PAGE ONE

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

APPLICATION FOR LICENSURE/EXAMINATION

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

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

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

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

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician / Surgeon	0 3 6	Endorsement of License	$ 300.00

PART II: Applicant Identifying Information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE	3. SOCIAL SECURITY NUMBER
Gordon,	Marcus	Tulio	Physician	[redacted]

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

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

6. MAIDEN OR GIVEN SURNAME
[redacted]

7. PLACE OF BIRTH CITY	STATE/COUNTRY	8. DATE OF BIRTH Month Day Year	9. AGE
New York,	N.Y USA	[redacted]	27

10. TELEPHONE N... BE REACHED DURING THE DAY
Area Code [redacted]

IL 486-1019 9/86 (LT-A)

PART III: Education Information

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

1 2 3 4 5 6 7 8 9 10 11 (12)

Graduated High School? [✓] Yes [ ] No

Received G.E.D.? [ ] Yes [ ] No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
DeWitt Clinton H.S.	New York, N.Y.	0 6 / 7 7 (Month / Year)

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

1 2 3 4 5 6 7 (8)

Graduated? [✓] Yes [ ] No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
City College of New York	New York, N.Y.	1/78	6/81	B.S.
Albert Einstein College of Medicine	Bronx, N.Y.	9/81	6/85	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)	DATES OF ATTENDANCE TO (Month/Year)	DID YOU COMPLETE TRAINING?
Montefiore Hospital/Medical Center	Bronx, N.Y.	7/85	7/86	[✓] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, complete the information requested below. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification (s) of Licensure in other state (s) prepared and submitted in support of your application. Enclosed in this application package are two Certification by Licensing Agency/Board forms for that purpose. If you have ever held a temporary, trainee or apprenticeship license or a permit or related license, it must be listed here also. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure New York	Medicine and Surgery	168240	10/20/86	active
State of Current Licensure where you most recently have been practicing. New York	Medicine and Surgery	168240	10/20/86	active
Other States of Licensure				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
National Boards Part I	New York	9/84	Passed
National Boards Part II	New York	11/84	Passed
National Boards Part III	New York	4/85	Passed
National Boards Part I	New York	4/84	Failed

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

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

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

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

a) CHART II – Select examination(s) you desire and enter Test Codes. — TEST CODES

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

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

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

PART VIII: Certifying Statement

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

[redacted]
Signature of Applicant

10/20/87
Date

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

WORK HISTORY

SUPPORTING DOCUMENT

W H

APPLICANT: *Complete Work History beginning with present employment and concluding with graduation. Account for entire time period. You are authorized to photocopy this form if additional space is required.*

1. NAME — LAST: Gordon — FIRST: Marcus — MIDDLE: Julio

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

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

Profession Name _____ Profession Code _____

6. MAIDEN OR GIVEN SURNAME

7. RECORD WORK HISTORY CHRONOLOGICALLY – BEGIN WITH PRESENT EMPLOYMENT AND CONCLUDE WITH GRADUATION.

A. NAME OF BUSINESS/INSTITUTION: Mount Sinai Hospital
JOB TITLE: Resident PGY I
ADDRESS — STREET, CITY, STATE, ZIP CODE: California Ave at 15th Street, Chicago, IL 60608
DESCRIPTION OF DUTIES PERFORMED:
SUPERVISOR NAME: Norbert Gleicher, MD Chairman Dept OB GYNE
DATES OF EMPLOYMENT/ATTENDANCE: From 07 / 01 / 87 (Month / Day / Year) To 10 / 20 / 87
TOTAL TIME WORKED (Yr./Mo.): 3.5 months
HOURS WORKED PER WEEK: 100
TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

B. NAME OF BUSINESS/INSTITUTION: Woodhull Hospital
JOB TITLE: House Physician
ADDRESS — STREET, CITY, STATE, ZIP CODE: 720 Flushing Ave, Brooklyn, NY 11206
DESCRIPTION OF DUTIES PERFORMED:
SUPERVISOR NAME: Paul Koerner, MD
DATES OF EMPLOYMENT/ATTENDANCE: From 10 / 05 / 86 To 06 / 01 / 87
TOTAL TIME WORKED (Yr./Mo.): 8 months
HOURS WORKED PER WEEK: 40
TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

C. NAME OF BUSINESS/INSTITUTION: Montefiore Hospital
JOB TITLE: Resident PGY I
ADDRESS — STREET, CITY, STATE, ZIP CODE: 211 th St, Bronx, N.Y.
DESCRIPTION OF DUTIES PERFORMED: General Surgery, 1st year Resident
SUPERVISOR NAME: M. Friedman MD
DATES OF EMPLOYMENT/ATTENDANCE: From 07 / 01 / 85 To 06 / 31 / 86
TOTAL TIME WORKED (Yr./Mo.): 12 months
HOURS WORKED PER WEEK: 100
TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

Complete the Reverse Side of this Form →

D. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

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

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

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

E. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

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

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

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

F. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

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

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

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

G. NAME OF BUSINESS/INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATES OF EMPLOYMENT/ ATTENDANCE

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

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

TOTAL TIME WORKED (Yr./Mo.)

HOURS WORKED PER WEEK

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

I do hereby declare that the information contained herein is true and correct.

Date

Signature

AN AFFILIATION OF NEW YORK UNIVERSITY

TRANSCRIPT FOR: GORDON, MARGARET [redacted] CLASS OF 1985
MATRICULATED: 26 AUGUST 1981

** BIOMEDICAL SCIENCES -- YEAR 1 **

CELL BIO-BIOCHEM [redacted]
GENETICS
HISTOLOGY
GROSS ANATOMY
NEUROBIOLOGY
PHYSIOLOGY
EMBRYOLOGY

GENERAL PATHOLOGY [redacted]
IMMUNOLOGY
ENDOCRINOLOGY
COMMUNITY HEALTH
HUMAN BEHAVIOR
GYN PATHOLOGY

ELECTIVES & SELECTIVES:
Family Life Pgm [redacted]

** BIOMEDICAL SCIENCES -- YEAR 2 **

PATHOPHYSIOLOGY
CARDIOVASCULAR [redacted]
RESPIRATORY
RENAL
GI-LIVER
NERVOUS SYSTEM
BONES & JOINTS
HEMATOLOGY

CANCER [redacted]
INFECTIOUS DIS
PARASITOLOGY
PHARMACOLOGY
PHYS DIAGNOSIS

** CLINICAL CLERKSHIPS -- YEARS 2 & 3 **

MEDICINE [redacted]
OBS/GYN

PEDIATRICS [redacted]
PSYCHIATRY
RADIOLOGY

SURGERY [redacted]
ORTHO/REHAB
ANESTHESIOLOGY

** SCIENTIFIC BASIS OF MEDICINE -- YEAR 3 **

CLIN PHARMACOLOGY [redacted]
EPIDEMIOLOGY

ELECTIVES:

** SENIOR PROGRAM -- YEAR 4 **

AMBULATORY CARE [redacted]
NEUROLOGY
SUBINTERNSHIP

ELECTIVES: [redacted]
Research
Cardiology
Ent

GRADING: H = HONORS I = INCOMPLETE
P = PASS D = DEFERRED
F = FAIL E = EXEMPT
N = NON-GRADED COURSE

M.D. DEGREE GRANTED: 4 JUNE 1985

NOT VALID WITHOUT SEAL
CERTIFIED BY:

[redacted]

Mrs. Lillian Lombardi
Registrar

NOV 17 1987

** SPECIAL ACADEMIC PROGRAMS AND HONORS **
MEMBER OF MEDICAL STUDENT RESEARCH PROGRAM
DISTINCTION IN ORTHOPEDIC SURGERY

** COMMENT **
NONE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CUSTOMER SERVICE UNIT
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, GORDON MARCUS TULIO
WAS ISSUED LICENSE/CERTIFICATE NUMBER 168240 FOR THE PRACTICE OF MEDICINE ON 10/20/86.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: [redacted]
SCHOOL ATTENDED: ALBERT EINSTEIN MED COL
DATE OF GRADUATION: 06/04/86
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:
B ACCEPTED NATIONAL BOARD CERTIFICATE #315961 DATED 070186

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER TRIENNIALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE.

