62915 (POG 1504)

EXAMINATION RECORD

	Anatomy	Physiology	Biochemistry	Pathology	Microbiology	Pharmacology	Behavioral Science	Basic Science Average	Medicine	Surgery	Obstetrics	Public Health	Pediatrics	Psychiatry	Clinical Science Average	Clinical Competence Average	Flex Weighted Average
1st Exam. Date	[redacted]																
2nd Exam. Date																	
3rd Exam. Date																	
4th Exam. Date																	
5th Exam. Date																	

PERSONAL INFORMATION

Applicant must fill in following blanks:

Name Robert P. Cervenka

Address [redacted]

Chicago, Ill. 60637

Is this your first application for a license in Illinois? yes

Total years of practice 1/2

As follows:

State Illinois Years 1980-81

" " "

" " "

" " "

" " "

DO NOT WRITE IN THIS PORTION

No. 62915

Application for Registration as
PHYSICIAN AND SURGEON

Diploma verified

Diploma returned

By

Certificate Issued 8-24-81

Certificate Forwarded 8-

DECLARATION OF INTENTION
OR
CERTIFICATE OF NATURALIZATION

No.

Issued at

on the , 19

as

Returned

By

FLEX

PERSONAL HISTORY

NOTE: If any of the following questions are answered "YES," full details must be furnished on separate sheet and attached.

		YES	NO
1.	Do you hold a license in any of the other healing arts?		X
2.	Have you ever been called before any state board or any medical association for interrogation concerning any violation of The Medical Practice Act or unethical conduct?		X
3.	Have you ever been convicted of a felony or misdemeanor other than traffic violations?		X
4.	Have you ever been addicted to or treated for addiction to drugs?		X
5.	Have you ever made an offer to compromise in connection with the Harrison Narcotic Law, or any narcotic law?		X
6.	Have you ever received psychiatric treatment or received treatment for mental illness?		X
7.	Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism?		X
8.	Have you ever engaged in the practice of medicine in a state, district or territory wherein you did not hold a valid license?		X
9.	Have you ever had an application for licensure refused or rejected by a licensing board?		X

HEIGHT [redacted] WEIGHT [redacted] HAIR [redacted] EYES [redacted]

COMPLEXION [redacted] SCARS AND MARKS [redacted]

PLACE PRINT OF RIGHT THUMB HERE [redacted]

IMPORTANT!

ANY FALSE OR MISLEADING INFORMATION IN, OR IN CONNECTION WITH, ANY APPLICATION, MAY BE CAUSE FOR DEBARMENT ON THE GROUND OF LACK OF GOOD MORAL CHARACTER.

Under penalties of perjury, I declare and affirm that the statements made in the foregoing application, including accompanying statements and transcripts are true, complete and correct.

STATE OF Illinois

COUNTY OF Cook

Robert P. Cervenka, M.D. being duly sworn, says that he is the person referred to in this application and that the statements therein contained are true.

[redacted]

(SIGNATURE OF APPLICANT)
(Please use legal name)

Subscribed and sworn to before me this 9 day of March, 19 81

[redacted]

(Notary Public)

My Commission Expires July 7, 1982

NOTARY SEAL

(MD 100c)

0 / 5 0 0 0 4 4 0 2 2

FLEX

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
SPRINGFIELD

RECEIVED
MAR 16 1981
DEPARTMENT OF REGISTRATION AND EDUCATION

APPLICATION FOR REGISTRATION AS PHYSICIAN AND SURGEON

016
N

I hereby make application for examination for a Certificate to practice Medicine and Surgery in all their branches, under the provisions of an Act entitled: The "Medical Practice Act" of Illinois.

Full name Robert Paul Cervenka
(As given on Diploma)

Permanent address [redacted] Chicago ~~Bethesda~~
(Street and number) (City)

Cook Illinois ~~Maryland~~ 60637 ~~20034~~
(County) (State) (ZIP Code)

Place of birth Cleveland, Ohio Date of birth [redacted] Age 26

Are you a citizen of the United States? yes NOTE: Naturalized citizens of the United States should submit Certificates of Naturalization.

