PART A: IDENTIFYING INFORMATION

1. PROFESSIONAL LICENSE FOR WHICH YOU ARE APPLYING: *(See attachment number 1 prior to completing PART A.)*

Profession Name

Physicians, Surgeons & Osteopaths

2. PRINT NAME AS YOU WISH IT TO APPEAR ON CERTIFICATE (Limited to 20 characters first name and 20 characters last name)

First: STEWART | M | Last: KERNES

[redacted] *Designation of number is not mandatory, used only to ensure identification, accessibility, and accuracy of the application.*

4. MAIDEN OR GIVEN SURNAME

[redacted]

7. STATE | 8. ZIP CODE | 9. COUNTY | 10. PLACE OF BIRTH

[redacted]

[redacted]

13. Telephone number where you may be reached during the day [redacted]

Area Code

PART B: EDUCATION AND OCCUPATIONAL TRAINING INFORMATION

1. PRELIMINARY EDUCATION (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. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 (8)

Graduated? [✓] Yes [ ] No

3. COLLEGES OR UNIVERSITIES ATTENDED	Total number of hours earned: Semester	Quarter	Major	Minor	Dates Attended: From (mo./yr.)	To (mo./yr.)	Type of Degree Earned	Date of Degree Month/Year
UNDERGRADUATE: Northern Illinois Univ	123		Biol		8-71	6-75	BS	6-75
GRADUATE: College of Osteopathic Medicine of the Pacific					8-82	6-86	DO	6-86

4. TYPE OF OCCUPATIONAL TRAINING RECEIVED

5. OCCUPATIONAL SCHOOLS ATTENDED: Name of School	Location	Dates Attended: From (mo./yr.)	To (mo./yr.)	Length of Course	Completed?
					[ ] Yes [ ] No
					[ ] Yes [ ] No
					[ ] Yes [ ] No
					[ ] Yes [ ] No

PART C: RECORD OF LICENSURE

If you have ever been licensed to practice the profession named in Part A of this application, complete the information requested below.

1. APPLICANT MUST COMPLETE THE FOLLOWING ITEMS IF APPLICABLE:

	State	Profession Name	License Number	Date of Issue (month/year)
Original License:				
Current License:	IL	OSTEOPATHY	Temp T018324	

2. OTHER LICENSE(S) HELD IN SAME AND/OR RELATED PROFESSION(S). *(If additional space is needed, write information on a separate sheet of paper and attach.)*

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUE (Month/Year)

PART D: PERSONAL HISTORY INFORMATION

		YES	NO
1	Have you ever written a licensure examination in Illinois or in any other state in the profession for which you are applying? *If yes, complete the following (If additional space is needed, write information on a separate sheet of paper and attach.)*		X
	List state(s) in which you took examination / Type of examination taken / Date of Examination / Passed / Failed		
2	Have you ever been denied a license, permit, or privilege of taking an examination by any licensing authority? *If yes, attach a detailed explanation.*		X
3.	Have you ever had a license or permit incumbered in any way (revoked, suspended, surrendered, censured, restricted, limited, placed on probation)? *If yes, attach a detailed explanation.*		X
4	Have you ever been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach statement including date and place of conviction(s) and nature of such offense(s).*		X
5	Do you have any physical impairment or disability that could interfere with your ability to practice your profession? *If yes, attach a detailed explanation.*		X
6	Are you now addicted to or do you excessively use alcohol, narcotics, barbiturates or habit-forming drugs? If yes, attach a detailed explanation.		X
7	Have you ever suffered from, or been diagnosed as having, or have 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		X

STATE OF _____)

COUNTY OF _____)

I hereby certify that I personally completed this application and that the answers appearing hereon are true and correct to the best of my knowledge and belief. I understand that providing fraudulent information may be grounds for refusal to issue the License for which I am applying or for disciplinary action against the license which may be issued.

[redacted]

NOTARY SEAL

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

Signature of Notary Public — My Commission Expires

ILLINOIS DEPARTMENT OF REGISTRATION AND EDUCATION TESTING PROGRAM

APPLICATION FOR EXAMINATION

General Application Instructions

0 3 3 0 5 3 0 3 2 9

1. Read all instructions carefully before you begin completing the application. See Attachment 1 for further instructions and requirements specific to the profession in which you are applying for registration or licensure.

2. Applications must be typed or printed legibly with **black** ink only. Illegible applications will be returned. Do not write in shaded areas marked "for official use only."

3. The profession name to be used to complete Part A1 of this application is indicated on Attachment 1. Also shown on Attachment 1 are the required fees and filing deadlines (when applicable). Filing deadlines for receipt of application and all supporting documents will be strictly enforced.

4. The fee must be in the form of a *certified check or money order* made payable to the Continental Testing Services, Inc. and must be in United States dollars. This fee is **not refundable.**

5. You will be notified of the date of the examination for which you have been scheduled upon approval of your application.

6. Any documents in a foreign language that are required to be submitted in support of your application must be accompanied by an original, notarized English version that has been translated by a person, **other than you** and not related to you by blood or marriage, who is fluent in both English and the language of the documents. The translator must certify to the aforementioned requirements as well as to the accuracy of the translation.

7. If the name shown on your supporting documents (e.g., transcripts, diplomas, etc.) is different from that shown on your application due to a name change, you must submit proof of legal name change (marriage license, divorce decree, affidavit, or court order) with your application.

8. If required by Attachment 1, transcripts submitted to support the educational requirements needed to qualify for your license must be submitted by you with the Application for Examination, and **must** have been completed by the school and bear its seal.

9. Two recent, passport-size photographs must be submitted with your application. Attach the photograph in the space provided on page 2 of this application. Photographs must have been taken within the last 3 months.

10. Your application must be notarized in the space provided on page 4.

11. To be complete, your application must include the green Examination Registration Form which will be used to schedule you for the examination, the white Application for Examination and the required attachments to be used to determine your eligibility to sit for the examination.

    To avoid unnecessary delay, all supporting documents, attachments and fee should accompany your properly completed application. It is your responsibility to notify Continental Testing Services, Inc. of any name or address change occurring after the filing of your application.

    Completed application, supporting documents, attachments and fee are to be sent to:

    Continental Testing Services, Inc.
    Illinois Department of Registration and Education Testing Program
    P. O. Box 7430
    Westchester, Illinois 60153

If you need assistance in completing your application, call (312) 343-0877. When calling, state the profession for which you are applying and that you need assistance with your application.

