND RESEARCH,
PONDICHERRY - 605006

OFFICE SEAL

OFFICE OF THE DIRECTOR

Folio No. 336

UNIVERSITY OF MADRAS

University Centenary Building,
Chepauk, Madras-600 005.

Dated 25 JAN 1980

C.P.No. 27

Register No. 1960

Disposal No. YE. 1775

PROVISIONAL CERTIFICATE-M.B. & B.S.

This is to certify that Vijay Laxmi Sood

has qualified for the Degree of Bachelor of Medicine and Surgery, she having passed in the Second Class the Final M.B. & B.S. Degree Examination held in December 1978 and having satisfactorily completed the period of Compulsory Rotatory Internship in January 1980.

UNIVERSITY 82 OF MADRAS

T. Ilangovan
Assistant Registrar.

725

Government of India

JAWAHARLAL INSTITUTE
OF POSTGRADUATE MEDICAL EDUCATION AND RESEARCH
DHANVANTARI NAGAR – PONDICHERRY-605006
(Directorate General of Health Services)

VERITAS CURAT

CHARACTER CERTIFICATE

This is to certify that ~~Thiru~~/Selvi. VIJAY LAXMI SOOD

has been a student of this Institute from 25 JULY 1973 to 3 FEB 1980

~~His~~/Her character and conduct during the period were GOOD

Date 14th Feb. 1980 (Seal)

Principal
DIRECTOR,
JAWAHARLAL INSTITUTE OF
POSTGRADUATE MEDICAL EDUCATION
AND RESEARCH
PONDICHERRY - 605006.

OFFICE OF THE DIRECTOR
JIPMER
PONDICHERRY-6

TAMIL NADU MEDICAL COUNCIL
MADRAS

MEDICAL REGISTRATION CERTIFICATE

Certificate No. 33010

.....5th February....., 1980

I HEREBY CERTIFY that the following is a true copy of the entry in the Tamil Nadu List of the Register relating to the fully registered medical practitioner named below :—

NAME	FATHER'S NAME	ADDRESS	DATE OF FULL REGISTRATION	QUALIFICATIONS
VIJAY LAXMI SOOD	Gian Chand Sood	C/O Dr.G.C.Sood, CII-11, J.I.P.M.E.R., Pondicherry-6.	5.2.1980	M.B.B.S. (Madras) 1980

COURT FEE 1Re 50P Rs. 40q INDIA 1 रुपया ५० पैसे 1 RUPEE 50 PAISE

M.A., B.L.,
REGISTRAR

SEAL OF THE REGISTRAR ★ TAMIL NADU MEDICAL COUNCIL, MADRAS.

IMPORTANT NOTICES

Registered Medical Practitioners should be careful to send the Registrar immediate notice of any change in their registered addresses and also to answer all inquiries that may be sent to them by the Registrar in regard thereto, in order that

1960

University of Madras

FACULTY OF MEDICINE

The Senate of the University of Madras hereby makes known that - Vijay Laxmi Sood - has been admitted to the Degree of Bachelor of Medicine and Surgery, She having been certified by duly appointed Examiners to be qualified to receive the same, and having been by them placed in the Second Class at the Examination held in the month of December 1978

Given under the seal of the University.

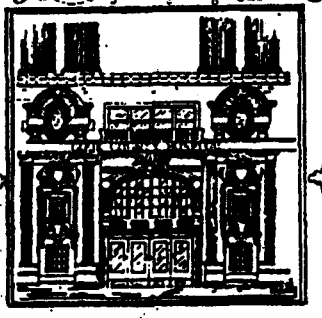
Senate House,

March 21, 1980

Registrar

B.Sc. Engg., D.Sc., C Engg., F.I.E.E. (Lond.)
F.I. Nuc. E. (Lond.), F.I.E. (Ind.),
Vice-Chancellor.

Cook County Hospital

CHICAGO,  ILLINOIS.

This certifies that

Vijay L. Goyal, M.D.

has satisfactorily completed

a Residency in Pediatrics

from July 1, 1980 to June 30, 1983

In Testimony Whereof the undersigned have affixed their signatures at Chicago, Illinois.

Louise Hayes Brown M.D.
Medical Director

Theodore Sheinfeld M.D.
President of Staff

COOK COUNTY HOSPITAL ORGANIZED 1865 CHICAGO, ILL.

