Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

PAT QUINN
Governor

MANUEL FLORES
Acting Secretary

JAY STEWART
Director
Division of Professional Regulation

April 14, 2014

Barry White
mouserules@hushmail.com

Mr. White:

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

We received your request for the following information related to Jennifer Lesko,

1. - lawsuits
2. - all complaints and disciplinary actions
3. - all applications and reapplications
4. - all hospital admitting privileges
5. - all limited licenses and temporary licenses
6. - all Controlled Substance Licenses (CS-3s)
7. - all Controlled Substance Licenses (CS-3s) Applications
8. - all Controlled Substance Additional Location License Applications
9. - all criminal documents
10. - all Board of Medicine Licenses
11. - all license (aka written agreement) with a licensed laboratory
12. - all hospital privileges in an Illinois based hospital
13. - all supervisory agreements/documents related to his supervising nurses.

Please find the attached requested application file. To view the physician profile, please visit the IDFPR website at https://www.idfpr.com/Applications/Professionprofile/default.aspx?AspxAutoDetectCookieSupport=1.

In the event the Department has received any complaint(s), conducted any investigation(s), retained any materials relevant to your request, or redacted any information from the documents provided this information would be exempt from disclosure through FOIA under 5 ILCS 140/7(a), (b), (c), (d)(ii), (d)(iv), (f), 225 ILCS 60/36, and 68 IL Admin. Section 1285.310

FOIA Sec. 7. Exemptions.

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

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

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

(c) Personal information contained within public records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, unless the disclosure is consented to in writing by the individual subjects of the information. "Unwarranted invasion of personal privacy" means the disclosure of information that is highly personal or objectionable to a reasonable person and in which the subject's right to privacy outweighs

any legitimate public interest in obtaining the information. The disclosure of information that bears on the public duties of public employees and officials shall not be considered an invasion of personal privacy.

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

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

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

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

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

(68 IL Admin Section 1285.310)

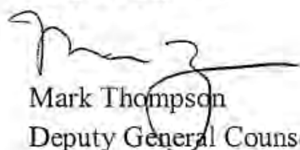
a) All investigative procedures, information arising out of the investigation of complaints, activities of the Complaint Committee, and informal conferences shall be confidential.

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

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

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

Very truly yours,



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

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

January 25, 2010

JENNIFER MARIE LESKO MD

The Illinois Temporary Medical License or Permit for the resident listed above has been approved and will be forwarded to your facility as soon as office routine permits. Information regarding all licensees is available instantly on our Web site at www.idfpr.com. Simply click on the Express Access License Look-up icon to verify a license.

LICENSE DETAILS

LICENSE NUMBER:	125.053570
PROGRAM START DATE:	06/18/2010
EXPIRATION DATE:	06/17/2011
PROGRAM:	Obstetrics & Gynecology
TRAINING FACILITY:	MCGAW MED CTR NORTHWESTERN

Utilization of this license is limited to the training program listed above.

Temporary licenses and permits may not be used for any clinical medical practice which occurs outside of the residency program (i.e. moonlighting).

Temporary licenses and permits are **not** automatically transferred from one program/institution to another. Should the resident transfer to a different residency program within your facility or to a program in another institution, the license or permit must be updated. The resident may not begin a new program until the current temporary license or permit has been returned to the Division and a license or permit has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of temporary licenses and permits. Any violation of the Act may result in disciplinary action by this Department.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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

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

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

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

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

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Extension/Reissue	1 25	Nonexamination	$ 125.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

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

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

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

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

[redacted]

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

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

7. MOTHER'S MAIDEN NAME: Dobrovic

8. PLACE OF BIRTH CITY STATE/COUNTRY — 9. DATE OF BIRTH — 10. AGE

[redacted]

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: [redacted] (Area Code) (Area Code)

Fax: ( ) (Area Code) Fax: ( ) (Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) [If available]

[redacted]

RECEIVED

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

IDPR-MEDICAL UNIT

PART III: Education Information

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

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

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION (Month / Year)
North Brunswick Township High School	North Brunswick, NJ	06 / 1997

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

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

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	TO (Month/Year)	TYPE OF DEGREE EARNED
University of Pennsylvania	Philadelphia PA	8/1997	5/2001	B.A.
Cornell University	New York, NY	8/2003	5/2007	MD