SHADED AREAS FOR OFFICIAL USE ONLY

COMMENTS

INITIALS	DATE	

INITIALS	DATE	

INITIALS	DATE	

INITIALS	DATE	

PHOTOGRAPHS

In the spaces at the left

attach two recent

2 ⁷⁄₈ X 2½ PASSPORT SIZE PHOTOGRAPHS

taken within last 3 months

DO NOT STAPLE

USE TRANSPARENT TAPE

TOP AND BOTTOM ONLY

ILLINOIS DEPARTMENT OF REGISTRATION AND EDUCATION TESTING PROGRAM
CONTINENTAL TESTING SERVICES, INC.
EXAMINATION REGISTRATION FORM

1 PROFESSION CODE	PROFESSION NAME	2 TEST FEE ENCLOSED
036	Physicians, Surgeons, & Osteopaths	$ 282.20

3 YOUR NAME: KERNES (PRINT LAST NAME) STEWART (PRINT FIRST NAME) M (MI)

4 MAIDEN NAME: (PRINT LAST NAME) 103330329

5 YOUR HOME ADDRESS: [redacted] (NUMBER AND STREET)

[redacted] (CITY) (STATE) (U.S. ZIP CODE)

6 COUNTY CODE: [redacted]

7 DATE OF BIRTH: [redacted] (MONTH) (DAY) (YEAR)

8 SOC SEC NO: [redacted]

TEST DATE: 12 (MONTH) 03 (DAY) 86 (YEAR)

10 ILLINOIS SCHOOL/PROGRAM CODE: 36-906 OTHER ☐ College of Osteo Med of the Pac.
(write School/Program name, city, and state here)

11 TEST CODE NUMBER(S): Enter the Test Code for each examination you want to take: 28 09

12 PREFERRED TEST CENTER CODE: 154

13 Telephone number where you can be reached during the day: [redacted] Area Code

14 PREVIOUS EXAMINATIONS: Have you previously taken the licensing examination for which you are registering?
☒ No ☐ Yes ☐ I was registered to take the examination previously, but was absent
If yes, how many times have you taken the examination? _____
List name(s) of examination(s) taken, year(s) taken and the state (e.g. Illinois) where you took the examination(s).
_____ examination _____ year(s) _____ state
If additional space is required, attach separate sheet

15 PERMISSION FOR RELEASE OF SCORES
Do you authorize the Illinois Department of Registration and Education to release your State Board Examination scores to the education program from which you graduated?
☒ Yes ☐ No

16 SIGNATURE AND DATE: [redacted]

INSTRUCTIONS: Read all instructions before you begin completing this form. You will need Attachment 1 of the application package to complete this form.

PRINT OR TYPE CAREFULLY - INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED.

The numbered instructions below correspond to the numbered items on this registration form.

1 PROFESSION CODE	Enter the three-digit profession code shown to the left of the appropriate profession listed on Attachment 1. Write out the name of the profession in the space given for "Profession Name."
2 TEST FEE	Write the total amount of the appropriate fee(s) in the space provided and include a certified check or money order with this Registration Form. The fees are listed on Attachment 1. Applications received after the filing date listed on Attachment 1 or received with improper fees will not be processed.
3 YOUR NAME	Print your last name, first name, and middle initial, one letter to a box.
4 MAIDEN NAME	Self explanatory.
5 YOUR HOME ADDRESS FOR YOUR ADMISSION LETTER AND SCORE REPORT	Your address must be complete. This is the address to which your admission ticket will be mailed. Print only one number or letter to a box. Skip a box where a space would normally appear. Abbreviate such words as Street (ST), Road (RD), and Drive (DR). Be sure to indicate the Zip Code in the boxes provided. Use the two-letter abbreviation for your state.
6 COUNTY CODE	Enter the three-digit number from the Illinois County Code List on the reverse side of this form. Out-of-state applicants leave this space blank.
7 DATE OF BIRTH	Self explanatory.
8 SOCIAL SECURITY NUMBER	Enter your Social Security Number, one digit to a box. Disclosure of your Social Security Number is on a voluntary basis. This number will be used as a secondary identification in verifying your registration and application data.
9 TEST DATE	Enter the Test Date for the examination you wish to take from the information given on Attachment 1. If you will be taking a multi-day examination, enter the date of the first day of the examination.
10 ILLINOIS SCHOOL/ PROGRAM CODE	Enter the appropriate Illinois School/Program Code for your school from the list that appears on the back of Attachment 1. Out-of-state and foreign-educated applicants should check "Other." Fill in the name of your school and the city and state of the school (and country for foreign-educated applicants) on the line provided.
11 TEST CODE NUMBER	Enter the appropriate two-digit code(s) located to the right of the examinations listed on Attachment 1.
12 PREFERRED TEST CENTER CODE	Enter the four-digit test center code for the center you desire. Your Admission Letter, which will show the specific location to which you should report, will be mailed to you prior to the test date. If the test center location you have selected is not available, you will be assigned to another center.
13 TELEPHONE NUMBER	Self explanatory.
14 PREVIOUS EXAMS	Self explanatory.
15 PERMISSION FOR RELEASE OF SCORES	Self explanatory.
16 SIGNATURE AND DATE	Self explanatory.

MAIL COMPLETED APPLICATION FORM WITH A CERTIFIED CHECK OR MONEY ORDER MADE PAYABLE TO
CONTINENTAL TESTING SERVICES, INC., P.O. BOX 7430, WESTCHESTER, ILLINOIS 60153

CTS-2

COUNTY CODE NUMBERS

001	ADAMS	052	LEE
002	ALEXANDER	053	LIVINGSTON
003	BOND	054	LOGAN
004	BOONE	055	MC DONOUGH
005	BROWN	056	MC HENRY
006	BUREAU	057	MC LEAN
007	CALHOUN	058	MACON
008	CARROLL	059	MACOUPIN
009	CASS	060	MADISON
010	CHAMPAIGN	061	MARION
011	CHRISTIAN	062	MARSHALL
012	CLARK	063	MASON
013	CLAY	064	MASSAC
014	CLINTON	065	MENARD
015	COLES	066	MERCER
016	COOK	067	MONROE
017	CRAWFORD	068	MONTGOMERY
018	CUMBERLAND	069	MORGAN
019	DE KALB	070	MOULTRIE
020	DE WITT	071	OGLE
021	DOUGLAS	072	PEORIA
022	DUPAGE	073	PERRY
023	EDGAR	074	PIATT
024	EDWARDS	075	PIKE
025	EFFINGHAM	076	POPE
026	FAYETTE	077	PULASKI
027	FORD	078	PUTNAM
028	FRANKLIN	079	RANDOLPH
029	FULTON	080	RICHLAND
030	GALLATIN	081	ROCK ISLAND
031	GREENE	082	ST CLAIR
032	GRUNDY	083	SALINE
033	HAMILTON	084	SANGAMON
034	HANCOCK	085	SCHUYLER
035	HARDIN	086	SCOTT
036	HENDERSON	087	SHELBY
037	HENRY	088	STARK
038	IROQUOIS	089	STEPHENSON
039	JACKSON	090	TAZEWELL
040	JASPER	091	UNION
041	JEFFERSON	092	VERMILION
042	JERSEY	093	WABASH
043	JO DAVIES	094	WARREN
044	JOHNSON	095	WASHINGTON
045	KANE	096	WAYNE
046	KANKAKEE	097	WHITE
047	KENDALL	098	WHITESIDE
048	KNOX	099	WILL
049	LAKE	100	WILLIAMSON
050	LA SALLE	101	WINNEBAGO
051	LAWRENCE	102	WOODFORD

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.