CURRENTLY REGISTERED: YES TRIENNIUM ENDS: 12/31/88
ADDRESS: [redacted]

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I DAVID FRIBOURG , HEAD CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS HEAD CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

FEB 2 2 1988

SEAL

[redacted] 02/19/88

OP026 56 HEAD CLERK [redacted]

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CERTIFICATION BY LICENSING AGENCY/BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: Complete the applicant section of this form then forward this form or the information in which you are requesting a licensing agency/board.

1. NAME LAST FIRST MIDDLE: GORDON, Marcus Tulio

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Physician/Surgeon — Profession Name
036 — Profession Code

6. MAIDEN OR GIVEN SURNAME:

7a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)

7b. LICENSE NUMBER (If applicable): 168740

7c. ISSUANCE DATE OF LICENSE (If applicable): 10/20/86

I hereby authorize New York State Education Dept. Div. Prof. Licensing to furnish to the Illinois Department
Name of Licensing Agency or Board
of Registration and Education or its designated testing service, the information requested below.

Date 2/16/88 Signature Marcus Gordon

LICENSING AGENCY: The Illinois Department of Registration and Education will accept other forms of certification if the information requested on this form is contained in the Certification. Please record "CT" in upper right corner and forward.

PART I. – CERTIFICATION OF EXAMINATION STATUS

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

Name of Examination

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

EXAM RECEIVED
FEB 19 1988
Date of Examination
CC

PART II. – CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE

B. LICENSE NUMBER

C. ISSUANCE DATE OF LICENSE

D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD

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

F. CURRENT LICENSE STATUS

[ ] Active
[ ] Inactive
[ ] Lapsed
[ ] Other (Explain) _____

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination — Score
Written FEB 22 1988 _____
Practical _____
Other (Describe) _____ _____
Received no Grade Below _____
Examination Period _____ days _____ hours

IL486–0850 9/86 (LT-A)

Complete the Reverse Side of this Form →

PART III. CERTIFICATION OF EXAMINATION SCORES

A. National or other Profession Specific Examination
(Record all available information)

1.

Date of Examination		Raw Score	
Standard Deviation		Corrected Score	
National Mean		Percent Score	

2.

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV. FORMAL ACTIONS

A. Is there now or has there ever been any action commenced against the applicant? [ ] Yes [ ] No

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

PART V. RECIPROCAL REGISTRATION

This state [ ] does [ ] does not grant the same privilege of reciprocal registration to Illinois registrants.

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

Print Name

Title

Signature

SEAL

Agency/Board Street Address

Date

City, State, Zip Code

Area Code ( ) Telephone Number

NATIONAL BOARD OF MED[redacted] EXAMINERS • 3930 CHESTNUT STREE[redacted] HILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Marcus T. Gordon, M.D.

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

Attest C. WILLIAM DAESCHNER, JR., M.D.
Chairman of the Board

SEAL EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa
07/01/86 Certificate # 315961

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from ALBERT EINSTEIN COLL MED in JUNE 1985 and whose birth date is [redacted] This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/84		
Anatomy, incl. histology and embryology		
Physiology		
Biochemistry		
Pathology		
Microbiology, incl. immunology		
Pharmacology and Materia Medica		
Behavioral Sciences		
TOTAL TEST (Minimum Passing Score 380/75)		[redacted]
Part II passed 09/84		
Internal medicine and the medical specialties		
Surgery and the surgical specialties		
Obstetrics and Gynecology		
Public Health and Preventive Medicine		
Pediatrics		
Psychiatry		
TOTAL TEST (Minimum Passing Score 290/75)		
PART III passed 05/86		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)		[redacted]
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		

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

[redacted]
Secretary for Certification
02/18/88

SEAL

Date

THE CITY COLLEGE OF THE CITY UNIVERSITY OF NEW YORK

RECORD OF GORDON MARCUS [redacted]

MAJOR – PSY

Graduated with degree of: B.S.
Date: SEPT 1, 1981

Conditioned in:

Conditions removed:

Address of student:
Transcript of record to:
Division:

Marking System: A–Excellent, B–Good, C–Fair, D–Lowest passing grade, FEN (E)–Conditioned, F–Failure ...

☐ In attendance ☐ Withdrew ☐ Dropped for unsatisfactory work

Dated:

Not valid as official transcript without ... seal of the City College.

FEB 2 2 1988

Lib. Arts 75 (015) Matric.
Arch.
Educ. Grad.
Eng'r.
Nursing Non-Mat.

HIGH SCHOOL ENTRANCE UNITS

Soc. Stud.		Biology	
[illegible]	3	Chemistry	
Algebra		Physics	
Geometry		Gen. Science	
Trigonometry		Art	

TITLE	Term Ending	Subject		Gr.	Cr.
[redacted]	6/78	2201	015		
INTRO PRINCIPLES		ART	100	[redacted]	3
GENERAL		CHEM	3		8
AMERICAN EXPERIENCE		HIST	106		3
FURTHER ESSNTLS ALG		MATH	55		1
INTRO PHILOSOPHY		PHIL	101		3
TOTAL 13.0				+61	9
THE CITY COLLEGE AWARDS 12 TRANSFER CREDITS FOR WORK PREVIOUSLY COMPLETED					
CHEYNEY STATE COLLEGE					21
[redacted]	8/78	2201	015		
BASIC WRITING-3		ENGL	3	[redacted]	3
FURTHER ESSNTLS ALG		MATH	55		1
TOTAL 4.0				+14	55
[redacted]	1/79	1201	015		
ORGANISMIC BIO-LEC		BIO	101	[redacted]	3
GENERAL		CHEM	3		3
WRTNG-SCI & TECH-1		ENGL	240.05		3
TRIG & PRE-CALCULUS		MATH	56		3
SOC OF MEDICINE		SOC	270		3
TOTAL 15.0				120	40
		120			