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	TO (Month/Year)	Did You Complete Training?
Northwestern University	Chicago IL	6/2007	present	[ ] Yes [X] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No

NAME (Last, First, MI): Losco, Jennifer

SS#: [redacted]

Profession: MD - Ob/Gyn

NAME (Last, First, MI): Lesko, Jennifer

SS#:

Profession: MD-Ob/Gyn

PART IV: Record of Licensure Information

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure Illinois	Ob/Gyn-MD	125-053070	6/18/07	Active
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
USMLE Step 1	New York, NY	5/2005	passed
USMLE Step 2 CK	New York NY	1/2007	passed
USMLE Step 2 CS	Philadelphia PA	7/2007	passed
USMLE Step 3	Chicago IL	7/2008	passed

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

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

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

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

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

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

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

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

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

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

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

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

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

PART IX: Certifying Statement

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

[signature redacted] Signature of Applicant — 1/5/2010 Date

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

NAME (Last, First, MI): Leslo, Jennifer

SS#: [redacted]

Profession: MD-061979

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM**	SUPPORTING DOCUMENT **CA-MED**

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

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

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Lesko Jennifer	Month Day Year	
4. ADDRESS STREET CITY STATE ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.	
6. MAIDEN OR GIVEN SURNAME	Temp. Physician Extension / Reissue — Profession Name; 125 — Profession Code	

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
Northwestern McGaw	06 / 18 / 2010 (Month Day Year)	06 / 17 / 2011 (Month Day Year)
D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE	E. SPECIALTY / RESIDENCY NAME	
420 E. Superior, 12th, Chgo, IL 60611	OB/Gyn	
F. BUSINESS TELEPHONE NUMBER	G. YEAR OF POSTGRADUATE TRAINING	
Area Code (312) 503-4748	PGY 4	

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

Signature of Program Director

Magdy Milad
Print Name of Program Director

SEAL

Program Director
Title

1/7/10
Date

IL486-0272 08/04 (MD)

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

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE
Lesko Jennifer

3. ADDRESS STREET, CITY, STATE, ZIP CODE

4. DATE OF BIRTH

5.

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

		Profession Code
☐	Permanent Physician License	036
☒	Temporary Physician Training License	125
☐	Chiropractic Physician License	038

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION
McGaw Medical Center/Prentice Women's Hospital

ADDRESS STREET, CITY, STATE, ZIP CODE
250 E Superior St. Sta. Chicago IL 60611

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 24 / 2007 (Month Day Year)
To 06 / 17 / 2011 (Month Day Year)

HOURS WORKED PER WEEK
80+

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
Two years, six months

JOB TITLE
Resident - Ob/Gyn

DESCRIPTION OF DUTIES PERFORMED
Resident training in Ob/Gyn

B. NAME OF BUSINESS / INSTITUTION

ADDRESS STREET, CITY, STATE, ZIP CODE

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

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

JOB TITLE

DESCRIPTION OF DUTIES PERFORMED

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

January 21, 2010

Attn: Daniel E. Bluthardt, Director
Illinois Dept of Financial and Professional Regulation
Springfield Office
320 W. Washington St, 3rd FL
Springfield, IL 62786

