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

May 8, 2013

MELISSA JOY CHEN MD
MCGAW MEDICAL CENTER/NORTHWESTERN
DEPT OF GME
420 E SUPERIOR SUITE 12-174
CHICAGO, IL 60611

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

LICENSE DETAILS

LICENSE NUMBER:	125.058584
PROGRAM START DATE:	06/23/2013
EXPIRATION DATE:	06/22/2014
PROGRAM:	Obstetrics and Gynecology
TRAINING FACILITY:	MCGAW/NORTHWESTERN

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

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

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

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

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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

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

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

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

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

PART I. Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Extension	1 2 5	Nonexamination	$100

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☐ 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 Financial and Professional Regulation, Division of Professional Regulation and/or Continental Testing Service in writing of any address change after you file this application in order to receive any further information.

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

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

[redacted]

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

250 EAST SUPERIOR CHICAGO IL USA 60617 - _____ COOK

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

7. MOTHER'S MAIDEN NAME [redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY [redacted]

9. DATE OF BIRTH [redacted] Month Day Year

10. AGE 28 ☒ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (312) 921-8517 (Area Code)

Home: ([redacted] (Area Code)

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

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

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

[redacted]

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

NAME (Last, First, MI):

SS#:

Profession:

PART III: Education Information

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

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

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
CALIF ACAD OF MATH & SCIENCE	CARSON, CA	06 / 2002 (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
UNIV OF CALIF, BERKELEY	BERKELEY, CA	08/02	05/06	BA
NORTHWESTERN UNIVERSITY	CHICAGO, IL	08/06	06/10	MD, MPH

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?
MCGAW MEDICAL AT NORTHWESTERN UNIV	CHICAGO, IL	08/10	current	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

SS#:

Profession:

PART IV: Record of Licensure Information

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure Illinois	Temporary physician extension	125058584	6/23/2010	Active
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
Step I USMLE	IL	6/2008	(Passed), Failed, Absent)
Step II USMLE CK	GA	12/2009	Passed
Step II USMLE CS	GA	10/2009	Passed
Step III USMLE	IL	10/2011	passed

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

NAME (Last, First, MI):

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

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

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

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

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

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

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

SS#:

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

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

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

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

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

Profession:

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.

[redacted] 1/23/13

Signature of Applicant — Date

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

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

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME — LAST: CHEN — FIRST: MELISSA — MIDDLE: J

3. PROFESSIONAL LICENSE NUMBER (if any): 125 - 058584

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

4. SOCIAL SECURITY NUMBER: [redacted]

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturists
- ☐ Advanced Practice Nurses
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☒ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☒
2) Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration?	☐	☒
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☒
4) Are you currently charged with or have you been convicted of a forcible felony? *	☐	☒

*If **YES** to any of the above, 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.*

Certification Statement

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

[redacted]

Signature of Applicant

Date: 4/18/13

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

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

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

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

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
Chen	Melissa		[redacted]	[redacted]

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

6. MAIDEN OR GIVEN SURNAME:

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)

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
McGw Medical Center of Northwestern University	06 / 23 / 2013 (Month / Day / Year)	06 / 22 / 2014 (Month / Day / Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE:
420 E. Superior Street, Rubloff Bldg,, 12th Floor
Chicago, IL 60611

E. SPECIALTY / RESIDENCY NAME: OB/Gyn

F. BUSINESS TELEPHONE NUMBER: Area Code (312) 503 — 7975

G. YEAR OF POSTGRADUATE TRAINING: PGY 4

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

SEAL

[redacted]
Signature of Program Director

Magdy Mijad
Print Name of Program Director

Program Director
Title

1/28/2013
Date

IL486-0272 08/04 (MD)

Northwestern University
Feinberg School of Medicine

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

Magdy P. Milad, MD, MS
Division Head
Professor

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

NORTHWESTERN
UNIVERSITY

January 23, 2013

Department of Financial and
Professional Regulation
ATTN: Division of Professional Regulation
P.O. Box 7199
Springfield, IL 62791

RE: Melissa Chen, IL license: 125058584

To Whom It May Concern:

Dr. Melissa Chen began her residency at Northwestern McGaw Center for Graduate Medical Education on June 23, 2010 and will complete her 4th year of residency on June 29, 2014.

Dr. Chen's current license will expire on June 22, 2013. In order to complete the residency training program, she will need her temporary license extended.

Please contact me should you have any questions or concerns.