TITLE	Term Ending	Subject		Gr.	Cr.
[redacted]	6/79	1301	015		
ORGANISMIC BIO-LAB		BIO	102	[redacted]	2
GENERAL		CHEM	4		3
BASIC LAB TECHS		CHEM	8		2
ILLNS:THE SICK ROLE		HMS	314		1
ELEM OF CALCULUS 1		MATH	61		4
PSYCHOPATHOLOGY		PSY	248		3
TOTAL 15.0				+40	35
[redacted]	8/79	1401	015		
INFANCY & CHILDHOOD		PSY	246	[redacted]	3
TOTAL 3.0				+34	58
[redacted]	1/80	1401	015		
CELL & MOLECULAR		BIO	209	[redacted]	5
ORGANIC 1		CHEM	261		3
ECO & HEALTH CARE		HMS	315		1
ELEM OF CALC & STAT		MATH	311		4
LAB & FIELD WORK		PSY	233		1
TOTAL 14.0				+63	72
[redacted]	6/80	1501	015		
ORGANIC LAB 1		CHEM	262	[redacted]	2
ORGANIC 2		CHEM	263		3
GENERAL		PHYS	203		4
LAB & FIELD WORK		PSY	234		1
LAB & FIELD WORK		PSY	235		1
COMMUNITY PSYCH		PSY	357		4
TOTAL 15.0 13				+71	85
					72

TITLE	Term Ending	Subject		Gr.	Cr.
[redacted]	1/81	1601	015		
ECO DVLP BLK COMTY		BLST	135	[redacted]	
ORGANIC LAB 1		CHEM	262		
BIOCHEM		CHEM	359		
GENERAL		PHYS	204		
INDEPENDENT STUDY		PSY	310.03		
TOTAL 16.0				113	
[redacted]	6/81	1701	015		
PHOTOGRAPHY 1		ART	140	[redacted]	2
PRACTICUM-MEDICINE		BLST	204		4
INDEPENDENT STUDY		CHEM	310.04		4
RSCH SEM:BMED SCI 2		CHEM	319		1
INTRO TO HATHA YOGA		P E	145		1
TENNIS		P E	187		1
EXPERIMENTAL 1		PSY	321		4
RESEARCH & FLD WORK		SOC	233.03		3
Total 20					

[redacted] 1701
ENGLISH PROFICIENCY EXAM
PASSED SPRING TERM 1981

CREDIT [illegible] 560 [illegible]
[illegible] 5560 ... 81

T [illegible] 5 ... 13

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

CERTIFICATION OF TRAINING

SUPPORTING DOCUMENT

TN

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

1. NAME — LAST: GORDON FIRST: Malcolm MIDDLE: Tulio

2. DATE OF BIRTH — Month / Day / Year: [redacted]

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Profession Name: Physician and Surgeon
Profession Code: 036

6. MAIDEN OR OTHER SURNAME:

7. DATES OF TRAINING
FROM Month 07 / Day 01 / Year 85 TO Month 06 / Day 31 / Year 86

8. ILLINOIS TEMPORARY CERTIFICATE OF REGISTRATION
NUMBER (If Applicable):
ISSUANCE DATE (If Applicable):

9. SPECIFIC NAME OF TRAINING RECEIVED: General Surgery PGY I

10. SUPERVISOR/INSTRUCTOR NAME: DR M. Gleidman (Chairman Dept. Surgery)

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

A. SUPERVISOR/INSTRUCTOR NAME: Marvin Gleidman, M. D.

B. INSTITUTION/BUSINESS NAME: Bronx Municipal Hospital Center

C. SUPERVISOR/INSTRUCTOR JOB TITLE/PROFESSION NAME: Chairman & Director - Surgery

D. INSTITUTION/BUSINESS STREET ADDRESS: Pelham Parkway S. & Eastchester Rd.

E. SUPERVISOR/INSTRUCTOR LICENSE OR CERTIFICATE NUMBER: License #: 083511

F. INSTITUTION/BUSINESS CITY, STATE, ZIP CODE: Bronx, New York 10461

G. SUPERVISOR/INSTRUCTOR STATE OF LICENSURE OR CERTIFYING ASSOCIATION NAME:

H. INSTITUTION/BUSINESS TELEPHONE NUMBER
AREA CODE (212) 430 - 8801

I. APPLICANT'S TRAINING DATES
FROM Month 7 / Day 1 / Year 85 TO Month 6 / Day 30 / Year 86

J. TRAINING CLOCK HOURS APPLICANT COMPLETED:

K. SPECIALIZATION NAME IN WHICH APPLICANT TRAINED: Neurology

L. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE? [X] Yes [ ] No

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

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

I do hereby declare that the information provided is true and correct according to the official records of this institution/business.

INSTITUTIONAL SEAL: BRONX MUNICIPAL HOSPITAL CENTER, PELHAM PARKWAY SOUTH & EASTCHESTER ROAD, BRONX, NEW YORK 10461

Barry Jastli
Print or Type Name

Associate Executive Director
Title

[redacted]
Date: 11-30-87

IL406 1141 9/86 (LTR)

Encountered
2.94 129 6 2/78 2/81

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

CERTIFICATION OF EDUCATION

SUPPORTING DOCUMENT

ED

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
GORDON Marcus Julio

2. DATE OF BIRTH [redacted]
Month Day Year

3. SOCIAL SECURITY NUMBER [redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Physician and Surgeon — Profession Name
036 — Profession Code

7. NAME OF INSTITUTION ATTENDED
City College of New York

8. DATE OF GRADUATION/COMPLETION
09 / __ / 81
Month Day Year

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

October 21, 1987
Date

[redacted]
Signature of Applicant

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

A. NAME OF INSTITUTION

B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE

C. DEPARTMENT OF INSTITUTION
L.A

D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT
L.A. (Chemistry)

E. MAJOR AREA OF STUDY OF THE APPLICANT
CHEMISTRY

F. APPLICANT WAS: (CHECK ONE)
[X] Full-time
[ ] Part-time
[ ] Co-op

G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE)
[ ] ____ Semester Hours
[ ] ____ Quarter Hours
[ ] ____ Course Hours

H. DATES OF ATTENDANCE
From 09 / __ / 78 To 06 / __ / 81
Month Day Year Month Day Year

I. Total academic years attended ____ / ____ / ____
Years Months Days
OR
Total calendar years attended ____ / ____ / ____
Years Months Days

J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., M.D., Ph.D.)

K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET
09 / 01 / 81
Month Day Year

L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED
09 / 01 / 81
Month Day Year

M. CHECK THE APPROPRIATE STATEMENT (S) AND COMPLETE
[ ] Applicant has graduated on 09 / 01 / 81
Month Day Year
[ ] Applicant will graduate on ____ / ____ / ____
Month Day Year
[ ] Applicant has completed program on 09 / 01 / 81
Month Day Year
[ ] Applicant will complete program on ____ / ____ / ____
Month Day Year

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

IL 486-1306 9/86 (LTA)

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

Received
Emergency
Contract
for Clearance
12/4/87

WHEN THIS FORM IS CERTIFIED PRIOR TO THE ACTUAL GRADUATION OF THE APPLICANT, THE SCHOOL OFFICIAL IS RESPONSIBLE FOR NOTIFYING THE DEPARTMENT OF REGISTRATION AND EDUCATION 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.

Print Name of School Official

Signature of School Official

Title

Date

SCHOOL SEAL

OR

NOTARY SEAL

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

Subscribed and sworn before me this _____ day of _____, 19____.