Please designate your Social Security Number [redacted] NOTE: Designation of your Social Security Number is not mandatory--used ONLY to insure identification, accessibility, and accuracy of your application.

Please print your name exactly as you wish it to appear on any Certificate to practice as a Registered Physician and Surgeon which may be issued to you. Robert Paul Cervenka

COLLEGE OR UNIVERSITY EDUCATION

Name and location of school attended	Period of Attendance
1st year Emory University	9/72 - 6/73
2nd year Emory University	6/73 - 3/74
3rd year Emory University	3/74 - 3/75
4th year Emory University	3/75 - 3/76

I have credit for 186 quarter hours of college work. I received the degree of B.S. Chemistry
(No. of majors, semester hours, or clock hours)

from Emory University (College or University) on the 18th day of March 1976

RECEIVED
STATE OF ILLINOIS
MAR 18 1981
DEPARTMENT OF REGISTRATION AND EDUCATION
PHYSICIANS ASSISTANT

MEDICAL EDUCATION

I attended four years of full courses of medical lectures as follows:

at University of Maryland School of Medicine (Name of Medical College)
from the 30th day of August, 1976 to the 22nd day of May, 1980

at _____ (Name of Medical College)
from the _____ day of _____, 19____ to the _____ day of _____, 19____

at _____ (Name of Medical College)
from the _____ day of _____, 19____ to the _____ day of _____, 19____

at _____ (Name of Medical College)
from the _____ day of _____, 19____ to the _____ day of _____, 19____

I was granted the degree of Doctor of Medicine by University of Maryland (Name of Medical College)
located at Maryland State or Country U.S.A., on the 29th day of May, 1980, and the Diploma presented with this application is the genuine Diploma of said institution.

(MD 100a)

POSTGRADUATE HOSPITAL TRAINING AND PRACTICE (CHRONOLOGICALLY)

Description	Name of Institution	Dates from	Dates to	Location
Intern - OB-GYN	University of Chicago	6/25/80	present	Chicago, Ill.

THE FILING OF AN APPLICATION OR THE TAKING OF AN EXAMINATION DOES NOT ENTITLE THE APPLICANT TO PRACTICE IN THE STATE OF ILLINOIS.

FOREIGN CREDENTIALS MAY NOT BE PRESENTED FOR REVIEW AT AN EXAMINATION.

DEPARTMENT OF REGISTRATION AND EDUCATION
MEDICAL SECTION

EXAMINATION CHECKLIST

NAME OF APPLICANT: Robert Paul Cervanka

FEE ✓ APPLICATION NOTARIZED ✓

PHOTOGRAPH/PHOTOSLIPS ✓ PERSONAL HISTORY SHEET ✓

CERTIFICATE OF COLLEGE ATTENDANCE 76-81

TRANSCRIPTS [illegible] ORIGINAL DIPLOMA Copy TRANSLATION(S) ____

PROOF OF COMPLETION OF 12 MONTHS' APPROVED CLINICAL TRAINING ✓ 9-24-81

PROOF OF COMPLETION OF 4 MONTHS' APPROVED CLINICAL TRAINING ✓ 8mo

CERTIFICATION OF OTHER STATE(S) OF LICENSURE NA

TWO RECOMMENDING LICENSED PHYSICIANS ✓

COMMENTS:

