01000004701

MAY 1 0 2002
ILLINOIS DEPARTMENT OF PROFESSIONAL REGULATION

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.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

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

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

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 Licensure	1 2 5	Nonexamination	$ 100.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

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

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

1. NAME: LAST HALLBERG FIRST AMANDA MIDDLE JOY
2. TITLE (e.g. MD, DDS, etc.): MD
3. UNITED STATES SOCIAL SECURITY NO.: [redacted]
4. PERMANENT MAILING ADDRESS: STREET [redacted] CITY STATE/COUNTRY ZIP CODE COUNTY
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): [redacted]
7. PLACE OF BIRTH: CITY STATE/COUNTRY [redacted]
8. DATE OF BIRTH: [redacted] Month Day Year
9. AGE: 24 [x] Female [ ] Male
10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED: Work ([redacted] (Area Code) Home: ([redacted] (Area Code)
11. PREFERRED e-MAIL ADDRESS(ES) [If available]: [redacted]

RECEIVED
MAY 1 4 2002
IDPR-MEDICAL UNIT

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION

May 31, 2002

Amanda Joy Hallberg MD
[redacted]

Dear Dr. Hallberg:

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 06/20/2002. Assuming you remain in the training program listed below, this license will be valid until 06/19/2005.

PROGRAM: Family Practice
TRAINING FACILITY: St Joseph Hospital

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 the residency program; i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferable from one program/institution to another.

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

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

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

Alicia Purchase, Manager
Medical Unit

FC: lv3.125

PART III: Education Information

1□ PRELIMINARY EDUCATION (Elementary and High School or GED□ Circle number of years completed)

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

2□ NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3□ LAST PRELIMINARY SCHOOL LOCATION (City and State)	4□ DATE OF GRADUATION
Northville High Sch'l	Northville, MI	06/1995 (Month / Year)

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

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

6□ COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	TO (Month/Year)	TYPE OF DEGREE EARNED
University of Michigan	Ann Arbor, MI	09/95	06/98	B.A.
University of Michigan Medical School	Ann Arbor, MI	08/98	06/02	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?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Hallberg, Amanda J.

SS#: [redacted]

Profession: Temp. Physician License

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				
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
USMLE Step 1	MI	06/00	(Passed, Failed, Absent)
USMLE Step 2	MI	08/01	Passed

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

NAME (Last, First, MI): Halberg, Amanda J.

SS#: [redacted]

Profession: Temp. Physician Licensure

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*□		✓
2□ Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e.□ (1) mental or emotional disease or condition, (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment*□		✓
3□ Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation*□		✓
4□ Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation*□		✓

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

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

a) CHART II - Select examination(s) you desire and enter Test Codes□ N/A

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

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

d) Record the number of times you have taken this exam in Illinois or any other state: 0

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

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

Every licensee is required by law to respond to the following question regardless of whether or not he or she is subject to a child support order.

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"□)

In accordance with 5 Illinois Compiled Statutes 100/10-35(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**□

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□

Amanda Hallberg
Signature of Applicant

[redacted]
Date

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

NAME (Last, First, MI): Hallberg, Amanda, J.

SS#: [redacted]

Profession: Temp. Physician Licensure

Additional application forms can be downloaded from the IDPR Web site at www.dpr.state.il.us□

5/

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et seq. (Illinois Compiled Statues). 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 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: HALLBERG AMANDA JOY

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.

TEMPORARY PHYSICIAN — Profession Name

125 — Profession Code

6. MAIDEN OR GIVEN SURNAME:

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

A. HOSPITAL/INSTITUTION NAME: ST. JOSEPH HOSPITAL

B. BEGINNING DATE: 06 / 20 / 2002 (Month Day Year)

C. ENDING DATE: 06 / 19 / 2005 (Month Day Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: 2900 N. LAKESHORE CHICAGO, IL 60657

E. SPECIALTY / RESIDENCY NAME: FAMILY PRACTICE

F. BUSINESS TELEPHONE NUMBER: Area Code (773) 665-3300

PGY I

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

SEAL

[redacted]

Signature of Program Director

ROGER A NOSAL, M.D.