Date of Expiration

Signature of Notary Public

RETURN THIS FORM TO APPLICANT

STATE OF ILLINOIS

DRE DEPARTMENT OF REGISTRATION AND EDUCATION

320 West Washington—3rd Floor • Springfield, Illinois 62786 • (217) 785-0800

GARY L. CLAYTON—Director

October 26, 1987

RECEIVED

OCT 29 1987

DISCIPLINARY INQUIRIES

Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

The Ill. Dept. of Registration & Education requests a disciplinary search concerning the following individual:

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

OCT 29 1987

BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE-PRESIDENT

Marcus Tulio Gordon
Name

[redacted]
Address

[redacted]
City, State and Zip

[redacted]
Date of Birth

[redacted]
Social Security Number

Albert Einstein Coll. Med. Bronx, N. Y.
Medical School of Graduation and Branch Location

June 1985
Date of Graduation

Please mail the response to the following address:

IL Dept. of Registration & Education

320 W. Washington, 3rd Floor - Unit IV

Springfield, IL 62786

ATTENTION: Karen Dunlap - Unit Manager

[redacted]
Signature

ORIGINAL SEEN BY DR.
ON 10-20-87
INITIALED RB

YESHIVA UNIVERSITY

IN THE CITY OF NEW YORK

IN RECOGNITION OF THE SATISFACTORY FULFILLMENT OF THE REQUIRED COURSE OF STUDIES OF THE

ALBERT EINSTEIN COLLEGE OF MEDICINE

AND UPON THE RECOMMENDATION OF THE FACULTY OF THE COLLEGE HAS CONFERRED UPON

MARCUS TULIO GORDON

THE DEGREE OF

DOCTOR OF MEDICINE

WITH SPECIAL DISTINCTION FOR RESEARCH IN
ORTHOPAEDIC SURGERY

THEREBY ADMITTING HIM TO THAT DEGREE WITH ALL THE RIGHTS, PRIVILEGES AND HONORS APPERTAINING THERETO. IN WITNESS WHEREOF THE SEAL OF THE UNIVERSITY AND THE SIGNATURE OF THE OFFICIALS OF THE UNIVERSITY AND THE DEAN OF THE FACULTY OF MEDICINE ARE HERETO AFFIXED.

GIVEN IN THE CITY OF NEW YORK ON THE 4TH DAY OF JUNE, IN THE YEAR OF 1985.

[redacted]
PRESIDENT, YESHIVA UNIVERSITY

[redacted]
CHAIRMAN, BOARD OF TRUSTEES

[redacted]
CHAIRMAN EMERITUS, BOARD OF TRUSTEES

YESHIVA UNIVERSITY

[redacted]
DEAN, ALBERT EINSTEIN COLLEGE OF MEDICINE

[redacted]
CHAIRMAN, BOARD OF OVERSEERS

OFFICE MEMORANDUM — DEPARTMENT OF REGISTRATION AND EDUCATION

TO: (Name, Division) [ ]Springfield [ ]Chicago

Max Rowe, Prosecutions

FROM: (Name, Division) [ ]Springfield [ ]Chicago

Pat Eubanks, Unit Manager/Unit IV

Extension:

SUBJECT: Marcus Tulio Gordon, M.D. - Physician & Surgeon licensure
Unlicensed Activity - Endorsement [redacted]

DATE: February 23, 1988

The required documentation for licensure has been submitted and the applicant is currently eligible for licensure but for the problem below.

However, Dr. Gordon came to the front desk of the Department on October 20, 1987. The only part of an application he had completed was an application jacket. He also had his original diploma with him. He wanted to apply for reciprocity due to the fact he is licensed in New York. He inquired about different methods of licensure and due to the fact he was already licensed in another state he felt he should just be able to transfer his license. He indicated he was already working and needed proof to take back to the hospital that he had been here on that date to submit his application. He completed Work Hisotry form while he was here that day and when asked for his fee he indicated he had not brought any cash but did have a Visa card and would go somewhere and pick up a money order. He did leave and return with a M.O. made out to the Board of Education. He then left once again to have money order corrected. Dr. Gordon wanted a receipt to take back to the hospital to show he had been in this Department on that date. No other documents were received and the application remained in pending until Dr. Gordon appeared once again at the front desk on February 16, 1988. At that time he had brought an ED(education form) for premedical education, which was not acceptable, due to the fact we must receive a transcript of grades. A processor from the unit went to the front desk and informed the doctor what was still needed to complete his application. Again Dr. Gordon wanted proof to take back to the hospital that day to show he had been here. He was given a copy of a deficiency letter dated to show he had been here on February 16, 1988 as his proof. He then asked to speak to the supervisor. Nancy Melton then went to the desk to speak with Dr. Gordon. He was told again what was deficient in his application and another search was made of pending to see if anything else had come for the application, which it had not. Dr. Gordon told Nancy that if he did not go back to the hospital with a license that day, he was being let go from his residency. Nancy told the doctor that he could have documents sent to her attention so that she would know when they arrived and would see that they were processed as soon as possible. He was informed upon completion the application would still have to go through a final review to determine eligibility. The porcessor from the unit had already advised Dr. Gordon that he would not be working without a license. Dr. Gordon's application became complete February 22, 1988 and is being routed for unlicensed activity from July 1, 1987 to February 22, 1988 at Mount Sinai Hospital, California Ave. at 15th Street, Chicago, Illinois as a resident in the Dept. of Ob/Gyne. A person from Mount Sinai Hospital called the Department on February 22, 1988 as did Dr. Gordon and they were advised that all documents were now here to complete the application, however, an exact date the license would be issued was not available at that time.

cc: Tom Battista

IL 486-0711 (GO)

Illinois Department of Professional Regulation

Stephen F. Selcke
Director

James R. Thompson
Governor

February 22, 1988

Marcus T. Gordon, M.D.
[redacted]

Dear Dr. Gordon :

The Illinois Department of Professional Regulation acknowledges receipt of your application for Physician and Surgeon licensure in the State of Illinois.

Your application for licensure is now complete and has been referred to our Chicago Office Enforcement Division for further evaluation.

Every effort will be made to expedite your application. You will be notified by the Enforcement Division if additional information will be required or if there are problems regarding the application. If you have not received further information within two weeks of receipt of this letter you may contact the following person regarding the status of your application:

Mr. Max Rowe
312/917-4477

Please do not attempt to contact the above named department representative prior to the two week period as time must be allowed for receipt and review of the documents.

Sincerely,

/s/
Pat Eubanks
Unit Manager

PE:kdw

cc: Max Rowe

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800

State of Illinois Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/917-4500

OFFICE MEMORANDUM — **DEPARTMENT OF PROFESSIONAL REGULATION**

TO: (Name, Division) [ ]Springfield [ ]Chicago
Patty Eubanks, Unit IV

FROM: (Name, Division) [ ]Springfield [ ]Chicago
Vince Zara
Extension: 5-2175

SUBJECT: Returning applications

DATE: 5-2-88

We are hereby returning the following Medical applications per your request.

- Gordon, Marcus T. - [redacted]
- Nagarakanti, Nageswara R.
[redacted]

IL486-0711 1/88 (CO)

Illinois Department of Professional Regulation

Stephen F. Selcke
Director

James R. Thompson
Governor

February 22, 1988

Marcus T. Gordon, M.D.
[redacted]

Dear Dr. Gordon :

The Illinois Department of Professional Regulation acknowledges receipt of your application for Physician and Surgeon licensure in the State of Illinois .