APPLICATION FOR FLEX: COMPONENT 1 AND/OR COMPONENT 2

PART A – To Be Completed By Applicant.

Print all information. Complete all 12 items and return this form to the state medical board for which you are taking FLEX.

1. NAME

KERWES
Last (Surname)

STEWART M 03 05 29
First and Middle Name or Initial

ALTERNATE SURNAME. To be filled out only by individuals who used another name for FLEX previously.

2. DATE OF BIRTH [redacted]

3. CITIZENSHIP AT BIRTH ☒ U.S.A. ☐ Canada ☐ Other (Specify) 081 USA
*Country Code — Name of Country
*Refer to Country Code List on back.

4. SOCIAL SECURITY NUMBER [redacted]

5. SEX ☒ Male ☐ Female

6. HAVE YOU PREVIOUSLY TAKEN FLEX? ☐ YES If Yes a) When was the most recent FLEX taken? ____ (Month) 19__ (Year)
☒ NO b) How many previous FLEX examinations have you taken? ____

7. CITIZENSHIP UPON ENTERING MEDICAL SCHOOL ☒ U.S.A. ☐ Canada ☐ Other (Specify) 081 USA
*Refer to Country Code List on back. *Country Code — Name of Country

8. MEDICAL EDUCATION
a) College of Osteopathic Medicine of the Pacific
Name of Medical School of Graduation
b) Country of Medical School ☒ U.S.A. ☐ Canada ☐ Other (Specify) 081 USA
*Country Code — Name of Country
c) Graduation Year 1986
*Refer to Country Code List on back.
d) Degree ☐ M.D. ☒ D.O. ☐ Other (Specify) ____

9. OTHER EXAMINATIONS TAKEN

Examination	Most Recent Date Taken (Month, Year)	Identification Number
☐ ECFMG	____ /19__	ECFMG
☐ VQE or FMGEMS	____ /19__	VQE or FMGEMS
☐ NBME	____ /19__	NBME

☒ None of the Above

10. FEDERATION IDENTIFICATION NUMBER (FIN) IF KNOWN

11. DATE OF THIS APPLICATION 09 (Day) 27 (Month) 1986 (Year)

12. APPLICATION STATEMENT & SIGNATURE
I certify that the information supplied in this application is true and accurate to the best of my knowledge.
SIGNATURE [redacted]

PART B – To Be Completed Or Validated By State Board

1. STATE FOR WHICH FLEX IS BEING TAKEN Illinois (Name of State) 114 (State Code No.)

2. APPLICANT'S STATE BOARD ID NUMBER

3. TEST CENTER & DATE OF EXAMINATION Chicago, Illinois (City and State) ____ (Center State Code No.)
☐ June 19__
☒ December 19 86

4. EXAMINATION(S) FOR WHICH REGISTERED (CHECK ONE)
☐ COMPONENT 1 ONLY ☐ COMPONENT 2 ONLY ☒ COMPONENTS 1 AND 2

(OVER)

COUNTRY CODES (ALPHABETICAL)

112 Aden (Yemen)
130 Afars — Issas
001 Afghanistan
002 Albania
098 Algeria
300 Andorra
168 Angola (Port W Afr)
003 Argentina
104 Aruba
175 Ascension
004 Australia
005 Austria
064 Azores

188 Bahamas
345 Bahrain
125 Bangladesh
113 Barbados
350 Barbuda
007 Belgium
355 Bermuda
360 Bhutan
008 Bolivia
104 Bonaire
365 Botswana
009 Brazil
115 Brit E Africa
370 Brit Honduras
375 Brunei
010 Bulgaria
011 Burma
380 Burundi

385 Cape Verde Island
012 Cambodia
029 Cameroon
013 Canada
390 Central African Rep
014 Ceylon (Sri Lanka)
395 Chad
015 Chile
016 China (Mainland)
016 China (Red/People s Rep)
017 Colombia
400 Comoro Islands
006 Congo (Zaire)
028 Corsica
018 Costa Rica
085 Croatia
019 Cuba
104 Curacao
090 Cyprus
020 Czechoslovakia

405 Dahomey
021 Denmark
410 Dominica
022 Dominican Rep
111 Dutch East Indies

450 E Germany (Dem Rep)
023 Ecuador
093 Egypt (United Arab Rep)
025 El Salvador
060 England (U.K.)
415 Equatorial Guinea
079 Estonia
091 Ethiopia

420 Falkland Islands
425 Faroe Islands
030 Fed Rep Germany (West)
026 Fiji
027 Finland
016 Formosa
028 France
455 French Guiana
129 French Polynesia

131 Gabon
132 Gambia
450 Germany (Dem Rep)
030 Germany (Fed Rep)
094 Ghana
133 Gibraltar
039 Goa
080 Great Britain (U.K.)
080 Great Britain & Wales (U.K.)
032 Greece
134 Greenland
135 Grenada
136 Guadeloupe
033 Guatemala
092 Guyana

034 Haiti
035 Honduras
036 Hong Kong
037 Hungary

038 Iceland
039 India
040 Indonesia
041 Iran
042 Iraq
043 Ireland
080 Ireland (North/U.K.)
044 Israel
045 Italy
120 Ivory Coast

046 Jamaica (West Indies)
047 Japan
087 Jordan (Palestine)

110 Kenya
012 Khmer Republic
048 Korea (North)
475 Korea (South/Rep of)
460 Kuwait

119 Laos
079 Latvia
049 Lebanon
141 Leeward Islands
142 Lesotho
105 Liberia
106 Libya (Arab Rep)
122 Liechtenstein
079 Lithuania
099 Luxembourg

116 Macao
050 Madagascar
064 Madeira Islands

016 Mainland China
050 Malagasy Republic
465 Malawi
124 Malaysia
150 Mali
051 Malta
016 Manchuria

152 Martinique
470 Mauritania
153 Mauritius
052 Mexico
210 Monaco
103 Morocco
126 Mozambique (Port E Afr)
155 Muscat

117 Nepal
053 Netherlands
104 Netherlands Antilles
159 New Caledonia
128 New Guinea Territory
161 New Hebrides
054 New Zealand
055 Nicaragua
162 Niger
056 Nigeria
080 Northern Ireland (U.K.)
057 Norway