Print Name of Program Director

PROGRAM DIRECTOR

Title

5/13/02

Date

L486-0272 12/00 (MD)

RECEIVED

MAY 28 2002

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IMPORTANT NOTICE Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et seq (Illinois Compiled Statues). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF EDUCATION

SUPPORTING DOCUMENT

ED - MED

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

1. NAME (LAST, FIRST, MIDDLE): Hallberg Amanda Joy

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

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

Temporary Physician Licensure (Profession Name) 125 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

7. NAME OF INSTITUTION ATTENDED: University of Michigan 48109

8. DATE OF GRADUATION / COMPLETION: 06/07/2002 (Month Day Year)

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

April 23, 2002 (Date) [redacted] (Signature)

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

A. NAME OF INSTITUTION: The University of Michigan Medical Sch

B. ADDRESS OF INSTITUTION (STREET, CITY, STATE, ZIP CODE): 1301 Catherine Ann Arbor, MI 48109

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

From 08/18/1998 (Month Day Year) To 05/17/1999 (Month Day Year)

From 08/16/1999 (Month Day Year) To 05/05/2000 (Month Day Year)

From 07/03/2000 (Month Day Year) To 07/01/2001 (Month Day Year)

From 07/02/2001 (Month Day Year) To 06/02/2002 (Month Day Year)

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

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

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

OR

Total calendar years attended: ___ Years / ___ Months / ___ Days

E. TYPE OF DEGREE OR CERTIFICATE AWARDED: Doctor of Medicine

F. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET: 06/02/2002 (Month Day Year)

G. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED: 06/07/2002 (Month Day Year)

H. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

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

[ ] Applicant will graduate on 06/02/2002 (Month Day Year)

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

[ ] Applicant will complete program on 06/02/2002 (Month Day Year)

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

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

NAME (Last, First, MI): Hallberg, Amanda J

SS#: [redacted]

Profession:

WHEN THIS FORM IS CERTIFIED PRIOR TO THE ACTUAL GRADUATION OF THE APPLICANT, THE SCHOOL OFFICIAL IS RESPONSIBLE FOR NOTIFYING THE DEPARTMENT OF PROFESSIONAL REGULATION OF ANY FAILURE ON THE PART OF THE APPLICANT TO COMPLETE THE REQUIREMENTS FOR GRADUATION

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

[redacted]
Signature of School Official

Susan K. Hayward
Print Name of School Official

SCHOOL SEAL

Registrar
Title

April 24, 2002
Date

RETURN THIS FORM TO APPLICANT

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

WORK HISTORY

SUPPORTING DOCUMENT

WH

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

1. NAME LAST FIRST MIDDLE: HALLBERG AMANDA JOY

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application:
Temporary Physician Licensure (Profession Name) 1 2 5 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: Same as Above

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

8. DATE FORM COMPLETED: April 23, 2002

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

A. NAME OF BUSINESS / INSTITUTION: University of Michigan

ADDRESS STREET, CITY, STATE, ZIP CODE: Ann Arbor, MI 48109

SUPERVISOR NAME: Dr. Carmen Green, M.D.

DATE OF EMPLOYMENT/ATTENDANCE: From 06/01/1999 (Month Day Year) To 08/20/1999 (Month Day Year)

HOURS WORKED PER WEEK: 40

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

TOTAL TIME WORKED (Year/Month): 3 Months (Summer)

JOB TITLE: Anesthesia Tech / Research Ass't

DESCRIPTION OF DUTIES PERFORMED: Assisted Anesthesia Staff before and during surgeries in preparing rooms for surgery.
Data Entry as Research Ass't

B. NAME OF BUSINESS / INSTITUTION: Planned Parenthood

ADDRESS STREET, CITY, STATE, ZIP CODE: 3100 Professional Drive
Ann Arbor, MI 48109

SUPERVISOR NAME: Peg Hill-Callahan

DATE OF EMPLOYMENT/ATTENDANCE: From 03/01/1997 (Month Day Year) To 06/01/1999 (Month Day Year)

HOURS WORKED PER WEEK: Average 20

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

TOTAL TIME WORKED (Year/Month): 3 years

JOB TITLE: Medical Assistant / HIV Test Counselor.