Conrad Tarshis, M.D.
Department of Medical Education

Robert A. Miller M.D.
Department Chairman

SARAVANOS KAREN KYRIAKI
10426 SPRINGROSE DRIVE
TAMPA, FL 33626

YERALDINE TO
5950 SW 74 STI
MIAMI, FL 3314:

FLORIDA DEPARTMENT OF HEALTH
Division of Medical Quality Assurance
P.O.Box 6330
Tallahassee, Florida 32314-6330

FLORIDA DEPARTMENT OF HEALTH
Division of Medical Quality Assurance
P.O.Box 6330
Tallahassee, Florida 32314-6330

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS, IL 60004

PAZ ACUNA FE
19 BELVOIR AV
CHATTANOOG/

ı.

(850)488-0595 for further information.

ır application. Once your application
ed in writing by the appropriate

This is to acknowledge receipt of your application. Once your application has been reviewed, you will be notified in writing by the appropriate regulatory specialist.

ıing of your application prior to
t timeframe, you may contact
ı.

Please allow 30 days for the processing of your application prior to contacting the board office. After that timeframe, you may contact (850)488-0595 for further information.

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
SUITE 110
ARLINGTON HEIGHTS, IL 60004

93464

Your Medical Doctor License # **ME 93464** will expire at midnight, Eastern Standard Time (EST) on **Saturday, January 31, 2009**. The total fee due for this renewal is **$391.00**.

Please log onto **www.FLHealthsource.com** and follow these steps:

1. Click **Renew My License** and log in.
2. Click **Renew License** and select your renewal option:
    a. Renew on-line
    b. Print your renewal notice to submit with your payment via mail

You will be prompted to complete the Physician Workforce Survey online.

Renewals by mail **MUST** include the renewal notice, not this postcard.

Remember all renewals MUST be submitted **no later than January 31, 2009**.
Questions? Contact the MQA Call Center at (850) 488-0595.

7. CHANGES TO CURRENT LICENSE INFORMATION:

◯ CHANGE OF NAME:

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the cle of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:

First Name:

Middle Name: Title Suffix: *(Jr,Sr,I,II,etc.)* Qualifier: *(PhD,DDS,etc.)*

◯ CHANGE OF MAILING ADDRESS:

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

◯ CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM:

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 2-4 weeks processing time.

REQUIRED:
- ◯ Renewal notice
- ◯ Check or Money order written to Department of Health
- ◯ Financial Responsibility form (check only one item on the FR form)
- ◯ Updated paper copy of Profile, if you are mailing your renewal notice
- ◯ Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

◯ Yes

CHANGE OF LICENSE STATUS:

◯ I wish to change my status from active to inactive. The fee for an inactive receipt is **$415.00**. The fee for inactive after January 31, 2007 is **$900.00**.

CHANGE TO MILITARY STATUS:

◯ I am requesting Military Active Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military active is **$00.00**.

CHANGE TO RETIRED STATUS:

◯ I am requesting retired status. The fee for retired status is **$55.00** postmarked on or before January 31, 2007. The fee for retired status on or after February 01, 2007 is **$540.00**.

DISPENSING:

◯ I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner is **$100.00** in addition to your renewal fee.

PHYSICIAN WORKFORCE QUESTIONNAIRE

The items below relate to very important questions regarding Florida's current and future physician workforce. Your responses will be instrumental in shaping Florida's health care and physician workforce policies. Secretary of the Department of Health, M. Rony François, M.D., M.S.P.H., Ph.D., and the Council of Florida Medical School Deans, Florida Graduate Medical Education Committee, Florida Medical Association and Florida Osteopathic Medical Association appreciate your time and effort in responding to the eight questions below.

Name: VIJAY LAXMI GOYAL **License Number:** ME 93464

1. Do you practice medicine at any time during the year in Florida?

Note: If you check 'No' then please stop here. ◯ Yes ◯ No

2. How many months/year do you practice medicine in Florida?

◯ 1-4 Months ◯ 5-8 Months ◯ 9-12 Months

3. In what Florida counties do you practice?(may select up to 5 counties)
Please note - County Names and Numeric Codes are listed on the back side of the form.
Please print or type County Names and Numeric Codes below.

	County Name	Numeric Code	1-20 Hrs/Wk	21-40 Hrs/Wk	More than 40 Hrs/Wk
a.			◯	◯	◯
b.			◯	◯	◯
c.			◯	◯	◯
d.			◯	◯	◯
e.			◯	◯	◯

4. Is more than twenty percent (20%) of your practice non-clinical? (i.e. research, teaching, administration)

◯ Yes ◯ No

5. Are you a resident or fellow?

◯ Yes ◯ No

6. What is the primary specialty area(s) of your current clinical practice?(may select up to 5 different areas)
Please note - Specialty Areas and Numeric Codes are listed on the back side of the form.
Please print or type Specialty Areas and Numeric Codes below.