Best Regards,

[redacted]

Magdy Milad, MD, MS
Residency Program Director

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VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME — LAST: CHEN — FIRST: MELISSA — MIDDLE: JOY

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

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

5. SOCIAL SECURITY NUMBER: [redacted]

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

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

6. MAIDEN OR GIVEN SURNAME: CHEN

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

A. NAME OF BUSINESS / INSTITUTION: MCGAN MEDICAL AT NORTHWESTERN

ADDRESS STREET, CITY, STATE, ZIP CODE: 250 EAST SUPERIOR CHICAGO IL 60611

DATE OF EMPLOYMENT/ATTENDANCE
From 08 / 01 / 2010 (Month / Day / Year)
To current (Month / Day / Year)

HOURS WORKED PER WEEK: 70

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

TOTAL TIME WORKED (Year/Month): cunently employed

JOB TITLE: RESIDENT PHYSICIAN

DESCRIPTION OF DUTIES PERFORMED: * resident physician in obstetrics and gynecology

B. NAME OF BUSINESS / INSTITUTION:

ADDRESS STREET, CITY, STATE, ZIP CODE:

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

HOURS WORKED PER WEEK:

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

TOTAL TIME WORKED (Year/Month):

JOB TITLE:

DESCRIPTION OF DUTIES PERFORMED:

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

June 7, 2010

MELISSA JOY CHEN MD
MCGAW MEDICAL CENTER/NORTHWESTERN
DEPT OF GME
420 E SUPERIOR SUITE 12-174
CHICAGO, IL 60611

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

LICENSE DETAILS

LICENSE NUMBER:	125.058584
PROGRAM START DATE:	06/23/2010
EXPIRATION DATE:	06/22/2013
PROGRAM:	Obstetrics & Gynecology
TRAINING FACILITY:	MCGAW/NORTHWESTERN

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

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A. Type or print legibly with black ink only.

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

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1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Licensure	1 2 5	nonexamination	$100

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- ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
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- ☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
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1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
CHEN	MELISSA	JOY	MD / MPH	[redacted]

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

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

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

7. MOTHER'S MAIDEN NAME: [redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY: [redacted]

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

10. AGE: 25 ☑ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (3 1 0) 8 0 1 – 2 6 9 8 (Area Code)

Home: [redacted] (Area Code)

Fax: (_ _ _) _ _ _ – _ _ _ _ (Area Code)

Fax: (_ _ _) _ _ _ – _ _ _ _ (Area Code)

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

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

NAME (Last, First, MI): CHEN, MELISSA J

SS#: [redacted]

Profession: 125

PART III: Education Information

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

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

Graduated High School? ☑ Yes ☐ No

Received OR G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
CALIFORNIA ACADEMY OF MATH AND SCIENCE	CARSON, CA	06 / 2003 (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
UNIVERSITY OF CALIFORMA, BERKELEY	BERKELEY, CA	08/2002	05/2006	BA
NORTHWESTERN UNIVERSITY	CHICAGO, IL	08/2006	05/2010	MD/MPH

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?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): CHEN, MELISSA J

SS#: [redacted]

Profession: 125

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	ILLINOIS	06/2008	(Passed), Failed, Absent)
USMLE STEP 2 CS	GEORGIA	10/2009	PASSED
USMLE STEP 2 CK	CALIFORNIA	12/2009	PASSED

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

NAME (Last, First, MI): CHEN, MELISSA J

SS#: [redacted]

Profession: 125

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

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

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

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

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

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

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

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

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

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

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

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

PART IX: Certifying Statement

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

[redacted]
Signature of Applicant

3/23/2010
Date

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

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

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

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

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

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Chen, Melissa	[redacted] Month Day Year	[redacted]
4. ADDRESS STREET, CITY, STATE, ZIP CODE [redacted]	5. REFER TO REFERENCE SHEET. Record profession name and three Digit profession code for which you are making Illinois application.	
6. MAIDEN OR GIVEN SURNAME	_____Temporary Physician _____ Profession Name	__1_ _2_ _5__ Profession Code

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
McGaw Medical Center of Northwestern University	**06 / 23 / 2010** Month Day Year	6/22/13 ~~06/29/13~~ Month Day Year
D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE **420 East Superior Street, Rubloff 12th floor Chicago, IL 60611**	D. SPECIALTY / RESIDENCY NAME Obstetrics and Gynecology	
F. BUSINESS TELEPHONE NUMBER **(312) 503-7975**	G. YEAR OF POSTGRADUATE TRAINING PGY 1	

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.