155 Oman
163 Outer Mongolia

058 Pakistan
087 Palestine (Jordan)
059 Panama
128 Papua
060 Paraguay
061 Peru
062 Philippines
063 Poland
064 Portugal
126 Port E Afr (Mozambique)
166 Portuguese Guinea
167 Portuguese Timor
168 Port W Afr (Angola)

169 Qatar

088 Rep of China (Taiwan)
137 Rep of Guinea
124 Rep of Maldives
156 Rep of Nauru
170 Reunion
097 Rhodesia
066 Romania
480 Rwanda
171 Ryukyu Is (South)

030 Saar
124 Saba
173 St. Christopher
104 St. Eustatius
175 St. Helena
176 St. Lucia
177 St. Pierre & Miquelon
178 St. Vincent
196 Sana (Yemen)
212 San Marino
069 Santa Cruz Is
089 Saudi Arabia
450 Saxony
080 Scotland (U.K.)
121 Senegal
180 Seychelles
123 Sierra Leone
213 Sikkim
068 Singapore
181 Solomon Is
182 Somalia
078 S Africa
095 S West Africa
069 Spain
215 Spanish Sahara
014 Sri Lanka (Ceylon)
000 Stateless
070 Sudan
040 Sumatra
071 Surinam
485 Swaziland
072 Sweden
073 Switzerland
074 Syria (Arab Rep)

088 Taiwan (Rep of China)
118 Tanzania
075 Thailand
183 Togo
184 Tonga
101 Trinidad/Tobago
175 Tristan Cunha
186 Trucial States
096 Tunisia
076 Turkey
188 Turks Is

077 Uganda
093 U Arab Rep (Egypt)
205 Unknown
079 U.S.S.R.
080 United Kingdom
081 U.S.A.
490 U.S. Trust Territories
190 Upper Volta
082 Uruguay

191 Vatican City
083 Venezuela
192 Vietnam (North)
084 Vietnam (South/Rep of)

080 Wales (U.K.)
046 West Indies (Jamaica)
193 Western Samoa
194 Windward Is

112 Yemen/Aden
196 Yemen/Sana
085 Yugoslavia

006 Zaire (Congo)
127 Zambia

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.

APPLICATION FOR FLEX: COMPONENT 1 AND/OR COMPONENT 2

PART A -- To Be Completed By Applicant.

Print all information. Complete all 12 items and return this form to the state medical board for which you are taking FLEX.

1. NAME

KERNES
Last (Surname)

STEWART, M, JR, 10/29
First and Middle Name or Initial

ALTERNATE SURNAME. To be filled out only by individuals who used another name for FLEX previously.

2. DATE OF BIRTH [redacted]

3. CITIZENSHIP AT BIRTH ☒ U.S.A. ☐ Canada ☐ Other (Specify) 081 USA
*Refer to Country Code List on back. *Country Code Name of Country

4. SOCIAL SECURITY NUMBER [redacted]

5. SEX ☒ Male ☐ Female

6. HAVE YOU PREVIOUSLY TAKEN FLEX? ☐ YES If Yes a) When was the most recent FLEX taken? Month Year 19
☒ NO b) How many previous FLEX examinations have you taken? _____

7. CITIZENSHIP UPON ENTERING MEDICAL SCHOOL ☒ U.S.A. ☐ Canada ☐ Other (Specify) 081 USA
*Refer to Country Code List on back. *Country Code Name of Country

8. MEDICAL EDUCATION

a) College of Osteopathic Medicine of the Pacific
Name of Medical School of Graduation

b) Country of Medical School ☒ U.S.A. ☐ Canada ☐ Other (Specify) 081 USA
*Country Code Name of Country

c) Graduation Year 1986

*Refer to Country Code List on back. d) Degree ☐ M.D. ☒ D.O. ☐ Other (Specify) _____

9. OTHER EXAMINATIONS TAKEN

Examination	Most Recent Date Taken: (Month, Year)	Identification Number:
☐ ECFMG	/19	ECFMG
☐ VQE or FMGEMS	/19	VQE or FMGEMS
☐ NBME	/19	NBME

☒ None of the Above

10. FEDERATION IDENTIFICATION NUMBER (FIN) IF KNOWN

11. DATE OF THIS APPLICATION 09 (Day) 27 (Month) 1986 (Year)

12. APPLICATION STATEMENT & SIGNATURE

I certify that the information supplied in this application is true and accurate to the best of my knowledge.

SIGNATURE [redacted]

PART B -- To Be Completed Or Validated By State Board

1. STATE FOR WHICH FLEX IS BEING TAKEN Illinois (Name of State) 114 (State Code No.)

2. APPLICANT'S STATE BOARD ID NUMBER

3. TEST CENTER & DATE OF EXAMINATION Chicago, Illinois (City and State) _____ (Center State Code No.)
☐ June 19 _____
☒ December 19 86

4. EXAMINATION(S) FOR WHICH REGISTERED (CHECK ONE)
☐ COMPONENT 1 ONLY ☐ COMPONENT 2 ONLY ☒ COMPONENTS 1 AND 2

(OVER)

FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.

APPLICATION FOR FLEX, COMPONENT 1 AND/OR COMPONENT 2

PART A – To Be Completed By Applicant.

Print all information. Complete all 12 items and return this form to the state medical board for which you are taking FLEX.

1. NAME

KERWES
Last (Surname)

STEWART JAMES DAVID
First and Middle Name or Initial

ALTERNATE SURNAME: To be filled out only by individuals who used another name for FLEX previously

2. DATE OF BIRTH [redacted]

3. CITIZENSHIP AT BIRTH ☒ U.S.A. ☐ Canada ☐ Other (Specify) 081 USA
*Refer to Country Code List on back. *Country Code Name of Country

4. SOCIAL SECURITY NUMBER [redacted]

5. SEX ☒ Male ☐ Female

6. HAVE YOU PREVIOUSLY TAKEN FLEX? ☐ YES If Yes: a) When was the most recent FLEX taken? Month 19 Year
☒ NO b) How many previous FLEX examinations have you taken? _____

7. CITIZENSHIP UPON ENTERING MEDICAL SCHOOL ☒ U.S.A. ☐ Canada ☐ Other (Specify) 081 USA
*Refer to Country Code List on back. *Country Code Name of Country

8. MEDICAL EDUCATION

a) College of Osteopathic Medicine of the Pacific
Name of Medical School of Graduation

b) Country of Medical School: ☒ U.S.A. ☐ Canada ☐ Other (Specify) 081 USA
*Country Code Name of Country

c) Graduation Year 1986

*Refer to Country Code List on back.

d) Degree ☐ M.D. ☒ D.O. ☐ Other (Specify) _____

9. OTHER EXAMINATIONS TAKEN

Examination:	Most Recent Date Taken (Month, Year)	Identification Number:
☐ ECFMG	/19	ECFMG
☐ VQE or FMGEMS	/19	VQE or FMGEMS
☐ NBME	/19	NBME

☒ None of the Above

10. FEDERATION IDENTIFICATION NUMBER (FIN) IF KNOWN

11. DATE OF THIS APPLICATION 09 Day 27 Month 1986 Year

12. APPLICATION STATEMENT & SIGNATURE

I certify that the information supplied in this application is true and accurate to the best of my knowledge.