	Specialty Area	Numeric Code	1-20%	21-40%	41-60%	61-80%	81-100%
a.			◯	◯	◯	◯	◯
b.			◯	◯	◯	◯	◯
c.			◯	◯	◯	◯	◯
d.			◯	◯	◯	◯	◯
e.			◯	◯	◯	◯	◯

7. Do you plan to retire, relocate outside of the state of Florida, or significantly reduce the scope of your practice within the next five years?

◯ Yes ◯ No

8. Do you currently take emergency call or otherwise work clinically in a hospital emergency department or provide for the immediate, acute care of trauma patients?

◯ Yes ◯ No

County Names and Numeric Codes (Reference for question # 3)

11 ALACHUA	25 DIXIE	39 HILLSBOROUGH	53 MARTIN	67 SANTA ROSA
12 BAKER	26 DUVAL	40 HOLMES	54 MONROE	68 SARASOTA
13 BAY	27 ESCAMBIA	41 INDIAN RIVER	55 NASSAU	69 SEMINOLE
14 BRADFORD	28 FLAGLER	42 JACKSON	56 OKALOOSA	70 SUMTER
15 BREVARD	29 FRANKLIN	43 JEFFERSON	57 OKEECHOBEE	71 SUWANNEE
16 BROWARD	30 GADSDEN	44 LAFAYETTE	58 ORANGE	72 TAYLOR
17 CALHOUN	31 GILCHRIST	45 LAKE	59 OSCEOLA	73 UNION
18 CHARLOTTE	32 GLADES	46 LEE	60 PALM BEACH	74 VOLUSIA
19 CITRUS	33 GULF	47 LEON	61 PASCO	75 WAKULLA
20 CLAY	34 HAMILTON	48 LEVY	62 PINELLAS	76 WALTON
21 COLLIER	35 HARDEE	49 LIBERTY	63 POLK	77 WASHINGTON
22 COLUMBIA	36 HENDRY	50 MADISON	64 PUTNAM	78 UNKNOWN
23 DADE	37 HERNANDO	51 MANATEE	65 ST.JOHNS	79 OUT OF STATE
24 DESOTO	38 HIGHLANDS	52 MARION	66 ST.LUCIE	80 FOREIGN

Specialty Areas and Numeric Codes (Reference for question # 6)