[redacted]
Signature of Program Director

Magdy Milad, MD
Print Name of Program Director

Program Director
Title

3/19/10
Date

Northwestern University
Feinberg School of Medicine

Augusta Webster, MD, Office
of Medical Education
303 E. Chicago Avenue, Ward 1-003
Chicago, Illinois 60611-3008

John X. Thomas Jr., PhD
Senior Associate Dean for Medical Education
Professor of Physiology and Medical Education

jxt@northwestern.edu
Phone 312-503-8970
Fax 312-503-0840

NORTHWESTERN
UNIVERSITY

June 4, 2010

Sandra Dunn, Manager
Health Services Section/Medical Licensing Unit
320 West Washington Street
Medical Unit, 3rd Floor
Springfield, Illinois 62786

Dear Sandra Dunn,

In lieu o the ED-MED (Certification of Education) form I have enclosed a roster for the graduates of Feinberg School of Medicine who graduated on May 20, 2010. This roster includes the name, date of birth, social security number and graduation date of students who've matched in the state of Illinois. All of the students listed have met the graduation requirements. If you have any further questions please feel free to contact Diane Hill at (312) 503-3842.

[redacted]

John X. Thomas, Jr., Ph.D.
Senior Associate Dean for Medical Education
Professor of Physiology & Medical Education

6/7/2010
Roster acceptable.
Need cover letter
w/ seal to be sent.
SDunn

Last Name	First Name	Middle	Birthdate	Social Security Number	Graduation Date
Abts	David	Peter	[redacted]		05/20/2010
Anchala	Praveen				05/20/2010
Aneja	Monika	Surinder			05/20/2010
Arnaout	Omar				05/20/2010
Berg	Sara	Rosenbaum			05/20/2010
Bissonnette	Mei Lin	Zimmerman			05/20/2010
Blackwell	Robert	Henry			05/20/2010
Chacko	Satish	Jacob			05/20/2010
Chan	Michael	Wing-Ming			05/20/2010
Chen	Melissa	Joy			05/20/2010
Clark	Brian	Joseph			05/20/2010
Collins	Catherine	Gillespie Allen			05/20/2010
DiBardino	David	M			05/20/2010
Duke	Eugene				05/20/2010
Dunlap	Beth	A.			05/20/2010
Eder	Katherine	E			05/20/2010
Gentile	Michelle	S			05/20/2010
Gomberawalla	Ameer	Mustafa			05/20/2010
Goyal	Sheila	Padma			05/20/2010
Hirshfeld	Meredith	McMillan			05/20/2010
Hotaling	Jeffrey	Morris			05/20/2010
Jain	Nelia				05/20/2010
Keene	Melissa	Ashley			05/20/2010
Keith	Lucas	Adam			05/20/2010
Klumpner	Thomas	Tam			05/20/2010
Kott	Andrew	Edward			05/20/2010
Krcmarik	Monica	Rose			05/20/2010
Lo	Ryan	Lee			05/20/2010
Macrie	Bryan	David			05/20/2010
Micev	Alan	Jordan			05/20/2010
Navanandan	Nidhya				05/20/2010
Nyaku	Amesika	N			05/20/2010
Ochenjele	George				05/20/2010

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

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

CHEN MELISSA Joy

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

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

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

5. SOCIAL SECURITY NUMBER

[redacted]

6. MAIDEN OR GIVEN SURNAME

[redacted]

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

A. NAME OF BUSINESS / INSTITUTION

UNIVERSITY OF CALIFORNIA, BERKELEY

JOB TITLE

RESEARCH ASSISTANT

ADDRESS STREET, CITY, STATE, ZIP CODE

120 SPROUL HALL, BERKELEY, CA, 94720

DESCRIPTION OF DUTIES PERFORMED

process slides, microscope use, operate flow cytometer, process blood for storage

DATE OF EMPLOYMENT/ATTENDANCE

From 08 / 01 / 2004 (Month / Day / Year)

To 05 / 31 / 2006 (Month / Day / Year)

HOURS WORKED PER WEEK

10 hrs / week

TYPE OF EMPLOYMENT

☐ Full-time ☑ Part-time

TOTAL TIME WORKED (Year/Month)

ABOUT 600 hours (22 months)

B. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

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)