PROCESSOR'S INITIALS: ES DATE: 3-19-81

ELIGIBLE FOR EXAMINATION ✓ DATE OF EXAMINATION _____ SCHEDULED ____

NOT ELIGIBLE FOR EXAMINATION ____ REASON: _____

PROCESSOR'S INITIALS: ES DATE: 4-16-81

EXAMINATION RESULTS: PASS ____ FAIL ____

ELIGIBLE TO RECEIVE LICENSE YES ____ NO ____

ELIGIBLE TO REPEAT EXAMINATION (IF APPLICABLE) ____

REQUIRED TO REPEAT ALL DAYS/SUBJECTS YES ____ NO ____

RETAKE FEE RECEIVED ____ DATE OF EXAMINATION _____ SCHEDULED ____

NOT ELIGIBLE TO REPEAT EXAMINATION ____ REASON: _____

PROCESSOR'S INITIALS: _____ DATE: _____

RETAKE EXAMINATION RESULTS: PASS ____ FAIL ____

(MD 87) 3/78

Flex

DEPARTMENT OF REGISTRATION AND EDUCATION
(Medical Section)

CERTIFICATION OF CLINICAL TRAINING COVERED BY THE ILLINOIS MEDICAL PRACTICE ACT

This is to CERTIFY:

(1) That Robert Cervenka
(full name of physician)

has satisfactorily completed 12 months in

a program of Obstetrics & Gynecology graduate - specialty - residency
(strike out whichever is not applicable)

at University of Chicago Hospitals and Clinics
(name of hospital)

extending from June 25, 1980 to June 24, 1981;

and

(2) That the physican hereinabove named

(check and complete whichever is applicable)

XXX presently holds Temporary Certificate of Registration No. T- 11140 issued under the provisions of Section 11a of the Illinois Medical Practice Act.

_____ previously held Temporary Certificate of Registration No. T- _____ issued under the provisions of Section 11a of the Illinois Medical Practice Act

_____ does not hold a Temporary Certificate of Registration issued under the provisions of Section 11a of the Illinois Medical Practice Act insofar as can be determined from the records of this hospital.

SIGNED: [redacted]
(Medical Director)
University of Chicago Hospitals and Clinics
(Name of Hospital)
950 East 59th Street, Chicago, Illinois 60637
(Address)

SEAL OF HOSPITAL

DATED: September 18, 1981

When completed, the hospital must forward this form directly to:

Medical Section
Department of Registration and Education
320 Washington Street, 3rd Floor
Springfield, Illinois 62786

(MD 129)

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
GARY L. CLAYTON
DIRECTOR

PHYSICIANS & SURGEONS
SECTION

08/18/81

ROBERT PAUL CERVENKA MD
[redacted]
CHICAGO IL 60615

SOC-SEC-NO: [redacted]
EXAMINEE NO:

DEAR ROBERT PAUL CERVENKA MD

THIS IS TO INFORM YOU THAT YOU WERE SUCCESSFUL IN THE JUNE 16-18, 1981, FLEX EXAMINATION AS A LICENSED PHYSICIAN AND SURGEON. YOU RECEIVED THE FOLLOWING SCORES:

ANATOMY	[redacted]
PHYSIOLOGY	
BIOCHEMISTRY	
PATHOLOGY	
MICROBIOLOGY	
PHARMACOLOGY	
BEHAVIORAL SCIENCE	
BASIC SCIENCE AVERAGE	
MEDICINE	
SURGERY	
OBSTETRICS	
PUBLIC HEALTH	
PEDIATRICS	
PSYCHIATRY	
CLINICAL SCIENCE AVERAGE	
CLINICAL COMPETENCE AVERAGE	
FLEX WEIGHTED AVERAGE	

IF YOU REQUIRE FURTHER INFORMATION, YOU MAY CALL AREA CODE 217/785-0876.

MEDICAL SECTION

The records of this Department indicate that you have not met the twelve months clinical training requirement. Before your license may be released from this office, it will be necessary that we receive proof of satisfactory completion of the required approved clinical training program, of any composition, of twelve months duration in a hospital approved by the Department.