000 NO CLINICAL PRACTICE
020 ALLERGY AND IMMUNOLOGY
040 ANESTHESIOLOGY
045 CRITICAL CARE MEDICINE
048 PAIN MEDICINE
042 PEDIATRIC ANESTHESIOLOGY
060 COLON AND RECTAL SURGERY
080 DERMATOLOGY
100 DERMATOPATHOLOGY
081 PROCEDURAL DERMATOLOGY
110 EMERGENCY MEDICINE
118 MEDICAL TOXICOLOGY
114 PEDIATRIC EMERGENCY MEDICINE
116 SPORTS MEDICINE
119 UNDERSEA AND HYPERBARIC MEDICINE
120 FAMILY MEDICINE
125 GERIATRIC MEDICINE
127 SPORTS MEDICINE
140 INTERNAL MEDICINE
141 CARDIOVASCULAR DISEASE
154 CLINICAL CARDIAC ELECTROPHYSIOLOGY
142 CRITICAL CARE MEDICINE
143 ENDOCRINOLOGY, DIABETES, AND METABOLISM
144 GASTROENTEROLOGY
151 GERIATRIC MEDICINE
145 HEMATOLOGY
155 HEMATOLOGY AND ONCOLOGY
146 INFECTIOUS DISEASE
152 INTERVENTIONAL CARDIOLOGY
148 NEPHROLOGY
147 ONCOLOGY
149 PULMONARY DISEASE
156 PULMONARY DISEASE AND CRITICAL CARE MEDICINE
150 RHEUMATOLOGY
157 SPORTS MEDICINE
160 MEDICAL GENETICS
190 MOLECULAR GENETIC PATHOLOGY
169 NEUROLOGICAL SURGERY
180 NEUROLOGY
185 CHILD NEUROLOGY
187 CLINICAL NEUROPHYSIOLOGY
183 NEUROMUSCULAR MEDICINE
186 NEURODEVELOPMENTAL DISABILITIES
181 PAIN MEDICINE
188 VASCULAR NEUROLOGY
200 NUCLEAR MEDICINE
220 OBSTETRICS AND GYNECOLOGY
240 OPHTHALMOLOGY
260 ORTHOPAEDIC SURGERY
261 ADULT RECONSTRUCTIVE ORTHOPAEDICS
262 FOOT AND ANKLE ORTHOPAEDICS
263 HAND SURGERY
270 MUSCULOSKELETAL ONCOLOGY
268 ORTHOPAEDIC SPORTS MEDICINE
267 ORTHOPAEDIC SURGERY OF THE SPINE
269 ORTHOPAEDIC TRAUMA
265 PEDIATRIC ORTHOPAEDICS
280 OTOLARYNGOLOGY
286 NEUROTOLOGY
288 PEDIATRIC OTOLARYNGOLOGY
300 PATHOLOGY-ANATOMIC AND CLINICAL
305 BLOOD BANKING/TRANSFUSION MEDICINE
306 CHEMICAL PATHOLOGY
307 CYTOPATHOLOGY
310 FORENSIC PATHOLOGY
311 HEMATOLOGY
314 MEDICAL MICROBIOLOGY
315 NEUROPATHOLOGY
316 PEDIATRIC PATHOLOGY
301 SELECTIVE PATHOLOGY
320 PEDIATRICS
321 ADOLESCENT MEDICINE
329 NEONATAL-PERINATAL MEDICINE
325 PEDIATRIC CARDIOLOGY
323 PEDIATRIC CRITICAL CARE MEDICINE
324 PEDIATRIC EMERGENCY MEDICINE
326 PEDIATRIC ENDOCRINOLOGY
332 PEDIATRIC GASTROENTEROLOGY
327 PEDIATRIC HEMATOLOGY/ONCOLOGY
335 PEDIATRIC INFECTIOUS DISEASES
328 PEDIATRIC NEPHROLOGY
330 PEDIATRIC PULMONOLOGY
331 PEDIATRIC RHEUMATOLOGY
333 PEDIATRIC SPORTS MEDICINE
336 DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
340 PHYSICAL MEDICINE AND REHABILITATION
341 PAIN MEDICINE
346 PEDIATRIC REHABILITATION
345 SPINAL CORD INJURY MEDICINE
360 PLASTIC SURGERY
361 CRANIOFACIAL CURGERY
363 HAND SURGERY
380 PREVENTIVE MEDICINE
399 MEDICAL TOXICOLOGY
398 UNDERSEA AND HYPERBARIC MEDICINE
400 PSYCHIATRY
401 ADDICTION PSYCHIATRY
405 CHILD AND ADOLESCENT PSYCHIATRY
406 FORENSIC PSYCHIATRY
407 GERIATRIC PSYCHIATRY
402 PAIN MEDICINE
409 PSYCHOSOMATIC MEDICINE
420 RADIOLOGY DIAGNOSTIC
421 ABDOMINAL RADIOLOGY
429 CARDIOTHORACIC RADIOLOGY
422 ENDOVASCULAR SURGICAL NEURORADIOLOGY
426 MUSCULOSKELETAL RADIOLOGY
423 NEURORADIOLOGY
425 NUCLEAR RADIOLOGY
424 PEDIATRIC RADIOLOGY
427 VASCULAR AND INTERVENTIONAL RADIOLOGY
430 RADIATION ONCOLOGY
520 SLEEP MEDICINE
440 SURGERY-GENERAL
443 HAND SURGERY
445 PEDIATRIC SURGERY
442 SURGICAL CRITICAL CARE
450 VASCULAR SURGERY
460 THORACIC SURGERY
480 UROLOGY
485 PEDIATRIC UROLOGY
999 OTHER

Division of Medical Quality Assurance
P.O. Box 4839
Tampa, Florida 33677-4839

***** License Renewal Notification *****

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
SUITE 110
ARLINGTON HEIGHTS, IL 60004

License Renewal Notification

Your Medical Doctor License # **ME 93464** will expire at midnight, Eastern Standard Time (EST) on **Thursday, January 31, 2013.**

Please log onto **www.FLHealthsource.com** and follow these steps:

1. Click **Renew My License** and log in.
2. Click **Renew License** and select your renewal option:
    a. Renew on-line
    b. Print your renewal notice to submit with your payment via mail

You will be prompted to complete the Physician Workforce Survey online.

Renewals by mail **MUST** include the renewal form, not this postcard.

Visit **www.cebroker.com/subscribe** to purchase your **optional** subscription and track your continuing education credits.

Section 456.0635, F.S., may affect your ability to renew your license. Please visit **http://www.doh.state.fl.us/mqa/laws.html** for more information.

Remember, all renewals MUST be submitted **no later than January 31, 2013** in order to avoid a delinquent fee. Questions? Contact the MQA Call Center at (850) 488-0595.