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Mr. Max Rowe
312/917-4477

Please do not attempt to contact the above named department representative prior to the two week period as time must be allowed for receipt and review of the documents.

Sincerely,

/s/

Pat Eubanks
Unit Manager

PE:kdw

cc: Max Rowe

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800

State of Illinois Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/917-4500

OFFICE MEMORANDUM — DEPARTMENT OF REGISTRATION AND EDUC

TO: (Name, Division) [ ]Springfield [ ]Chicago

Max Rowe, Prosecutions

FROM: (Name, Division) [ ]Springfield [ ]Chicago

Pat Eubanks, Unit Manager/Unit IV

Extension:

SUBJECT:
Marcus Tulio Gordon, M.D. - Physician & Surgeon licensure
Unlicensed Activity - Endorsement [redacted]

DATE:
February 23, 1988

The required documentation for licensure has been submitted and the applicant is currently eligible for licensure but for the problem below.

However, Dr. Gordon came to the front desk of the Department on October 20, 1987. The only part of an application he had completed was an application jacket. He also had his original diploma with him. He wanted to apply for reciprocity due to the fact he is licensed in New York. He inquired about different methods of licensure and due to the fact he was already licensed in another state he felt he should just be able to transfer his license. He indicated he was already working and needed proof to take back to the hospital that he had been here on that date to submit his application. He completed Work Hisotry form while he was here that day and when asked for his fee he indicated he had not brought any cash but did have a Visa card and would go somewhere and pick up a money order. He did leave and return with a M.O. made out to the Board of Education. He then left once again to have money order corrected. Dr. Gordon wanted a receipt to take back to the hospital to show he had been in this Department on that date. No other documents were received and the application remained in pending until Dr. Gordon appeared once again at the front desk on February 16, 1988. At that time he had brought an ED(education form) for premedical education, which was not acceptable, due to the fact we must receive a transcript of grades. A processor from the unit went to the front desk and informed the doctor what was still needed to complete his application. Again Dr. Gordon wanted proof to take back to the hospital that day to show he had been here. He was given a copy of a deficiency letter dated to show he had been here on February 16, 1988 as his proof. He then asked to speak to the supervisor. Nancy Melton then went to the desk to speak with Dr. Gordon. He was told again what was deficient in his application and another search was made of pending to see if anything else had come for the application, which it had not. Dr. Gordon told Nancy that if he did not go back to the hospital with a license that day, he was being let go from his residency. Nancy told the doctor that he could have documents sent to her attention so that she would know when they arrived and would see that they were processed as soon as possible. He was informed upon completion the application would still have to go through a final review to determine eligibility. The porcessor from the unit had already advised Dr. Gordon that he would not be working without a license. Dr. Gordon's application became complete February 22, 1988 and is being routed for unlicensed activity from July 1, 1987 to February 22, 1988 at Mount Sinai Hospital, California Ave. at 15th Street, Chicago, Illinois as a resident in the Dept. of Ob/Gyne. A person from Mount Sinai Hospital called the Department on February 22, 1988 as did Dr. Gordon and they were advised that all documents were now here to complete the application, however, an exact date the license would be issued was not available at that time.

cc: Tom Battista

IL 486-0711 (GO)

Application No. 036 Prof. Code [redacted] SSN/FEIN

Marcus Gordon, M.D.

or Label Space

APPLICATION REVIEW FINDINGS

AMF 2

1. DATE: 02/23/88

2. EMPLOYEE: 0401

3. STATUS: 6

4. DEFICIENCIES - ADD: 209

5. LAST CORRESPONDENCE RECEIVED DATE: __/__/__

CLEAR: 015, 020, 021, 099

6. LAST CORRESPONDENCE SENT DATE: __/__/__

7. IL APPRENTICE TRAINING LICENSE NO.: _____

EDUCATION INFO:

8. School Name: Albert Einstein Col of Med

9. School Code: _____ 10. Foreign School: No (Yes or No) 11. Date Graduated: 06/25/85

12. City/Country School Located: Bronx 13. State School Located: NY

RECIPROCITY INFO:

14. Original Licensure State: _____ 15. Licensure Date: ____/____ Month Year

16. Current Licensure State: _____ 17. Licensure Date: ____/____ Month Year

18. No. of States Licensed in: _____

ACCEPTANCE OF EXAM INFO:

19. Who Gave Exam: NB 20. Examination Date: 07/01/86

21. Grades: [redacted] 22. No. of Times Exam Taken: 1

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____

13. _____ 14. _____ 15. _____ 16. _____ 17. _____ 18 _____

MISC. INFO:

23. Related License No.: 24. Bond Insurance Expire Date: __/__/__

1. _____ D ___ 2. _____ D ___ 3. _____ D ___ 4. _____ D ___

5. _____ D ___ 6. _____ D ___ 7. _____ D ___ 8. _____ D ___

25. Agency Manager Name: _____ 26. Telephone No. _____

LICENSE ASSIGNMENT INFO:

27. Original IL License No. _____ 28. Issuance Date: __/__/__

Application No. _____ Prof. Code [redacted] SSN/FEIN

or Label Space

APPLICATION REVIEW FINDINGS

AMF 2

1. DATE: 4/[illegible]/[illegible]
2. EMPLOYEE: [illegible]
3. STATUS: A
4. DEFICIENCIES - ADD: _____
5. LAST CORRESPONDENCE RECEIVED DATE: 3/[illegible]/[illegible]
   CLEAR: [illegible]
6. LAST CORRESPONDENCE SENT DATE: ___/___/___
7. IL APPRENTICE TRAINING LICENSE NO.: _____

EDUCATION INFO:

8. School Name _____
9. School Code _____ 10. Foreign School _____ (Yes or No) 11. Date Graduated ___/___/___
12. City/Country School Located _____ 13. State School Located _____

RECIPROCITY INFO:

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

ACCEPTANCE OF EXAM INFO:

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

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

MISC. INFO:

23. Related License No.: 24. Bond Insurance Expire Date ___/___/___

1. _____ D ___ 2. _____ D ___ 3. _____ D ___ 4. _____ D ___
5. _____ D ___ 6. _____ D ___ 7. _____ D ___ 8. _____ D ___

25. Agency Manager Name _____ 26. Telephone No. _____

LICENSE ASSIGNMENT INFO:

27. Original IL License No. _____ 28. Issuance Date ___/___/___

IL 486-1323 1/87 (EDP)

OFFICE MEMORANDUM — **DEPARTMENT OF PROFESSIONAL REGULATION**

TO: (Name, Division) [ ]Springfield [ ]Chicago

Keith

FROM: (Name, Division) [ ]Springfield [ ]Chicago

Nancy

Extension:

SUBJECT:

Marcus T. Gordon 036-76724

DATE:

April 26, 1988

The attached Consent Order has now been signed by the Director and the error in wording has now been corrected. It is o.k. to issue the license with the date the order was signed by the Director as the issue date of the license.

Please return the application to me when the license has been issued.