SIGNATURE [redacted]

PART B – To Be Completed Or Validated By State Board

1. STATE FOR WHICH FLEX IS BEING TAKEN Illinois (Name of State) 114 (State Code No.)

2. APPLICANT'S STATE BOARD ID NUMBER

3. TEST CENTER & DATE OF EXAMINATION Chicago, Illinois (City and State) _____ (Center State Code No.)
☐ June 19 _____
☒ December 19 86

4. EXAMINATION(S) FOR WHICH REGISTERED (CHECK ONE)
☐ COMPONENT 1 ONLY ☐ COMPONENT 2 ONLY ☒ COMPONENTS 1 AND 2

(OVER)

MEDICAL
CERTIFICATION OF CLINICAL TRAINING

ATTACHMENT NUMBER
MD 4

APPLICANT

You must complete the applicant section of this form. The remainder of the form must be completed by the hospital administrator or medical education director of the institution at which you completed your specialty/residency training. 1 3 5 0 5 3 0 3 2 9

NAME OF APPLICANT (First, Middle Initial, Last)
Stewart M Kernes

ILLINOIS TEMPORARY CERTIFICATE NUMBER (If Applicable)
T 018326

ADDRESS (Street, City, State, ZIP Code)
6617 N. Ashland Chicago IL 60626

ADMINISTRATOR OR DIRECTOR

After the bottom portion of this form has been completed, return it directly to the applicant named above.

This is to certify that the above-named applicant has satisfactorily completed (4) months in a program of specialty/residency training in Obstetrics and Gynecology from July 1, 1986 to November 1, 1986 at the following hospital.

NAME OF HOSPITAL
Mercy Hospital and Medical Center

NUMBER OF STREET
Stevenson Expressway at King Drive

CITY, STATE, AND ZIP CODE
Chicago, Illinois 60616

Name of Administrator or Director: Robert L. Schmitz, M.D.

SEAL

Signature of Administrator or Director: [redacted]

Date: September 30, 1986

COLLEGE OF

0 0 8 8 0 5 8 0 3 2 9

OF

ON THE REC

THE BOARD O

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DOCTO

FOR HAVING COMPLETED TH

ALL REQUIREMENTS OF OSTE

TO ALL RIGHTS, PRIVILEGE

WHICH PERTA

GIVEN AT THE CITY OF P

DAY OF JUNE, IN THE YE

PRESIDENT OF THE COLLEGE

DEAN OF ACADEMIC AFFAIRS

OSTEOPATHIC MEDICINE
THE PACIFIC

OMMENDATION OF THE FACULTY,
F DIRECTORS OF THIS COLLEGE HAS
CONFERRED ON

TEWART KERNES

THE DEGREE OF

OR OF OSTEOPATHY

E PRESCRIBED COURSE OF STUDY, AND HAVING FULFILLED
OPATHIC MEDICINE AND SURGERY, IS DECLARED ENTITLED
S, AND RESPONSIBILITIES OF A PHYSICIAN AND SURGEON
IN TO THAT DEGREE HERE OR ELSEWHERE.
OMONA IN THE STATE OF CALIFORNIA ON THE EIGHTH
AR ONE THOUSAND NINE HUNDRED AND EIGHTY-SIX.

COLLEGE OF OSTEOPATHIC MEDICINE OF THE PACIFIC
COMP

CHAIRMAN OF THE BOARD

Wesley V. Bouldin DO.
VICE CHAIRMAN OF THE BOARD

COLLEGE OF OSTEOPATHIC MEDICINE OF THE PACIFIC

Pomona, California 91766

27 OCT 86 11:04

TRANSCRIPT OF RECORDS

STUDENT NAME: KERNES, STEWART M. SSN: [redacted]

STUDENT NUMBER: BIRTH DATE: [redacted]

A>90 CR - CREDIT
B>80 I - INCOMPLETE
C>70 W - WITHDRAWAL
D>65 U-UNSATISFACTORY
Au-AUDIT

KERNES, Stewart M.	CREDIT HOURS	GRADE
FIRST YEAR 1982-83		
FALL SEMESTER 1982		
Gross Anatomy	15.0	
Embryology	1.0	
Histology	2.0	
Emergency Medicine	1.0	
Biochemistry	5.0	
Microbiology	6.0	
Osteopathic Principles & Practice	2.5	
Pathology	2.0	
Pharmacology	2.5	
Physiology	2.5	
Medical Ethics	-	
TOTAL CREDIT HOURS	39.5	
GPA 2.54		
CUM. GPA 2.54		

KERNES, Stewart M.	CREDIT HOURS	GRADE
FIRST YEAR 1982 - 83		
SPRING SEMESTER 1983		
Dermal System	5.0	
History Taking	1.5	
Physical Diagnosis	2.0	
Neurosensory System (incl. Psychiatry)	27.5	
Osteopathic Principles & Practice	2.5	
Musculoskeletal System (incl. Sports Medicine)	10.0	
TOTAL CREDIT HOURS	48.5	
GPA 2.26		
CUM. GPA 2.39		

KERNES, Stewart M.	CREDIT HOURS	GRADE
SECOND YEAR 1983 - 84		
FALL SEMESTER 1983		
Blood & R.E. System	7.5	
Cardiovascular System	20.0	
Medical Jurisprudence	2.0	
Osteopathic Principles & Practice	2.5	
Public Health	1.0	
Respiratory System	17.5	
A.C.L.S.	--	
TOTAL CREDIT HOURS	50.5	
GPA 2.07		
CUM. GPA 2.27		

KERNES, Stewart M.	CREDIT HOURS	GRADE
SECOND YEAR 1983 - 84		
SPRING SEMESTER 1984		
Renal System	7.5	
Endocrine System	7.5	
Reproductive System (incl. Human Sexuality)	10.0	
Osteopathic Principles & Practice	5.0	
Gastrointestinal System (incl. Nutrition & Substance Abuse)	17.5	
TOTAL CREDIT HOURS	47.5	
GPA 2.63		
CUM. GPA 2.36		