AC# COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
12/07/2010	ME 93464	332540

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2013**

COPY COPY COPY

VIJAY LAXMI GOYAL
ATTN: MICHELE SHIN
1640 N ARLINGTON HEIGHTS RD
SUITE 110
ARLINGTON HEIGHTS, IL 60004

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
AC#
DATE 12/07/2010
LICENSE NO. ME 93464
CONTROL NO. 332540
The MEDICAL DOCTOR
COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: JANUARY 31, 2013

Your license number is **ME 93464**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

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1. Go to **www.flhealthsource.com**
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password that was provided to you on your initial license
6. If you do not know your account ID and password, click on **"Get Login Help"** or call for assistance.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

********** **AUTO** **********

VIJAY LAXMI GOYAL
ATTN: MICHELE SHIN
1640 N ARLINGTON HEIGHTS RD
SUITE 110
ARLINGTON HEIGHTS, IL 60004

COPY

COPY COPY COPY

COPY - NOT A VALID LICENSE - COPY

COPY - NOT A VALID LICENSE - COPY

:600043985357:

009_014_02610

Jeb Bush
Governor

FLORIDA DEPARTMENT OF HEALTH

John O. Agwunobi, M.D., M.P.H., M.B.A.
Secretary

July 22, 2005

VIJAY L GOYAL, M.D.
1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS, IL-60004

Re: License #:93464

Dear Dr. GOYAL:

The information that will be published in your practitioner profile is enclosed with this letter. In carrying out our legislative mandate to publish physician profiles, we want to do everything we can to ensure the information we publish is correct. Accordingly, we ask that you please review your profile for any changes, corrections and/or omissions. If you see the statement **"The practitioner did not provide this mandatory information"**, be sure to provide that information. We will **not** accept curriculum vitae or resumes in replacement of you providing specific information.

Under section 456.041(7), Florida Statutes, you have thirty (30) days from receipt of this letter to submit changes to the department. **Changes should be indicated directly in the Practitioner Profile Section** of this letter, if there are no changes, please indicate so in the space provided. Changes must be received in this office by **September 07, 2005** or your profile will be published as it appears in the Practitioner Profiling Section of this letter.

This document must be signed by you and returned to the address below within the timeframe specified above. If you have any questions, please call (850) 245-4226, Monday through Friday, 8:00a.m. to 5:00 p.m.,

☑ My profiling information is correct

☒ My profiling information is incorrect; changes are noted in the Practitioner Profile Section.

Sincerely,

RECEIVED
AUG 19 2005
LICENSURE SERVICES UNIT

Profile Section

Enclosures

Practitioner Profile Section

I. Practitioner Information

License Number : 93464
Profession : Medical Doctor
License Status : ACTIVE CLEAR
Year Began Practicing : 07/01/1980

Primary Business:

1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS IL 60004

Secondary Locations:

Staff Privileges:

This practitioner does not currently hold staff privileges at any hospital/medical/health institution in Florida. To confirm out-of-state staff privileges please see other affiliations.

Faculty Appointments:

This practitioner has not had the responsibility for graduate medical education within the last 10 years.

This practitioner does not currently hold faculty appointments at any medical/health related institutions of higher learning.

Participates in Medicaid Program:

The practitioner did not indicate if he/she participates in the Medicaid program.

II. Education and Training

Medical School : Dates of Attendance : Graduation Date : Degree Title
1. UNKNOWN : 07/01/1973 - 02/01/1980 : 02/03/1980 : MBBS

Other Health Related Degrees:

School/University : City : State/Country : Dates Attended : Degree Title
1. GOVT COLLEGE : SIMLA : INDIANA : 7/1/1971 - 6/1/1973 : BS - BACHELOR OF SCIENCE
INDIA

III. Professional and Postgraduate Training

This practitioner has completed the following graduate medical education:
Program Name : Program Type : Specialty Area : City : State/Country : Dates Attended

1. COOK COUNTY HOSPITAL : RESIDENCY : PD - PEDIATRICS : CHICAGO : ILLINOIS : 7/1/1980 - 6/1/1983

IV. Specialty

This practitioner does not hold any certifications from specialty boards recognized by the Florida board which regulates the profession for which he/she is licensed.

V. Optional Information

Committees:/Memberships

This practitioner has not indicated any committees on which they serve for any health entity with which they are affiliated.

Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

Languages Other Than English

This practitioner has not indicated that any languages other than English are used to communicate with patients, or that any translation service is available for patients, at his/her primary place of practice.

Other Affiliations

This practitioner has not provided any national, state, local, county, or professional affiliations.