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
GARY L. CLAYTON
DIRECTOR

PHYSICIANS & SURGEONS
SECTION

08/18/81

ROBERT PAUL CERVENKA MD
[redacted]
CHICAGO IL 60615

SOC-SEC-NO: [redacted]
EXAMINEE NO:

DEAR ROBERT PAUL CERVENKA MD

THIS IS TO INFORM YOU THAT YOU WERE SUCCESSFUL IN THE JUNE 16-18, 1981, FLEX EXAMINATION AS A LICENSED PHYSICIAN AND SURGEON. YOU RECEIVED THE FOLLOWING SCORES:

ANATOMY	[redacted]
PHYSIOLOGY	
BIOCHEMISTRY	
PATHOLOGY	
MICROBIOLOGY	
PHARMACOLOGY	
BEHAVIORAL SCIENCE	
BASIC SCIENCE AVERAGE	
MEDICINE	
SURGERY	
OBSTETRICS	
PUBLIC HEALTH	
PEDIATRICS	
PSYCHIATRY	
CLINICAL SCIENCE AVERAGE	
CLINICAL COMPETENCE AVERAGE	
FLEX WEIGHTED AVERAGE	

IF YOU REQUIRE FURTHER INFORMATION, YOU MAY CALL AREA CODE 217/785-0876.

MEDICAL SECTION

CERTIFICATION OF COLLEGE ATTENDANCE

(Give exact dates.)

RECEIVED
REGISTRATION & EDUCATION

FLEX

1981 MAR 30 AM 1:35

26 March 19 81

TO THE DEPARTMENT OF REGISTRATION AND EDUCATION, SPRINGFIELD, ILLINOIS:

CASH SECTION

This is to certify that Robert Paul Golwenka

was in regular attendance at the University of Maryland School of Medicine

from the 7th day of September 19 76 to the 27th day of May 19 77

from the 29th day of August 19 77 to the 28th day of May 19 78

from the 25th day of September 19 78 to the 23rd day of September 19 79

from the 24th day of September 19 79 to the 23rd day of May 19 80

from the ____ day of ____ 19 ____ to the ____ day of ____ 19 ____

and was granted a Diploma as Doctor of Medicine by University of Maryland School of Medicine

located at Baltimore State of Maryland

on the 29th day of May 19 80, having completed - hours.

[Seal of College]

[redacted]

(Dean, Secretary, or Registrar)

Associate Dean for Student Affairs

UPON COMPLETION, PLEASE FORWARD THIS FORM DIRECTLY TO:
MEDICAL SECTION
DEPARTMENT OF REGISTRATION AND EDUCATION
SPRINGFIELD, ILLINOIS 62786

(MD-18)

EMORY UNIVERSITY

COLLEGE OF ARTS AND SCIENCES — PERMANENT RECORD

File No. L-7130

Name CERVENKA, ROBERT PAUL Address Bethesda, Maryland Date of Entrance Sept 25, 19[illegible]

8/12/5[illegible] Cleveland, Ohio

[redacted]

EMORY UNIVERSITY • ATLANTA, GEORGIA 30322

CERVENKA ROBERT PAUL — L7130
STUDENT NAME — ID

ADMITTED TO: EMORY COLLEGE

[redacted]

COURSE TITLE | COURSE NUMBER | DEPARTMENT | CREDIT HOURS | GRADE | POINTS EARNED | QUALITY POINTS

[redacted]

OFFICIAL TRANSCRIPT ONLY IF UNIVERSITY REGISTRAR SEAL AFFIXED AND SIGNED.

PAGE ___ OF ___

FEDERATION OF STATE [illegible]

FLEX APPLICATION

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

CERVENKA
Last (Surname)

ROBERT PAUL
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]
Day Month Year

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

4. SOCIAL SECURITY NUMBER Used to assure identification. [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) *Country Code Name of Country
*Refer to Country Code List on back.