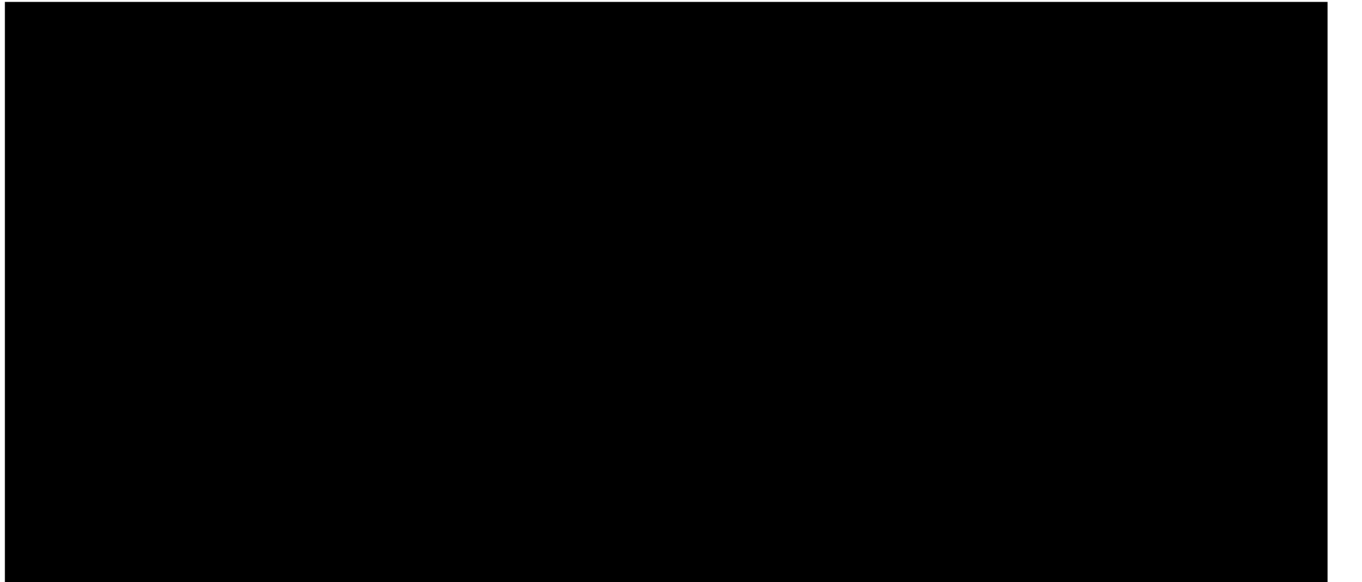
Re: Board Action Query Dated: January 21, 2010
Your Reference Number:
FSMB Batch Number:

The following is a report of the search results from the Board Action Data Bank as of January 21, 2010 for practitioners subm above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of January 21, 2010

Item	Name	DOB	School	Yr/Grad	Request ID
5	lesko, jennifer			2007	

LICENSE HISTORY
State Board
No License Information Available



Northwestern University
Feinberg School of Medicine

Division of Graduate Medical Education
Department of Obstetrics and Gynecology
Prentice Women's Hospital
and Maternity Center
250 East Superior Street, Suite 05-2177
Chicago, Illinois 60611

Magdy P. Milad, MD, MS
Division Head
Professor

mmilad@nmh.org
Phone 312-472-4673
Fax 312-472-4687

NORTHWESTERN
UNIVERSITY

January 14, 2010

RECEIVED
JAN 19 2010
IDPR-MEDICAL UNIT

Illinois Department of Professional Regulation
3rd Floor, Medical Unit #1
320 West Washington Street
Springfield, IL 62786

125-053570

Re: Jennifer Lesko

To Whom It May Concern:

Dr. Jennifer Lesko began her residency at Northwestern McGaw Center for Graduate Medical Education on June 22, 2007. She will complete her 4-year residency on June 29, 2011.

Her current license will expire on June 17, 2010. In order to complete the residency training program, she will need her current license extended from June 18, 2010 to June 19, 2011.

Please feel free to contact me should you have any questions or concerns at 312-472-4673.

Best regards,

Magdy Mild, MD
Residency Program Director

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

June 12, 2007

JENNIFER MARIE LESKO MD
DEPT OF GME

Your application for temporary licensure in Illinois has been approved, and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 06/18/2007. Assuming you remain in the training program listed below, this license will be valid until 06/17/2010.

PROGRAM: Obstetrics & Gynecology
TRAINING FACILITY: MCGAW MED CTR NORTHWESTERN

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

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

The Medical Practice Act sets forth the appropriate use of the temporary license. Any violation of the Act may result in disciplinary action by this Department.

If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department's Springfield address indicated below.

Sandra Dunn, Manager
Medical Unit

lv3.125-approval.rtf

01000005321

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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

RECEIVED
CASH SECTION
MAR 28 2007
IDFPR
Div. of Professional Regulation

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

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

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

A. Type or print legibly with black ink only.
B. **FEES ARE NOT REFUNDABLE.**
C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are ... [compl]ying with a child support ... [Re]venue to identify persons ... penalty or interest shown ... [asse]ssment or tax penalty or ... [ad]ministered by the Illinois ... [e]ntities for verification of

LESKO, JENNIFER MARIE
125 Cred #2284842 03/30/2007
By:NON-EXAM
SSN:141-76-5625

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician License	1 2 5	Nonexamination	$ 100.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