E-Mail Address

Not Provided

Other State Licensure

This practitioner has indicated the following additional state licensure:

Jurisdiction	Profession
Michigan	MD
Indiana	MD
Illinois	MD

VI. Financial Responsibility

I have elected not to carry medical malpractice; however, I agree to satisfy any adverse judgements up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.0085(5) (g)1, F. S. I understand that I must either post notice in the form of a 'sign' prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.0085(5)(g), F. S.

VII. Criminal Offenses

The criminal history information, if any exists, may be incomplete; federal criminal history is not available to the public.

This practitioner has indicated that he/she has NO criminal offenses.

VIII. Final Disciplinary Action (Within last 10 years)

Pursuant to section 455.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a specialty board.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a licensing agency.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

This practitioner has indicated that he/she has NEVER been asked to or allowed to resign from or had any medical staff privileges restricted or revoked within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

IX. Liability Claims Exceeding $5,000.00 (Within last 10 years)

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

There have not been any reported liability actions, which are required to be reported under section 455.697, F.S., within the previous 10 years.

Signature

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.072, 458.327, 458.331, 459.013, 459.015, 460.413, 461.013, 775.082, 775.083, and 775.084 Florida Statutes.

Jeb Bush
Governor

FLORIDA DEPARTMENT OF HEALTH

John O. Agwunobi, M.D., M.P.H., M.B.A.
Secretary

July 22, 2005

VIJAY L GOYAL, M.D.
1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS, IL-60004

Re: License #:93464

Dear Dr. GOYAL:

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◯ My profiling information is incorrect; changes are noted in the Practitioner Profile Section.

Sincerely,

Profile Section

Enclosures

Practitioner Profile Section

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Profession : Medical Doctor
License Status : ACTIVE CLEAR
Year Began Practicing : 07/01/1980

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1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS IL 60004

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E-Mail Address

Not Provided

Other State Licensure

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Signature

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.072, 458.327, 458.331, 459.013, 459.015, 460.413, 461.013, 775.082, 775.083, and 775.084 Florida Statutes.

FLORIDA DEPARTMENT OF HEALTH
Division of Medical Quality Assurance
P.O.Box 6340
Tallahassee, Florida 32314-6340

MAILED FROM ZIP CODE 32301
Aug 30
2012
PRSRT. FIRST-CLASS
U.S. POSTAGE
PAID
TALLAHASSEE, FL-32301
PERMIT NO. 543

AUTO 93464

38:63:25208 *** **Important License Information** ***

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
SUITE 110
ARLINGTON HEIGHTS, IL 60004

:600043985357:

Your license is scheduled for renewal within the next 5 months. You are required to review and, if appropriate, update your profile before renewing your license. In addition, Section 456.042, Florida Statutes, requires you to submit profile updates within 15 days of any changes.

You may review, update and confirm the accuracy of your practitioner profile information online by visiting **www.FLHealthsource.com**. Select LICENSEE/PROVIDER, click on VIEW PROFILE, and Login with your Account ID and Password. If you make changes to your profile, BE SURE to click on "confirm changes" to update the Department's information system.

If you have any questions, please contact the MQA Call Center at (850) 488-0595.

AC# COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
12/28/2006	ME 93464	206848

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2009**

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS, IL 60004

COPY COPY COPY

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
DATE 12/28/2006 | LICENSE NO. ME 93464 | CONTROL NO. 206848
The MEDICAL DOCTOR
COPY - NOT A VALID LICENSE - COPY

LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR DISPLAY IF REQUIRED BY LAW SECRETARY

EXPIRATION DATE: JANUARY 31, 2009

Your license number is **ME 93464**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to **www.flhealthsource.com**
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password here **(Account ID and Password are case sensit**
6. Click on Login

To request a duplicate license, submit this form and a check or money order, payable to the **DEPARTMENT OF HEALTH**, in the amount of **$25.00**.
Now that you have your license, make sure you keep it. Go to **www.doh.state.fl.us/mqa/mwoid.html** to find out more.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

☐ **PRACTICE LOCATION ADDRESS CHANGE**
(This address will be printed on your license and posted on the Internet.)

_____
_____
CITY STATE ZIP

☐ **MAILING ADDRESS CHANGE**
(This address will be used when mailing your license and for all other correspondence from the Department.)

_____
_____
CITY STATE ZIP

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS, IL 60004

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
10/30/2012	ME 93464	397615

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2015**

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
SUITE 110
ARLINGTON HEIGHTS, IL 60004

COPY COPY COPY

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
CONTROL NO. 397615
LICENSE NO. ME 93464
DATE 10/30/2012
The MEDICAL DOCTOR
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: JANUARY 31, 2015
COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

EXPIRATION **JANUARY 31, 2015**

Your license number is **ME 93464** , please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

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2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password that was provided to you on your initial license and e
6. If you do not know your account ID and password, click on "Get L ogin Help" or call our ssistance.