8. MEDICAL EDUCATION
a) University of Maryland
Name of Medical School of Graduation
b) Country of Medical School: ☒ U.S.A. ☐ Canada ☐ Other (Specify) *Country Code Name of Country
c) Graduation Year 1980
*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	/19	VQE
☒ NBME	Sept. 1978	NBME 2391259
☐ None of the Above		

10. FEDERATION IDENTIFICATION NUMBER (FIN) IF KNOWN

11. DATE OF THIS APPLICATION 03 Day 09 Month 1981 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 By State Board

1. STATE FOR WHICH FLEX IS BEING TAKEN DC Name of State 111 State Code No.

2. APPLICANT'S STATE BOARD ID NUMBER

3. PLACE & DATE OF EXAMINATION Chicago, Ill Test Center State _____ Center State Code No.
☒ June 19 81
☐ December 19 _____

4. EXAMINATION(S) FOR WHICH REGISTERED
☒ Complete FLEX ☐ Basic Science ☐ Clinical Science ☐ Clinical Competence
☐ Other _____ (Specify)

THE UNIVERSITY OF CHICAGO HOSPITALS AND CLINICS
950 EAST 59TH STREET
CHICAGO · ILLINOIS 60637
947-

MAR 1 6 1981

March 12, 1981

Department of Registration and Education
Medical Section
628 East Adams Street
Springfield, Illinois 62786

RE: Robert P. Cervanka, M.D.

TO WHOM IT MAY CONCERN:

This is to certify that Dr. Robert P. Cervenka has completed eight months of clinical training in the Department of Obstetrics and Gynecology at the University of Chicago Hospitals and Clinics from June 25, 1980 through February 28, 1981.

Sincerely,

[redacted]

Zephree McClinton
Housestaff Coordinator

ZM/mgh

RECEIVED
STATE OF ILLINOIS
MAR 18 1981
DEPARTMENT OF REGISTRATION
AND EDUCATION
PHYSICIANS ASSISTANT

The Board of Regents of the

University of Maryland

FLEX

STATE OF ILLINOIS

Department of Registration and Education

Attention: Medical Section
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786

(Use typewriter or print with pressure)

Enter all applicable information.

E.C.F.M.G. No. _____
Visa Type and No. _____
DBI No. _____
Full name before marriage _____
_____
Social Security No. _____

NOTE: Designation of your Social Security Number is not mandatory — used ONLY to ensure identification, accessibility and accuracy of your application.

NAME: Cervenka, Robert Paul
Family name — All other names (spell out completely)

Street Add: [redacted]
City: Chicago State: Illinois Postal code: 60637
Country: U.S.A. Place of birth: Cleveland, Ohio
City — Province — Country

DATE OF BIRTH: [redacted] Sex: Male X Female _____
CITIZENSHIP: At birth: United States Now: United States
MEDICAL DEGREE: Title of degree (M.D., M.B.-B.S., D.O., other) M.D. Date conferred 1980

MEDICAL SCHOOL: (School(s) attended) (Location) (Dates) (No. of school yrs.)
(Precise name) University of Maryland School of Medicine, Baltimore Md.; 1976-1980 4 years

SECONDARY SCHOOL, COLLEGE, UNIVERSITY Emory University

HOSPITAL TRAINING: Hospital(s) Location Position(s) Dates
University of Chicago Hospitals and Clinics, Chicago Ill.; Intern 6/80 - present

Are you a Diplomate of the National Board of Medical Examiners? Yes _____ No X
Are you certified by an American Specialty Board? Yes _____ No X
Board(s) with date(s): _____
Licensure: Name the state or states in which you have received an unrestricted license to practice medicine and state whether by examination or endorsement. (Give License No(s).) _____

Have you **ever** taken an E.C.F.M.G. examination? Yes _____ No X Date(s) _____ ☐ Passed ☐ Failed
Have you **ever** taken a FLEX examination? Yes _____ No X Date(s) _____ ☐ Passed ☐ Failed
Have you **ever** been refused admission to a recognized medical or osteopathic organization, or has any disciplinary action been taken against you by such an organization or by any licensing or registering authority?
Yes _____ No X (If answer is "Yes," explain fully on a separate sheet of paper.)