Thanks

OFFICE MEMORANDUM **DEPARTMENT OF PROFESSIONAL REGULATION**

TO: (Name, Division) [ ]Springfield [ ]Chicago	FROM: (Name, Division) [ ]Springfield [ ]Chicago
[illegible]	Nancy, [illegible] Extension:

SUBJECT:	DATE:
Marcus T. Gordon 035-[illegible]	April [illegible], 1989

The attached Consent Order has now been signed by the Director and the error in wording has now been corrected. It is o.k. to issue the license with the date the order was signed by the Director as the issue date of the license.

Please return the application to me when the license has been issued.

Thanks

State of Illinois Memo

To: File Date: 10/20/87

From: Nancy

Dept:

Re: Marcus Gordon, M.D.

- ☐ Take Necessary Action
- ☐ For Your Approval
- ☐ Reply
- ☐ For Your Comments
- ☐ For Your Information
- ☐ Draft (Letter) (Memo) For My Signature
- ☐ Per Your Request
- ☐ See Me About Attached
- ☐ Return
- ☐ File
- ☐ Route

Remarks:

Dr. Gordon's [redacted] application and fee taken to cash this day from front desk. When app. reaches unit please check for unlicensed activity on wk.

IL 001 0001 (1/80)

~~Committee Reads~~ (Unlicensed Activity)

DEPARTMENT OF REGISTRATION AND EDUCATION NAME

00211196

~~Committee Review~~ (Unlicensed Activity)

DEPARTMENT OF REGISTRATION AND EDUCATION
MEDICAL APPLICATION CHECK LIST

NAME: MARCUS Tulio GORDON

DATE APPLICATION RECEIVED: 10/22/87

BASIS OF APPLICATION	CHIRO. EXAM	PHYS. ASSIST.	FLEX EXAM	ACCEPT. OF EXAM	VISITING PROF	RECIPRO-CITY	RESTORA-TION	TEMP. LICENSE
1 Fee – Amount Received				✓				
2 Approv. Medical Education Prog.				✓		Unlicensed Activity		
3 Personnel History Statement				✓				
4 Application Signed & Dated				✓				
5 WH Form			Waiver NA	OK - 2nd 4/26/88 Kp		Re Consent Order Kp		
6. Name Change Papers				NA				
7. ED Form				NA				
8. ECFMG/FMGEMS	N/A			NA	N/A		N/A	
9. 3 Physician Affidavits				NA			N/A	
10. College Transcript/Pre-Medical				Med - 021			N/A	
11. Professional Transcript/Medical				OK - 021		2/16/88 Kp	N/A	
12. Professional Diploma – Copy				OK - 022		10/26/87 Kp	N/A	
13. Translations				NA			N/A	
14. CA-MED Form	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
15. AMA/AOA Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
16. AMA/Dept. Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
17. Clinical Training – 4	N/A	N/A		N/A	N/A	N/A	N/A	N/A
18. Clinical Training – 12	N/A	N/A		OK - 023	N/A	2/16/88 Kp	N/A	N/A
19. Clinical Training Waiver	N/A	N/A		NA	N/A		N/A	N/A
20. American Board Specialty	N/A	N/A	N/A	N/A	N/A		N/A	N/A
21. Curriculum Vitae	N/A	N/A	N/A	N/A			N/A	N/A
22. Request for 2 c	N/A	N/A	N/A	N/A	N/A		N/A	N/A
23. Contractual Agreement/VP Form	N/A	N/A	N/A	N/A		N/A	N/A	N/A
24. Current License/CT Form			N/A	NY	N/A			N/A
25. Certification of Original State/CT			N/A	Med NY - 015				
26. Certificate of Health	N/A		N/A	N/A	N/A	N/A	N/A	N/A
27 National P.A.	N/A		N/A	N/A	N/A	N/A	N/A	N/A
28. P.A. Exam Accepted	N/A		N/A	N/A	N/A	N/A	N/A	N/A
29 Exam Grade [ ]			N/A	Med - 020	N/A		N/A	N/A
30 Sup. Phys. Statement	N/A		N/A	N/A	N/A	N/A		N/A
31 RS Form				NA				
32. Disciplinary Report				OK	11/10/87 Kp			

[X] Not Eligible _____ [ ] Eligible [ ] Committee Review Initials Kp Date 10/26/87	[X] Not Eligible _____ [ ] Eligible [ ] Committee Review Initials Kp Date 11/10/87	[ ] Not Eligible _____ [ ] Eligible [ ] Committee Review Initials _____ Date _____
[ ] Not Eligible _____ [ ] Eligible [ ] Committee Review Initials _____ Date _____	[ ] Not Eligible _____ [ ] Eligible [ ] Committee Review Initials _____ Date _____	[ ] Not Eligible _____ [ ] Eligible [ ] Committee Review Initials _____ Date _____

EXAMINATION DATE	COMMITTEE DATE

Application No. 036 Prof. Code [redacted] SSN/FEIN

MARCUS [illegible]

or Label Space

APPLICATION DATA CHANGE

AMF 1

1. DATE: 1/15/88

2. EMPLOYEE: [illegible]

3. APPLICATION DATE: __/__/__

4. REAPPLICATION DATE: __/__/__

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

6. FELONY INDICATOR: _____

7. LICENSURE METHOD: _____

8. DATE OF BIRTH: __/__/__

NAME:

9. Individual (Human) Last [illegible] First [illegible]

M.I. _____ Title [illegible]

10. Business (Non-human) _____

11. ADDRESS:

Line 1 _____

Line 2 _____

Line 3 _____

Line 4 _____

City/Country _____ State _____ Zip _____

County _____ Foreign Address _____ (Yes or No)

FINANCIAL/BATCH:

12. Payment Date __/__/__ 13. Batch No. _____ 14. Fee Amount _____

15. Payment Type _____

16. Delete Financial _____ (Yes or No)

17. ON CONTROL SLIP: _____ (Yes or No)

18. Add ☐ 19. Change ☐

IL486–1322 6/86 (EDP)

STATE OF ILLINOIS

DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION of the State of Illinois, Complainant	)	
v.	)	No. 88-254A
MARCUS T. GORDON License No. 036-076724 Respondent	)	

CONSENT ORDER

The Department of Professional Regulation by Max L. Rowe, one of its attorneys, and Marcus T. Gordon, Respondent, hereby agree to the following:

STIPULATIONS

Marcus T. Gordon has applied for a physician and surgeon license in the State of Illinois.

Information has come to the attention of the Department that prior to being issued a physician and surgeon license in Illinois the Respondent was employed as a resident in obstetrics/gynecology at Mt. Sinai Hospital, Chicago, Illinois from July 1, 1987 through February 22, 1988, the date Respondent's application in the Department became complete. During said time period(s), and with the knowledge and direction of said hospital(s), the Respondent did acts which could constitute the unlicensed practice of medicine.

As a result of the foregoing allegations, the Department held an Informal Conference at the offices of the Department, 100 West Randolph Street, Suite 9-300, Chicago, Illinois 60601 on the date the Department attorney and the Respondent signed this Consent Order. Respondent appeared in person on that date, and Max L. Rowe appeared as an attorney for the Department.

Respondent has been advised of the right to have the pending allegations reduced to written charges, the right to a hearing, the right to contest any charges brought, and the right to administrative review of any order resulting from a hearing. Respondent knowingly waives each of these rights as well as waiving any right to administrative review of this Consent Order.