MAIL **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

********** **AUTO** **********

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
SUITE 110
ARLINGTON HEIGHTS, IL 60004

COPY

COPY COPY COPY

COPY - NOT A VALID LICENSE - COPY

COPY - NOT A VALID LICENSE - COPY

:600043985357:

009_012_02322

Division of Medical Quality Assurance
P.O.Box 6340
Tallahassee, Florida 32314-6340

***** Important License Information *****

GOYAL, VIJAY LAXMI
1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS, IL 60004

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If you have any questions, please contact the MQA Call Center at (850) 488-0595, option 3.

AC# COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
02/03/2009	ME 93464	280596

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2011**

COPY COPY COPY

VIJAY LAXMI GOYAL
ATTN: MICHELE SHIN
1640 N ARLINGTON HEIGHTS RD
SUITE 110
ARLINGTON HEIGHTS, IL 60004
UNITED STATES

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
DATE 02/03/2009 | LICENSE NO. ME 93464 | CONTROL NO. 280596
The MEDICAL DOCTOR
named below has met all requirements of
COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: JANUARY 31, 2011

Your license number is **ME 93464**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

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1. Go to www.flhealthsource.com
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password here (Account ID and Password are case sensit
   Where 'l' is lowercase letter 'L' and 'o' is lowercase letter 'O'.
6. Click on Login

MAIL TO: DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

VIJAY LAXMI GOYAL
ATTN: MICHELE SHIN
1640 N ARLINGTON HEIGHTS RD
SUITE 110
ARLINGTON HEIGHTS, IL 60004
UNITED STATES

Florida Department of Health - Board of Medicine

LICENSE RENEWAL NOTICE

DEPARTMENT USE ONLY

Active Medical Doctor License # ME 93464 expires January 31, 2007.

The fee of **$454.00** and the renewal notice must be postmarked on or before January 31, 2007. Renewal notices postmarked on or after February 01, 2007 require renewal and delinquent fees of **$839.00**.

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

VIJAY LAXMI GOYAL
1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS, IL 60004

2. CURRENT PRACTICE LOCATION:

This address will be printed on your license and posted on the Internet.

1640 N ARLINGTON HEIGHTS RD
APT 110
ARLINGTON HEIGHTS, IL 60004

3. PROFILE CONFIRMATION:

Florida Statutes 456.039(1) and 456.0391(1) require that you update your profile at renewal. Please review and confirm the information in your profile before completing your renewal. Each practitioner who applies for license renewal must, in conjunction with procedures adopted by the Department of Health, and in addition to any other information that may be required, furnish the mandatory reporting requirements.

Note: A practitioner must submit updates to their profile within 15 days of any changes, 456.042, F.S.

You may review/update your profiling information by visiting the following link, **www.flhealthsource.com**. Use the login information provided on this notice. If you still choose to manually submit your information after visiting our website, please print out your profile using the print friendly version and make any changes directly on the profile. Please include your updates, if any, along with your other renewal information.

I have reviewed and confirmed the information in my profile. ◯

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license, please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. **Online Renewal:** Visit **www.flhealthsource.com**, from our main page, select **Licensee/Provider**, go to the **Practitioner Logon** box located on the left side of the page, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2007. To use the online system, you will need the following information:

Account ID **Password**

(Note: Account ID and Password must be entered exactly as they appear.)

The online system will allow practitioners to update their address, profile, and to confirm licensee information maintained by the Department. Practitioners will receive confirmation of their successful renewal before logging out of the system.

Avoiding complaints can protect your clients and your ability to practice. Go to **www.doh.state.fl.us/mqa/avoid.html** to find out more.

B. **U.S. Mail:** Mail completed form and fee payable to the Department of Health to the following address:

Department of Health, Division of Medical Quality Assurance, PO Box 6320, Tallahassee, FL 32314-6320

6. OTHER INFORMATION:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

A licensee who remains on inactive status for more than two consecutive biennial licensure cycles and who wishes to reactivate the license may be required to demonstrate the competency to resume active practice by sitting for a special purpose examination or by completing other reactivation requirements.

File Number: 89558 Sequence Number: 1756
Profession Code: 1501 20 20

ME 93464

Please make changes to your license information in section 7 on the BACK of this form.

EDUCATIONAL COMMISSION
for
FOREIGN MEDICAL GRADUATES

CERTIFIES THAT

VIJAY LAXMI GOYAL

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,

SUCCESSFULLY TS EXAMINATIONS

AND HAS BEEN AWARDED THIS CERTIFICATE.