KERNES, Stewart M.	CREDIT HOURS	GRADE
THIRD YEAR 1984 - 85		
Pathology	10.0	
Radiology	10.0	
Gen. Practice/Family Med. I	10.0	
Gen. Practice/Family Med. I	10.0	
Psychiatry	10.0	
Surgery I	10.0	
Surgery I	10.0	
Internal Medicine I	10.0	
Internal Medicine I	10.0	
Internal Medicine I	10.0	
ELECTIVE I: Neurology	10.0	
TOTAL CREDIT HOURS	110.0	
GPA 3.55		
CUM. GPA 2.80		

KERNES, Stewart M.	CREDIT HOURS	GRADE
FOURTH YEAR 1985 - 86		
Gen. Practice/Family Med. II	10.0	
Gen. Practice/Family Med. II	10.0	
Internal Medicine II	10.0	
Internal Medicine II	10.0	
OB-GYN	10.0	
Pediatrics	10.0	
Surgery II	10.0	
Surgery II	10.0	
Emergency Medicine	10.0	
ELECTIVE II: Obstetrics	10.0	
ELECTIVE II: Gastro-enterology	10.0	
TOTAL CREDIT HOURS	110	
GPA		
CUM. GPA		

DOCTOR OF OSTEOPATHY DEGREE CONFERRED JUNE 8, 1986

(signed) [signature] Registrar

Date: 10-24-86

This transcript is official only when signe
and imprinted with the official college sea

ACADEMIC RECORD

NORTHERN ILLINOIS UNIVERSITY

DE KALB, ILLINOIS 60115

OFFICE OF ADMISSIONS AND RECORDS

[redacted]

NAME [redacted] STEWART MITCHELL M

HIGH SCHOOL GRADUATED FROM [redacted] 0 3 3 0 5 3 0 YEAR GRADUATED JUNE 71 HIGH SCHOOL RANK [redacted]

DEGREE: BACHELOR OF SCIENCE MAY 10, 1975 MAJOR: BIOLOGY

DEGREE MINOR: CHEMISTRY

DEGREE

COURSE TITLE	DEPT	COURSE NO	SEM. HRS	GRADE
[illegible]			135650	
GENERAL CHEMISTRY	CHEM	220	4	
[illegible] & COMP [illegible]	ENGL	403	3	
CALC & LINEAR AL I	MATH	229	4	
LIFE SAVING & WATER	PE-M	251	1	
FUNDAMENTALS OF SPEE	SPCH	600	3	
25.0	25.0	37.0	15.0	
SPRING 1972			135650	
GENERAL CHEM & QUAL	CHEM	211	4	
COMPOSITION & LITERA	ENGL	104	3	
CALCULUS & LINEAR AL	MATH	230	4	
INTRODUCTION TO MUSI	MUSC	220	3	
25.0	22.0	47.0	22.0	
FALL 1972			135650	
HUMAN ANATOMY AND PH	BIOS	291	5	
ORGANIC CHEMISTRY I	CHEM	330	3	
ORGANIC CHEMISTRY LA	CHEM	332	2	
PERSONAL HEALTH	PE-M	290	2	
INTRODUCTION TO PSYC	PSYC	102	3	
BASIC STATISTICS	MATH	208	3	
43.0	40.0	95.0	40.0	
SPRING 1973			135650	
INTRODUCTION TO ANTH	ANTH	120	3	
INTRODUCTION TO VISU	ART	282	3	
PRINCIPLES OF BIOLOG	BIOS	200	4	
ORGANIC CHEMISTRY II	CHEM	331	3	
ORGANIC CHEM LABORAT	CHEM	333	2	
CONSERVATION OF NAT	GEOG	353	3	
61.0	58.0	154.0	56.0	

University of Illinois at Chicago Circle
Chicago, Illinois
Fall 1973 - Spring 1974

61.0	58.0	154.0	90.0	
FALL 1974			346-42-7078	
GENERAL BOTANY	BIOS	221	4.0	C
GENERAL ZOOLOGY	BIOS	251	4.0	C
COMPARATIVE PHYSIOLO	BIOS	452	3.0	B
BIOLOGICAL CHEMISTR	CHEM	470	3.0	C
ALTR L PROG SELECTN	PHSL	[illegible]	1.0	A
78.0	75.0	154.0	147.0	

[redacted] CUM-GPA 2.96

COURSE TITLE	DEPT	COURSE NO	SEM. HRS	GRADE
SPRING 1975			346-42-70	
GENERAL ECOLOGY	BIOS	346	3.0	
SPECIAL PROB IN BIO	BIOS	370M	2.0	
MICROBIAL PHYSIOLOG	BIOS	423	3.0	
APPLIED MICROBIOLOG	BIOS	465	3.0	
CRIT ISS MTH:HUM SE	PE-M	401A	3.0	
CHILD & ADOLESCENCE	PSYC	225	3.0	
95.0	92.0	[illegible]	124.5	

GRAD: TERM GPA [redacted] CUM-GPA [redacted]

ADMITTED STUDENT-AT-LARGE: June 23, 1975

SUMMER	1975		346-42-70	
GENETICS	BIOS	408	3.0	
SOIL MICROBIOLOGY	BIOS	518	3.0	
6.0	6.0		6.0	

GRAD: TERM GPA [redacted] CUM-GPA [redacted]

ADMITTED TO GRADUATE SCHOOL: August 25, 1975

FALL	1975		346-42-7078	
ELECTRON MICROSCOPY	BIOS	525	3.0	
SPEC TOP: MICROBIOS	BIOS	6000	3.0	
SEMINAR	BIOS	661	1.0	
QUANTITATVE ANALYSI	CHEM	321	5.0	
12.0	12.0	48.0	12.0	

GRAD: TERM GPA [redacted] CUM-GPA [redacted]

SPRING	1976		346-42-7078	
TPCS:MED MYCOLOGY	BIOS	493D	3.0	
SPEC TOP: MICROBIOS	BIOS	6000	3.0	
SEMINAR	BIOS	661	1.0	
BIOLOGICAL CHEM LAB	CHEM	471	2.0	
18.0	18.0	[illegible]	18.0	

GRAD: TERM GPA [redacted] CUM-GPA [redacted]

Richard J. Dunfee

[illegible]

NORTHERN ILLINOIS UNIVERSITY
DEKALB, ILLINOIS 60115

KEY TO TRANSCRIPT

THIS TRANSCRIPT OF RECORD IS FORWARDED ON THE CONDITION THAT IT CANNOT BE RELEASED IN WHOLE OR PART TO ANY OTHER PARTY WITHOUT THE WRITTEN CONSENT OF PERSON TO WHOM IT PERTAINS IN ACCORDANCE WITH THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974.