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

RECEIVED MAR 28 2007 IDFPR-MEDICAL UNIT

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

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

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

[redacted]

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

_____-____

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

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

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: ([redacted]
(Area Code) (Area Code)

Fax: (___) ___-____ Fax: (___) ___-____
(Area Code) (Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) [If available]

[redacted]

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

PART III: Education Information

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

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

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION (Month / Year)
North Brunswick Township High School	North Brunswick, NJ 08902	05 / 2007

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

1 2 3 (4) 5 6 7 8 — Graduated? ☒ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	TO (Month/Year)	TYPE OF DEGREE EARNED
University of Pennsylvania	Philadelphia, PA	8/1997	5/2001	BA
Weill Medical College of Cornell University	New York, NY	8/2003	5/2007	M.D.

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	TO (Month/Year)	Did You Complete Training?
N/A				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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

SS#:

Profession: Temporary Physician

PART IV: Record of Licensure Information

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

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

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
USMLE Step I	New York	5/2005	passed
USMLE Step II CK	New York	1/2007	passed
USMLE Step II CS	Philadelphia PA	3/2007	(to take)

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

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

SS#:

Profession: Temporary Physician

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

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

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

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

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

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

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

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

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

SS#:

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

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

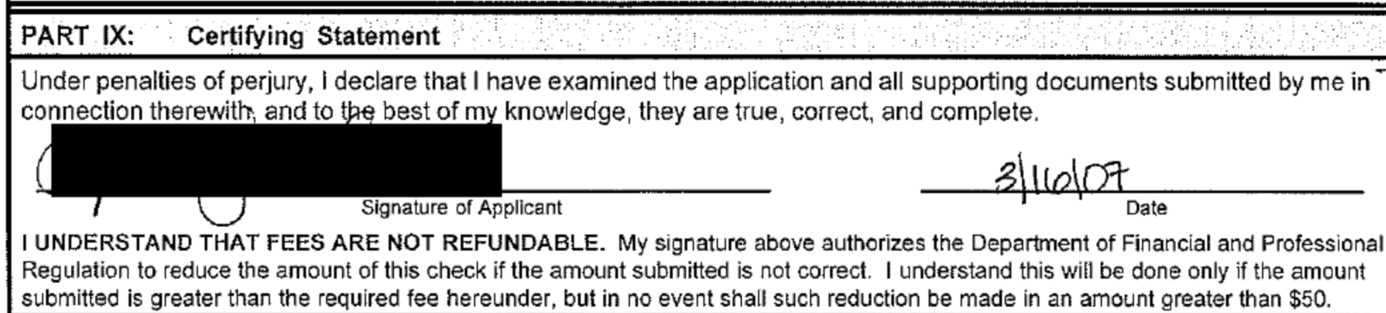
2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance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

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

Profession: Temporary Physician

PART IX: Certifying Statement

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



Signature of Applicant — Date: 3/16/07

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

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

CERTIFICATION OF EDUCATION
(LCME and COCA-Accredited Programs Only)

SUPPORTING DOCUMENT

ED - MED

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

1. NAME LAST FIRST MIDDLE
Lesko Jennifer M

2. DATE OF BIRTH [redacted]
3. SOCIAL SECURITY NUMBER [redacted]

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

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

Temporary Physician — Profession Name; 125 — Profession Code

6. MAIDEN OR GIVEN SURNAME
Lesko

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

3/19/07 — Date
[redacted] — Signature

SCHOOL OFFICIAL: Complete the bottom portion of this page and RETURN THIS FORM TO THE APPLICANT.
DO NOT complete this form more than 30 days prior to the graduation date.

A. MEDICAL SCHOOL INFORMATION

Name: WEILL MEDICAL COLLEGE OF CORNELL UNIVERSITY
Address: 1300 YORK AVENUE, C-118
City, State, Zip: NEW YORK, NY 10021
Phone: 212/746-1055
Fax: 212/746-5981

B. DATES OF ATTENDANCE

Start: 08 / 25 / 2003 (Month Day Year)
End: 05 / 25 / 2007 (Month Day Year)
Degree: ✓ MD ___ DO

C. CHECK THE APPROPRIATE STATEMENT

{✓} Applicant has graduated on 05 / 30 / 2007 (Month Day Year)

{ } Applicant will complete all requirements for the medical degree as of ___ / ___ / _____ (Month Day Year) and will graduate on ___ / ___ / _____ (Month Day Year).