CERTIFICATE NUMBER 309-839-9

MEDICAL EXAMINATION JULY 25, 1979

ENGLISH EXAMINATION JULY 25, 1979

DATE ISSUED February 20, 1981

VALID THROUGH

CERTIFICATE NUMBER
0-309-839-9
ENGLISH EXAMINATION
February 4, 2004
VALID THROUGH
February 2006

ECFMG

PRESIDENT

EXECUTIVE DIRECTOR

MEDICINE BOARD
2005 MAY -3 AM 10: 58

THE DEPARTMENT OF HEALTH
FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FLORIDA 32399-3253

APPLICANT COMPLETES #'S 1 THROUGH 5

1. **TO:** Jawaharlal Institute of Postgraduate Medical Education & Research
NAME OF MEDICAL SCHOOL

Dhanvantri Nagar
ADDRESS OF MEDICAL SCHOOL

Pondicherry - 605006, India
CITY - STATE - ZIP - COUNTRY

FROM: MEDICAL GRADUATE

MEDICAL SCHOOL: PLEASE VERIFY NUMBERS 2-5 AND COMPLETE NUMBER 6, AND AUTHENTICATE BY SIGNATURE AND SCHOOL SEAL. RETURN THIS FORM TO THE FLORIDA BOARD OF MEDICINE. THANK YOU!

2. **NAME:** Vijay L. Sood M.D. **S.S.#** _____

3. **PROFESSION:** MEDICAL DOCTOR

4. **DATE OF BIRTH:** 08/24/1955

5. **TYPE OF DEGREE:** MBBS **DATE DEGREE GRANTED:** ~~December 1979~~/January 1980 - March 21/1980

6. **COMMENTS:**

SEAL

DEAN
Dr. K. S. REDDY
JAWAHARLAL INSTITUTE OF POSTGRADUATE
MEDICAL EDUCATION AND RESEARCH
PONDICHERRY -605 006.

18/04/2005

VERIFIED BY
Dr.K.S.REDDY
NAME

TITLE DEAN

Form # DH MQA1000-10/03

WA

STAFF PRIVILEGE VERIFICATION FORM
DEPARTMENT OF HEALTH
MQA DIVISION
FLORIDA BOARD OF MEDICINE
4052 Bald Cypress Way, BIN #C03
Tallahassee, Florida 32399-3253
(850) 245-4131/FAX 488-0596

MEDIC BOARD
2004 SEP - 3 PM 2:00

The physician listed in #1 submitted an application for licensure and is under investigation by this authority. Please complete items 1 through 4 of this form,

and return. Thank You!

August 10, 2004

TO: **Medical Staff Office**
Attn: Chief of Staff
Access Health Center Ltd
1640 N. Arlington Heights Road
Arlington Heights, IL 60004

FROM: **Florida Board of Medicine -- Medical Endorsement/Examination Section**

NAME: Vijay L. Goyal, MD

1. Does (s)he have full staff privileges in his/her specialty? Yes X No___

   If no, explain _____

2. Does (s)he perform competently? Yes X No___

   If no, explain _____

3. Has (s)he been regularly reappointed? Yes X No___

   If no, explain _____

4. Have any restrictions ever been placed on this individual beyond the original period of probation? Yes ~~X~~ (error) No X

   If yes, explain No restrictions.

REMARKS: We are happy to have her on staff...

DATE: 8/16/04

SIGNATURE OF CHIEF OF STAFF: [signature]
(No STAMPED signatures please)

Exec. Director

Fermina C Ventura MD

(Medical Director)

WA

MEDICINE BOARD
2004 AUG 24 AM

JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 08/13/2004

THE DEPARTMENT OF HEALTH
MEDICAL QUALITY ASSURANCE/BOARD OF MEDICINE
HMQAM
4052 BALD CYPRESS WAY
BIN # C03
TALLAHASSEE, FL 32399-3253

NAME: Vijay Laxmi Goyal

SSN

ADDRESS: PO Box 772
Barrington IL 60010

BIRTHDATE: 08/24/1955

TYPE: Medical Doctor

ORIGINAL DATE: 03/11/2004

LICENSE NUMBER: 4301083202 **STATUS:** Active

EXPIRATION DATE: 01/31/2005

OBTAINED BY: Endorsement - Licensed > 10 Years

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

Jennifer Smith
JENNIFER L. SMITH

BUREAU OF HEALTH PROFESSIONS
611 W. OTTAWA • P.O. BOX 30670 • LANSING, MICHIGAN 48909-8170
www.michigan.gov • (517) 335-0918