DESCRIPTION OF DUTIES PERFORMED: Counseled client prior to HIV test counseling.
Other counseling, blood drawing, ~~duty~~ assisting physicians

IL486-1071 9/99 (LT)

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

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

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

NAME (Last, First, MI): Halbers, Amanda, J

SS#: [redacted]

Profession: Temp. Physician License

TEMPORARY CHECKLIST 125___ 130___

APPLICATION FINDINGS

___Application Complete
___Personal History Yes#_____
___CA-MED(125)
Start Date: 6-20-02
End Date: 6-19-05
Program: 015
___CA-LTD(130) - Illinois Program
Start Date:_____
End Date: _____
Program: _____
___CA-MED(130) - Out-of-State Program

PERSONAL HISTORY DOCUMENTS

DOMESTIC GRADUATES

✓ED-MED or Roster Date 6-2-02
___Medical Transcripts
___Premedical Transcripts
___Diploma Date_____

FOREIGN GRADUATES

___ECFMG/5th Pathway/Social Service
___Premedical Transcripts ___Translations
___Medical Transcripts ___Translations
___Diploma Date_____ ___Translation
___AF-MED Part A
___AF-MED Part B

INTERNAL MED: Evaluation ____
Hospital: _____
Agreement_____
Affidavits: Hospital_____School_____

OB/GYN: Evaluation_____
Hospital: _____
Agreement_____
Affidavits: Hospital_____School_____

PEDIATRICS: Evaluation ____
Hospital: _____
Agreement_____
Affidavits: Hospital_____School_____

PSYCHIATRY: Evaluation_____
Hospital: _____
Agreement_____
Affidavits: Hospital_____School_____

SURGERY: Evaluation ____
Hospital: _____
Agreement_____
Affidavits: Hospital_____School_____

___ED-NON _____Total months -must be minimum 36 w/premed; 54 combined
___Minimum 4-weeks in Core Rotations: ___Med___Ob/Gyn___Peds___Psych ___Surgery
Psychiatry Affidavit if only 2-weeks verified_____

SUPPORTING DOCUMENTS

___Work History Clinical Skills OK____
___Original Jurisdiction of Licensure
License State & Number_____ No Discipline_____
___Current Jurisdiction of Licensure
License State & Number_____ No Discipline_____
___Name Change
___Federation Check

Profession: 185
Date: 5-29-02 Initials: TT

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:
St. Joseph Hospital
Dept. of GME

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield Illinois 62786

Re: Chandra Halliday

	1. Submit the required fee of $_____ made payable to the Department of Professional Regulation. This fee is not refundable.
	2. Your application is being returned for completion of Part _____.
	3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from _____ to _____.
	4. All documents in a foreign language 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).
	5. Submit proof that you are a lawfully admitted alien.
	6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.
	7. When your application is complete, the Medical Licensing Board will review your qualifications.
	8. Your application will be reviewed by the Medical Licensing Board on_____.
X	9. Submit completed **CA-MED** form which indicates beginning and ending program dates.
	10. Submit **CA-LTD** form.
	11. Submit **ED-MED** form (certification of education).
	12. Submit **ED-NON** form completed in its entirety.
	13. Affidavits, (**ED-AFF** forms) must be completed in accordance with DPR policy. Copy of policy attached.
	14. **Verification of Pass/Fail Exam History**—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.
	15. Submit official premedical/medical transcript with school seal afixed.
	16. Submit photocopy of your degree.
	17. Submit proof of Titulo or Acta.
	18. Submit proof of Social Service or Fifth pathway.
	19. Submit proof of E.C.F.M.G. certification.
	20. Submit copy of evaluation form for each of the following core rotations: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
	21. Complete **AF-MED** form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
X	25. Submit a list of your work experience from graduation to present. You must account for entire time period since graduation from medical school (Supporting Document **WH**).
	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
	28. Have your _____ scores forwarded directly from _____.
	29. Submit evidence of remedial training.
	30. Submit **TN-MED** form signed by program director, with seal of hospital.
X	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on offical stationary must be attached verifying no seal exists.)
	32. Sign form(s) where indicated.
	33. Submit certification of original/current licensure (Supporting Document **CT**) from_____.
	34. Submit proof that you are Board-certified in a specialty.
	35. Submit restoration questionnaire (Supporting Document **RS**).
	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
	37. Returning original documents.

Other Instructions:
Please submit new CA-MED form, with accurate dates also attach to new work history form w/ completion of 1-8

IL486-1588 5/94 (LT)