When this form is certified prior to the actual graduation of the applicant, the school official is responsible for notifying the Department of Financial and Professional Regulation of any failure on the part of the applicant to complete the requirements for graduation.

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

[redacted] — Signature of School Official

SCHOOL SEAL

MaryKate Brennan
Registrar
Print Name of School Official

Title

MAY 31 2007
Date

RECEIVED
JUN 11 2007
IDFPR - MEDICAL UNIT

3/30/07

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

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

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

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

1. NAME LAST / FIRST / MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Lesko / Jennifer / Marie	[redacted] Month Day Year	[redacted]
4. ADDRESS STREET, CITY, STATE, ZIP CODE [redacted]	5. REFER TO REFERENCE SHEET. Record profession name and three Digit profession code for which you are making Illinois application.	
6. MAIDEN OR GIVEN SURNAME Lesko	Temporary Physician Licensure (Profession Name) 1 2 5 (Profession Code)	

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
McGaw Medical Center of Northwestern University	06/18/07 (Month Day Year)	06/17/10 (Month Day Year)
D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE 645 N. Michigan Avenue, Suite #1058-A, Chicago, IL 60611	D. SPECIALTY / RESIDENCY NAME OB-GYN	
F. BUSINESS TELEPHONE NUMBER (312) 503-7975	G. YEAR OF POSTGRADUATE TRAINING PGY-1	

RECEIVED

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

DFPR - MEDICAL UNIT

[redacted]
Signature of Program Director

Magdy Milad
Print Name of Program Director

Program Director
Title

3/19/07
Date

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

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE
Lesko Jennifer Marie

3. ADDRESS STREET, CITY, STATE, ZIP CODE
[redacted]

4. DATE OF BIRTH
[redacted]
Month Day Year

5. SOCIAL SECURITY NUMBER
[redacted]

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

		Profession Code
☐	Permanent Physician License	036
☒	Temporary Physician Training License	125
☐	Chiropractic Physician License	038

6. MAIDEN OR GIVEN SURNAME
Lesko

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION
Memorial Sloan Kettering Cancer Center

JOB TITLE
Research Assistant

ADDRESS STREET, CITY, STATE, ZIP CODE
1275 York Ave New York, NY 10021

DESCRIPTION OF DUTIES PERFORMED
- Analyzed data collected from research project on treatment of elderly patients c̄ colorectal cancer

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 20 / 2004 (Month Day Year)
To 08 / 20 / 2004 (Month Day Year)

HOURS WORKED PER WEEK
40

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
2 months

B. NAME OF BUSINESS / INSTITUTION
The Urban Institute

JOB TITLE
Research Assistant

ADDRESS STREET, CITY, STATE, ZIP CODE
2100 M Street, NW Wash DC 20037

DESCRIPTION OF DUTIES PERFORMED
- Analyzed survey data for health policy research

DATE OF EMPLOYMENT/ATTENDANCE
From 08 / 06 / 2001 (Month Day Year)
To 05 / 10 / 2003 (Month Day Year)

HOURS WORKED PER WEEK
40

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
1 year, 9 months

C. NAME OF BUSINESS / INSTITUTION	JOB TITLE
Topaz Hotel	Waitress
ADDRESS STREET, CITY, STATE, ZIP CODE: 1733 N St. NW Washington DC 20036	DESCRIPTION OF DUTIES PERFORMED: Served drinks + food
DATE OF EMPLOYMENT/ATTENDANCE: From 09 / -- / 2002 (Month Day Year) To 05 / -- / 2003 (Month Day Year)	
HOURS WORKED PER WEEK: 12	
TYPE OF EMPLOYMENT: ☐ Full-time ☒ Part-time	
TOTAL TIME WORKED (Year/Month): 9 months	