Respondent and the Department have agreed, in order to resolve this matter, that Marcus T. Gordon be permitted to enter into a Consent Order with the Department, providing for the imposition of disciplinary measures which are fair and equitable in the circumstances and which are consistent with the best interests of the people of the State of Illinois.

CONDITIONS

WHEREFORE, the Department, through Max L. Rowe, its attorney, and Marcus T. Gordon agree:

A. Respondent shall be issued a physician and surgeon license upon approval of this Order by the Director, and the Department's records of such ~~Temporary~~ Permanent license shall bear a notation that it is probational for a period of eight (8) months from the effective date of this Consent Order.

B. Respondent shall inform the Department of any and all criminal and/or civil complaints and/or judgments brought against him during the term of probation, including traffic offenses involving or relating to DUI, DWI, or other alcohol or drug offenses. Failure to comply with this provision shall constitute a

violation of this Order and may be grounds for further discipline of Respondent's license.

C. This Consent Order shall become effective upon approval by the Director of the Department.

DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

March 14, 1988
DATE

[redacted]
Max LP Rowe
Attorney for the Department

3/14/88
DATE

[redacted]
Marcus T. Gordon
Respondent

4.12.88
DATE

[redacted]
Lawrence L. Hirsch, M.D., Chm., Medical Licensing Board

The foregoing Consent Order is approved in full.

DATED THIS 14th day of April, 1988.

DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

[redacted]
STEPHEN F. SELCKE
DIRECTOR

SFS:MLR:kai

original given back to Rowe 4/20/88 for correction of error in wording per May, hold and do not issue until I hear from him. JM

STATE OF ILLINOIS

DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION of the State of Illinois, Complainant	)	
v.	)	No. 88- A
MARCUS T. GORDON License No. 036- 076724 Respondent	)	

CONSENT ORDER

The Department of Professional Regulation by Max L. Rowe, one of its attorneys, and Marcus T. Gordon, Respondent, hereby agree to the following:

STIPULATIONS

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Information has come to the attention of the Department that prior to being issued a physician and surgeon license in Illinois the Respondent was employed as a resident in obstetrics/ gynecology at Mt. Sinai Hospital, Chicago, Illinois from July 1, 1987 through February 22, 1988, the date Respondent's application in the Department became complete. During said time period(s), and with the knowledge and direction of said hospital(s), the Respondent did acts which could constitute the unlicensed practice of medicine.

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DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

March 14, 1988
DATE

[redacted]
Max LP Rowe
Attorney for the Department

3/14/88
DATE

[redacted]
Marcus T. Gordon
Respondent

4-12-88
DATE

[redacted]
Lawrence L. Hirsch, M.D., Chm., Medical Licensing Board

The foregoing Consent Order is approved in full.

DATED THIS 14TH day of April, 1988.

DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

[redacted]
STEPHEN F. SELCKE
DIRECTOR

SFS:MLR:kai

Application No. _____ Prof. Code _____ SSN/FEIN

or Label Space

APPLICATION REVIEW FINDINGS

AMF 2

1. DATE: ___/___/___

2. EMPLOYEE: _____

3. STATUS: _____

4. DEFICIENCIES - ADD: _____

5. LAST CORRESPONDENCE RECEIVED DATE: ___/___/___

CLEAR: _____

6. LAST CORRESPONDENCE SENT DATE: ___/___/___

7. IL APPRENTICE TRAINING LICENSE NO.: _____

EDUCATION INFO:

8. School Name _____

9. School Code _____ 10. Foreign School _____ (Yes or No) 11. Date Graduated ___/___/___

12. City/Country School Located _____ 13. State School Located _____

RECIPROCITY INFO:

14. Original Licensure State _____ 15. Licensure Date ___/___ Month Year

16. Current Licensure State _____ 17. Licensure Date ___/___ Month Year

18. No. of States Licensed in _____

ACCEPTANCE OF EXAM INFO:

19. Who Gave Exam: _____ 20. Examination Date ___/___/___

21. Grades: 22. No. of Times Exam Taken _____

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____

13. _____ 14. _____ 15. _____ 16. _____ 17. _____ 18 _____

MISC. INFO:

23. Related License No.: 24. Bond Insurance Expire Date ___/___/___

1. _____ D ___ 2. _____ D ___ 3. _____ D ___ 4. _____ D ___

5. _____ D ___ 6. _____ D ___ 7. _____ D ___ 8. _____ D ___

25. Agency Manager Name _____ 26. Telephone No. _____

LICENSE ASSIGNMENT INFO:

27. Original IL License No. _____ 28. Issuance Date ___/___/___

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION

CASE ENTRY

Applicant Name: MARCUS GORDON, M.D. Applicant Number: 036

Record significant events and case contacts involving this case, specify: Profession: Medical-Permanent
Type of Contact: Who was contacted or present; the purpose, significant content and anticipated activity.
*P – Phone IP – Person A – Attempted C – Collateral

DATE AND TIME	TYPE*	INITIAL	
10-20-87	IP	DB	Dr. Gordon came to front desk to submit application. He was totally unprepared and the only part of application he had completed was application cover. He also had original diploma with him. He wanted to apply for reciprocity due to the fact he is licensed in New York. He also inquired about a Temporary license in the meantime. I explained the documents needed for a Temporary and Permanent. He indicated he wished to be licensed by Endorsement of licensure. He indicated he felt that Endorsement or Reciprocity should be faster due to the fact he was already licensed. His chief concern seemed to be that he needed proof to take back to hospital that he had been here today. He completed the work history while he was here and when I asked for fee he indicated that he had not brought any checks but that he did have a Visa card and would go some place to pick up a money order. He did leave and when he came back the money order was made out to the Board of Education. He then left again to go pick up another money order made out correctly to the Dept. R & E.
10-20-87	IP	NM	Dorothy had to leave for lunch so I finished the desk call for her. I went to front desk and Dr. Gordon had the correct fee in the form of a money order made

IL 486-1234 7/85 (L&T)

Over

*P – Phone IP – Person A – Attempted C – Collateral

DATE AND TIME	TYPE*	INITIAL	
			out to this Dept. Dr. also wanted a receipt to take with him. Upon giving him the receipt he questioned me regarding Reciprocity. I explained the process for reciprocity and that he would have to be Board certified. I explained that neither Endorsement or Recip. was faster than Acceptance. He indicated that because he was licensed in N.Y. he felt he sould just be able to transfer license so to speak. I explained that was not the case. He then left.
12:15 2/16/88	IP	KM	Keith went to front desk to speak with Dr. Gordon. He explained to the doctor what was still deficient in his application. Dr. Gordon wanted some proof to take back to hospital to show that he was in this Dept. on this day. Keith prepared the standard deficiency letter and gave original to doctor. Dr. Gordon then wanted to see the supervisor so I went to the front desk. I explained regardless of how he applied for license he must still have a complete application before being considered. I explained the same as Keith; what was still missing in application. I got the feeling that possibly Dr. Gordon had not requested the additional documents needed, even though he said he had. Dr. Gordon

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION

CASE ENTRY

Applicant Name: Marcus Gordon, M.D. Applicant Number:

Record significant events and case contacts involving this case, specify: Profession
Type of Contact: Who was contacted or present; the purpose, significant content and anticipated activity.
*P – Phone IP – Person A – Attempted C – Collateral

DATE AND TIME	TYPE*	INITIAL	
cont. 2/16/88			also indicated to me that he would be fired from residency upon return to hospital without a license, because he had been informed by hospital of such. I told him to have additional documents sent to my attention and gave him the phone number for the Natl. Board of Medical Examiners.