GRADING POLICY

Mark	Meaning	Honor Points Per Hour
A	Superior	4
B	Good	3
C	Average	2
D	Passing	1
F	Failing	0
I	Incomplete	–
W	Passing at time of withdrawal from a course or from the University	–
S	Satisfactory	–
U	Unsatisfactory	–
O	Audit – no grade and no credit	–
OW	Audit requirements not completed	–
P	Pass	–
NR	Grade not reported	–
IN	Permanent incomplete (graduate students only)	–

INTRODUCTION TO PSYC	PSYC	102	3	
COMPOSITION & LITERA	ENGL	104	3	
ENVIRONMENTAL GEOLOG	GEOL	105	3	
BASIC MATHEMATICAL A	MATH	210	3	
INTRO TO AMER GOV PO	POLS	140	3	
12.0	15.0	27.0	20.0	

GPA Hours Attempted At NIU

Hours Earned At NIU Includes P and S Marks

Honor Points for GPA Hours Earned at NIU

Total Hours Includes Transfer, Proficiency, Etc.

Grade Point Average (GPA) is computed on a 4.0 scale. GPA hours attempted and corresponding honor points earned include NIU courses for which an A, B, C, D or F are given.

In this example,

$$\text{GPA} = \frac{27.0 \text{ (honor points for GPA hours)}}{12.0 \text{ (GPA hours attempted)}} = 2.25$$

Beginning Fall 1974 the semester and cumulative NIU grade point average will be listed following each semester's coursework.

R = This course is repeated later. Credit has been removed from academic totals.

* = This course is a repeat of one taken earlier. Credit is given with most recent repeat.

Student is in good academic standing unless otherwise indicated.

CREDIT

Credit is recorded in semester hours. Each semester hour represents one fifty-minute period per week for a fifteen week semester. The normal class load is 14–18 hours per semester. A minimum of 124 semester hours is one of the requirements for graduation with a Bachelor's degree.

COURSE NUMBERING SYSTEM

1–099	noncredit courses	*Certain 400 level courses may be taken for either undergraduate or graduate credit.* ***Credit type will correspond with the student's classification*** *unless noted following semester hours as shown below.*
100–299	lower division	* indicates graduate credit for a course completed by an undergraduate student
300–499	upper division	– indicates undergraduate credit for a course completed by a graduate student
500–699	graduate courses	

COURSE NUMBER SUFFIXES

E Experimental
F First half of session
G General education elective
H Honors
L Last half of session
S Lab
T Temporary number
Z International Studies Program
X Cross listed with another department

All other course number suffixes indicate specific sections of that course.

STUDENT CLASSIFICATIONS

Nondegree student	A student who does not hold a degree and is not currently seeking one.
*Visiting student**	A student regularly enrolled at another institution who is taking courses at NIU.
Post-graduate student	A student with a bachelor's degree and working toward a second degree or for teacher certification.
Student-at-Large	A student who holds a bachelor's degree and enrolls for graduate or undergraduate courses without seeking a degree. If enrolled for U.G. credit, credit will be shown with (–) as indicated above.
Graduate student	A student in a graduate degree program.

*Extramural Student prior to Fall 1975.

SENATE BILL 195 (1953) — ILLINOIS SCHOOL CODE

Students who pass Political Science 100 prior to Fall 1977, Political Science 140 prior to Fall 1974, or Political Science 200 prior to Spring 1975 are automatically certified as having satisfied the requirements of Senate Bill 195. Students who pass the Constitution Test or who meet the requirement through transfer work will have an appropriate statement stamped on their records.

GRADING FOR COLLEGE OF LAW

Students admitted to the College of Law will have such admission basis as first entry to the record and before law credits begin.

A student's performance is expressed on a four point scale in terms of the following letter grades: A (4.00), A– (3.67), B+ (3.33), B (3.00), B– (2.67), C+ (2.33), C (2.00), C– (1.67), D+ (1.33), D (1.00), F (0.00).

The following marking symbols may also be used: O – audit, no grade or credit; I – incomplete; w – withdrawal.

A pass/high (HP) – pass (P)/fail (F) grading system can be elected by some students. A grade of "pass" or pass high is not included in a student's grade point average. An F is a failure and is included in a student's grade point average.

"Student is in good academic standing unless otherwise indicated.

Repeated Courses: Law students repeating courses within the College of Law have all attempts at the course included in the grade point average. Designation on the academic record is as follows: R – course repeated later; * this course is a repeat of one taken earlier.

Returned
10-9-86

PAULA M. PAMBIANCO 11/83

PHONE 271-3756
5813 N. WAYNE
CHICAGO, IL 60660

10-4 19 86 900

75-148/919

PAY TO THE ORDER OF Continental Testing Services $ 282.20

Two hundred and eighty two and 20/100 DOLLARS

ILLINOIS HOSPITALS
EMPLOYEES
CREDIT UNION

MEMO [redacted]

[redacted]

CERTIFICATION OF TRAINING

SUPPORTING DOCUMENT: **TN**

458157 253

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 KERNES FIRST STEWART MIDDLE M.

2. DATE OF BIRTH [redacted]

3. SOCIAL SECURITY NUMBER [redacted]

4. [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. TRAINING BEGAN: 7 (Month) 1 (Day) 86 (Year)

7. TRAINING ENDED: 6 (Month) 30 (Day) 87 (Year)

8. ILLINOIS TEMPORARY CERTIFICATE OF REGISTRATION NUMBER [redacted] ISSUANCE DATE (If Applicable) 7/1/86

9. SPECIALTY NAME IN WHICH TRAINING RECEIVED: Obstetrics/Gynecology

10. SUPERVISOR/INSTRUCTOR NAME: Drs. S. Douvas/R Schmitz, M.D.

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

A. SUPERVISOR/INSTRUCTOR NAME: Drs. S. Douvas/R. Schmitz

B. INSTITUTION/BUSINESS NAME: Mercy Hospital and Medical Center OK

C. SUPERVISOR/INSTRUCTOR TITLE/PROFESSION NAME: Chairman-Ob/Gyne; Director of Medical Educaton

D. INSTITUTION/BUSINESS STREET ADDRESS: Stevenson Expressway at King Drive, Chicago, Illinois 60616

E. SUPERVISOR/INSTRUCTOR LICENSE OR CERTIFICATE NUMBER: N/A

F. INSTITUTION/BUSINESS CITY, STATE, ZIP CODE: N/A

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

H. INSTITUTION/BUSINESS TELEPHONE NUMBER: AREA CODE [redacted]

I. TRAINING DATES: FROM [redacted] (Month Day Year) TO (Month Day Year)

J. TRAINING CLOCK HOURS APPLICANT COMPLETED: N/A

K. SPECIALIZATION NAME IN WHICH APPLICANT TRAINED: Obstetrics/Gynecology

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.