D. NAME OF BUSINESS / INSTITUTION	JOB TITLE
Kramerbooks + the Afterwords Cafe	Waitress
ADDRESS STREET, CITY, STATE, ZIP CODE: 1517 Connecticut Ave, Wash DC 20036	DESCRIPTION OF DUTIES PERFORMED: Served drinks + food
DATE OF EMPLOYMENT/ATTENDANCE: From 09 / -- / 2001 (Month Day Year) To 09 / -- / 2002 (Month Day Year)	
HOURS WORKED PER WEEK: 16	
TYPE OF EMPLOYMENT: ☐ Full-time ☒ Part-time	
TOTAL TIME WORKED (Year/Month): 1 year	

E. NAME OF BUSINESS / INSTITUTION	JOB TITLE
National Institutes of Health - NINDS	Summer Intern
ADDRESS STREET, CITY, STATE, ZIP CODE: 9000 Rockville Pike Bethesda MD 20892	DESCRIPTION OF DUTIES PERFORMED: Researched effects of transcranial magnetic stimulation on children w/ Attention Deficit Hyperactivity Disorder
DATE OF EMPLOYMENT/ATTENDANCE: From 05 / -- / 2000 (Month Day Year) To 08 / -- / 2000 (Month Day Year)	
HOURS WORKED PER WEEK: 40	
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month): 3 months	

F. NAME OF BUSINESS / INSTITUTION	JOB TITLE
University of Pennsylvania - Dept. of Pharm	Research Assistant
ADDRESS STREET, CITY, STATE, ZIP CODE: 3620 Hamilton Walk	DESCRIPTION OF DUTIES PERFORMED: Researched effects of mutant protein on normal cell lines.
DATE OF EMPLOYMENT/ATTENDANCE: From 01 / -- / 1999 (Month Day Year) To 05 / -- / 2001 (Month Day Year)	
HOURS WORKED PER WEEK: 20	
TYPE OF EMPLOYMENT: ☐ Full-time ☒ Part-time	
TOTAL TIME WORKED (Year/Month): 2.5 years	

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

SS#:

Profession: Temporary Physician

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 4/10/2007

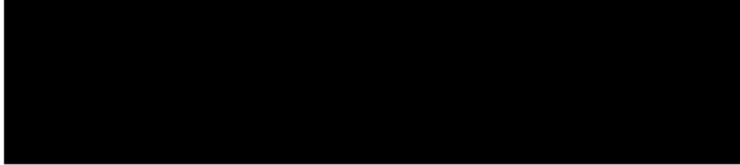
Initials: tb

License No: 125 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

JENNIFER MARIE LESKO MD



RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Submit ED-MED completed by your medical school with seal affixed not more than 30-days prior to graduation

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.

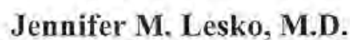
IL486-0923 07/01 (LMU)

MCGAW Center for Graduate Medical Education

March 26, 2007

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

Jennifer M. Lesko, M.D.



Dear Director:

The enclosed application packet is for the initial temporary Illinois medical license for Dr. **Lesko.**

Enclosed are the following documents:

- Four page application
- Dr. sent check for $100
- VE-PC-Form
- CA-Med Form

If you have any questions or need more information, please feel free to call (312 503-4748 of fax (312) 503-5230.

Sincerely,

Kate Kuhel
Graduate Medical Education

Office of Graduate Medical Education
645 North Michigan Avenue, Suite 1058-A
Chicago, Illinois 60611-2875
Tel: (312)503-7975
Fax: (312)503-5230

The McGaw Medical Center of Northwestern University includes:

Children's Memorial Hospital
Evanston Northwestern Healthcare
Jesse Brown VA Medical Center

Northwestern Memorial Hospital
Rehabilitation Institute of Chicago
Northwestern University

CORNELL
UNIVERSITY

Joan and Sanford I. Weill
Medical College

Office of Academic Affairs
1300 York Avenue, C-118
New York, NY 10021-4805
Telephone: 212 746-1050
Fax: 212 746-5981

May 31, 2007

Sandy Dunn, Section Manager
Illinois Dept of Financial & Professional Regulation
Div. of Professional Regulation
Medical Licensing Unit
320 West Washington, 3rd Floor
Springfield, IL 62786

To Whom It May Concern:

Enclosed please find the following document(s) being sent in support of the licensing application of Jennifer M. Lesko, MD, a 2007 graduate of the Weill Cornell Medical College.

- Certification of Education

Sincerely,

MaryKate Brennan
Registrar

RECEIVED
JUN 11 2007
IDFPR - MEDICAL UNIT