IL 486–1234 7/85 (L&T)

Application No. _____ Prof. Code [redacted]

or Label Space

APPLICATION REVIEW FINDINGS | **AMF 2**

1. DATE: 2/16/88
2. EMPLOYEE: 0702
3. STATUS: _____
4. DEFICIENCIES - ADD: _____
5. LAST CORRESPONDENCE RECEIVED DATE: 2/5/88
   CLEAR: CLR
6. LAST CORRESPONDENCE SENT DATE: ___/___/___
7. IL APPRENTICE TRAINING LICENSE NO.: _____

EDUCATION INFO:

8. School Name _____
9. School Code _____ 10. Foreign School _____ (Yes or No) 11. Date Graduated ___/___/___
12. City/Country School Located _____ 13. State School Located _____

RECIPROCITY INFO:

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

ACCEPTANCE OF EXAM INFO:

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

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

MISC. INFO:

23. Related License No.: 24. Bond Insurance Expire Date ___/___/___

1. _____ D ___ 2. _____ D ___ 3. _____ D ___ 4. _____ D ___
5. _____ D ___ 6. _____ D ___ 7. _____ D ___ 8. _____ D ___

25. Agency Manager Name _____ 26. Telephone No. _____

LICENSE ASSIGNMENT INFO:

27. Original IL License No. _____ 28. Issuance Date ___/___/___

IL486-1323 1/87 (EDP)

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

Profession _____
Date _____
Initials _____

NOTICE CONCERNING YOUR APPLICATION WITH THE DEPARTMENT

TO

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

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

Other Instructions

11/87 (LET)

STATE OF ILLINOIS
DRE DEPARTMENT OF REGISTRATION AND EDUCATION
320 West Washington—3rd Floor • Springfield, Illinois 62786 • (217) 785-0800
GARY L. CLAYTON—Director

October 26, 1987

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

The Ill. Dept. of Registration & Education requests a disciplinary search concerning the following individual:

Marcus Tulio Gordon
Name

[redacted]
Address

Chicago, Il. 60615
City, State and Zip

[redacted]
Date of Birth

[redacted]
Social Security Number

Albert Einstein Coll. Med. Bronx, N. Y.
Medical School of Graduation and Branch Location

June 1985
Date of Graduation

Please mail the response to the following address:

IL Dept. of Registration & Education
320 W. Washington, 3rd Floor - Unit IV
Springfield, IL 62786

ATTENTION: Karen Dunlap - Unit Manager

[redacted]
Signature

Application No. ____ Prof. Code ____ SSN/FEIN

or Label Space

APPLICATION REVIEW FINDINGS

AMF 2

1. DATE: ___/___/___

2. EMPLOYEE: _____

3. STATUS: _____

4. DEFICIENCIES - ADD: _____

5. LAST CORRESPONDENCE RECEIVED DATE: ___/___/___

CLEAR: _____

6. LAST CORRESPONDENCE SENT DATE: ___/___/___

7. IL APPRENTICE TRAINING LICENSE NO.: _____

EDUCATION INFO:

8. School Name _____

9. School Code _____ 10. Foreign School _____ (Yes or No) 11. Date Graduated ___/___/___

12. City/Country School Located _____ 13. State School Located _____

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18. No. of States Licensed in _____

ACCEPTANCE OF EXAM INFO:

19. Who Gave Exam _____ 20. Examination Date ___/___/___

21. Grades: 22. No. of Times Exam Taken _____

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____

13. _____ 14. _____ 15. _____ 16. _____ 17. _____ 18. _____

MISC. INFO:

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25. Agency Manager Name _____ 26. Telephone No. _____

LICENSE ASSIGNMENT INFO:

27. Original IL License No. _____ 28. Issuance Date ___/___/___

IL486-1323 1/87 (EDP)

Application No. ____ Prof. Code [redacted] SSN/FEIN or Label Space	APPLICATION DATA CHANGE	AMF 1

1. DATE: __/__/__

2. EMPLOYEE: _____

3. APPLICATION DATE: __/__/__

4. REAPPLICATION DATE: __/__/__

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

6. FELONY INDICATOR: _____

7. LICENSURE METHOD: _____

8. DATE OF BIRTH: __/__/__

NAME:

9. Individual (Human) Last _____ First _____

M.I. _____ Title _____

10. Business (Non-human) _____

11. **ADDRESS:**

Line 1 _____

Line 2 _____

Line 3 _____

Line 4 _____

City/Country _____ State _____ Zip _____

County _____ Foreign Address _____ (Yes or No)

FINANCIAL/BATCH:

12. Payment Date __/__/__ 13. Batch No. _____ 14. Fee Amount _____

15. Payment Type _____

16. Delete Financial _____ (Yes or No)

17. **ON CONTROL SLIP:** _____ (Yes or No)

18. Add ☐ 19. Change ☐

IL486-1322 6/86 (EDP)

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
320 West Washington—3rd Floor • Springfield, Illinois 62786 • (217) 785-0800
GARY L. CLAYTON—Director

10/26/87

[redacted]
MARCUS T GORDON
[redacted]

This is to inform you that your application for registration as a physician-surgeon is incomplete. Before your application may be given further consideration, you must comply with the items marked below. This form must accompany any materials, fees, etc., required to be returned to the Department.

____ Submit fee in the amount of _____.

____ Application must be signed and notarized.

____ Part(s) ____ Number(s) ____ of your application must be completed.

____ Submit one recent photograph.

____ Submit work experience - On a separate sheet of paper, list work experience from date of graduation to present (account for entire time period).

____ Submit diploma - A copy of your original diploma with official translation if not in the English language.

X Submit transcripts - Official original transcripts of a 2-year course of instruction in Pre-Med with school seal affixed. Official translation is required if not in the English language.

X Submit transcripts - Official original transcripts from a medical college or university, with school seal affixed. Official translation required if not in the English language.

____ Submit official translation - If translation is required, an original notarized translation that has been performed by a person other than yourself or a person related to you by blood or marriage, who is fluent in both English and the language of the document, must also be submitted. The translator must certify to the accuracy of the translation.

OVER

IL 486-0268 10/85 (MD)

STATE OF ILLINOIS

DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION of the State of Illinois,	Complainant	)	
v.		)	No. ~~88-2374~~
MARCUS T. GORDON License No. 036-076724	Respondent	)	88-2372

CONSENT ORDER

The Department of Professional Regulation by Max L. Rowe, one of its attorneys, and Marcus T. Gordon, Respondent, hereby agree to the following:

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Marcus T. Gordon
Max L. Rowe

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DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

March 14, 1988
DATE

[redacted]
Max L. Rowe
Attorney for the Department

3/14/88
DATE

[redacted]
Marcus T. Gordon
Respondent

4-12-88
DATE

[redacted]
Lawrence L.Hirsch, M.D., Chm., Medical Licensing Board

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DATED THIS 14th day of April, 1988.

DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

[redacted]
STEPHEN F. SELCKE
DIRECTOR

SFS:MLR:kai