INSTITUTION SEAL

Robert L. Schmitz, M.D. (Print or Type Name)

Director of Medical Educatin (Title)

[redacted] (Signature)

6/11/87 (Date) JUN 26 1987

(486 1341 9/86 (LTA)

Mercy Hospital and Medical Center
Stevenson Expressway at King Drive
Chicago, Illinois 60616-2477
(312) 567-2000

Caring with Mercy since 1852

0 1 1 0 5 3 0 3 2 9

June 23, 1987

Department of Registration and Education
State of Illinois
Medical Section
320 West Washington
Springfield, Illinois 62786

To Whom It May Concern:

Enclosed please find Supporting Document **TN** in support of my application for a permanent medical license. I am also enclosing a check in the amount of $300.00 to cover this fee. Please note, I did forward a $25.00 fee with my FLEX results in March, 1987. Could you please reimburse me this $25.00.

Thank you.

Sincerely,

[redacted]

Stewart Kerner, D.O.
Resident Physician
Department of Ob/Gyne

SK:pm

Enclosures

Application No. Prof. Code SSN/FEIN or Label Space	APPLICATION REVIEW FINDINGS	AMF 2

0 1 3 9 5 1 0 3 2 9

1. DATE: ___/___/___

2. EMPLOYEE: _____

3. STATUS: _____

4. DEFICIENCIES ADD: _____

CLEAR: _____

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

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 ___/___/___

Application No. Prof. Code SSN/FEIN or Label Space	APPLICATION REVIEW FINDINGS	AMF 2

1 0 3 1 0 5 1 0 3 2 9

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
320 West Washington–3rd Floor • Springfield, Illinois 62786 • (217) 785-0800
GARY L. CLAYTON–Director

0 3 3 0 5 3 0 March 26, 1987

Stewart Kerner M.D.

[redacted]

300.00 returned 6/30/87 MS

NOTE: PLEASE DISREGARD PREVIOUS DEFICIENCY LETTER RECEIVED.

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.

_____ 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.

_____ 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

X Submit proof of completion of specialty/residency program - Proof of completion of an approved program of clinical training of 12-months' duration in a hospital in the United States or Canada approved by the Department or, proof of substantially equivalent training (to be determined by the Medical Examining Committee). This form MUST have the hospital seal or school seal affixed, and must be verified not more than 15-days prior to the completion date or after the completion date.

____ Submit certification of original AND any current licensure, with State Board seal affixed.

____ Submit National Board grades - A certified copy of your grades must be forwarded directly to this Department by the National Board.

____ Submit FLEX Examination grades - A transcript of your grades from any FLEX examination taken in the United States or Canada must be forwarded directly to this Department by the Federation of State Medical Boards.

____ Submit proof of successful completion of State constructed examination - Verification of the grades from the state in which you took the examination is required, with the State Board seal affixed.

____ If American Board certified, please forward a copy of your certificate.

____ Submit proof of a valid ECFMG, or VQE or FMGEMS certificate.

____ Submit a copy of marriage certificate, divorce decree or court order indicating proof of legal name change.

____ OTHER:

STATE OF ILLINOIS

DEPARTMENT OF REGISTRATION AND EDUCATION

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

GARY L. CLAYTON - Director

March 23, 1987

0 0 3 1 0 5 3 0 3 2 9

Stewart Kerres

[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.

___ 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.

___ 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)

Application No. 236 Prof. Code [redacted]

or Label Space 0 0 3 3 0 5 3 0 3 2 9

APPLICATION REVIEW FINDINGS

AMF 2

1. DATE: [redacted]

2. EMPLOYEE: [redacted]

3. STATUS: _____

4. DEFICIENCIES - ADD: 699

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 ___/___/___

IL486--1323 1/87 (EDP)

LICENSED PHYSICIAN, SURGEON AND OSTEOPATHS | 036

Personal Check

Examination

Complete Application Must Include:

(COMPREHENSIVE EXAM MODEL)

Forward the following categories of applications to DRE for Review:

1.( ) Ex-offender Applications
2.( ) Positive Personal History Applications
3.( ) Questionable Education Records
4.( ) Applications that have no educational records or verifying affidavits of education
5.( ) Applications for Restoration or Reciprocity
6.( ) If Education Program is not on approved list
10.( ) Fifth Pathway Applicants
7.( ) Applicants requesting a determination of equivalency to the 12 months clinical training in the United States or Canada
8.( ) Applicants requesting a determination of equivalency to the 2 year pre-medical education requirement.
9.( ) Applicants who have failed the examination on five occasions and have subsequently pursued furtner education

Fifth Pathway Candidates Are Those Individuals Who:

1. Have graduated from a non-approved medical education program.
   a. have been awarded diploma but not a degree, and;
   b. have completed a Fifth Pathway Program which is one year of post-graduate training in an approved U.S. medical education program/ hospital, and;
   c. completed 1 year clinical training

I. Application Jacket:

A. Page 2
   ( ) Photograph (one)

B. Page 3
   ( ) Part A1-13: Completed (note 11 and 12 must indicate at least 21 years of age)
   ( ) Part B3: Must indicate 2 years of liberal arts education or its equivalent. Must indicate Medical Education Program of graduation. Program must be approved by Department. (See approved Medical Education Program Lists.)
   (✓) 3.1C Original Pre-Medical and Medical transcripts must be included.

1. DRE lists of NonLCME Accredited Medical Education Programs.

/

2. LCME list of accredited Medical Schools of the United States and Canada.
   ( )Is a graduate of a program approved by the Department
3. DRE list of approved United States Osteopathic Medical Education Programs as established by the American Osteopathic Association

( )For additional verification of education, candidates must submit a copy of diploma conferring the M.D. or D.O. degree.

C. Page 4

( ) Part C.: N/A - If yes attachments MD2 and MD3 must be completed.

( ) Part D1-7: All negative responses (if yes is checked on any personal history question immediately forward application packet to DRE).

( ) Part D Notary Section: Must be signed by the applicant and properly notarized.

II. Attachment MD4 - Certification of Clinical Training

( ) Must indicate proof of completion of at least four (4) months of satisfactory clinical training from an approved general practice residency or residency specialty program in the United States or Canada OR proof of substantially equivalent training as determined by the Department--the four (4) months of clinical training must be completed by the date of the examination for which the applicant is applying.

III. Examination Registration Form and Federation's FLEX Application

( ) Both completed.

IV. Graduates from Medical Education Programs Outside United States, Its Territories, or Canada

( ) Must submit verification of either ECFMG or VQE (or FMGEMS after July 1, 1984)

V. General

( )A. Any documents in a language other than English must be accompanied with an official translation. (Policy L&T 81-7)

( )B. If the name on any of the documents is different from that shown on the application, then supply proof of name change (copy of marriage certificate, divorce decree, affidavit or court order. (Policy L&T 82-1)

( )C. If applicant is unable to verify education records (i.e., no transcript or diploma), he must comply with supporting documents in Policy. (Policy L&T 81-5D)