I hereby certify that the information given in this application is true and accurate to the best of my knowledge and belief. I hereby authorize the State of Illinois or its licensing or registering authority to transmit to any person, governmental authority or legal entity information contained in this application or information which otherwise may become known or available to any State Board of Medical Examiners, any Medical Examining Committee appointed or otherwise constituted pursuant to statute and the Federation of State Medical Boards of the United States, Inc., or any of them, when written request is made to such State or such authority for such information and such writing states that such information is to be used exclusively in connection with licensure to practice medicine or any problem (describing it) related thereto.

I, Zephree McClinton, a Notary Public, DO HEREBY CERTIFY, that Robt. Cervenka appeared before me this day in person and acknowledged that he signed the above instrument as a free and voluntary act, for the uses and purposes therein set forth.

Given under my hand and official seal, this 9th day of March, 19 81

[redacted] (Seal)
Notary Public
My Commission Expires July 7, 1982

NOTE: Accompanying this preliminary application must be two photographs taken within the past six months. They should be at least passport size (2½ x 2½) and be signed on the reverse by the applicant.

[redacted]
Signature of Applicant

3/9/81
Date

(MD 157)

PLEASE RETURN ALL COPIES OF THIS PRELIMINARY APPLICATION UPON COMPLETION. CHECK (X) TYPE OF FORMAL APPLICATION DESIRED.
FLEX EXAM ( ) NATL BD ENDORSEMENT ( ) FLEX ENDORSEMENT ( ) RECIPROCITY ( )

FLEX

This is to certify that I, _____ am personally acquainted with Robert Paul Cervenka, MD for licensure to practice medicine in all of its branches in the State of Illinois; that I hereby attest to the educational background of Dr. Robert Paul Cervenka, who graduated from University of Maryland and was issued the degree and diploma of Doctor of Medicine on the 29th day of May, 19 80; and that Dr. Robert Paul Cervenka is of good moral character and professional background. I further endorse Dr. Robert Paul Cervenka's application for a license to practice medicine in all of its branches in the State of Illinois, attest that the hereto attached photograph is a true likeness of Dr. Cervenka and that I personally viewed the original medical diploma of this applicant.

Signed [redacted]

LAWRENCE D. DEVOE, M.D.
PRINTED NAME

State of Illinois Medical Certificate No.

Ref. 36-048590
PRINT NUMBER

State of Illinois in the County of Cook

Subscribed and sworn to before me this 9 day of March, 19 81

[redacted]
NOTARY PUBLIC My Commission expires: 7-7-82.

(MD 154)

FLEX

This is to certify that I, Geoffrey M. Adkins am personally acquainted with Robert Paul Cervenka MD, who is applying for licensure to practice medicine in all of its branches in the State of Illinois; that I hereby attest to the educational background of Dr. Robert Paul Cervenka, who graduated from University of Maryland and was issued the degree and diploma of Doctor of Medicine on the 29th day of May, 19 80; and that Dr. Robert Paul Cervenka is of good moral character and professional background. I further endorse Dr. Robert Paul Cervenka's application for a license to practice medicine in all of its branches in the State of Illinois, attest that the hereto attached photograph is a true likeness of Dr. Cervenka and that I personally viewed the original medical diploma of this applicant.

MAR 16 1981

Signed [redacted]

Geoffrey M. ADKINS
PRINTED NAME

PHOTOGRAPH

State of Illinois Medical Certificate No.

Act. 036-057614
PRINT NUMBER

State of Illinois in the County of Cook

Subscribed and sworn to before me this 11 day of March, 19 81

[redacted]
NOTARY PUBLIC My Commission expires: 7/7/82.

(MD 154)

FLEX

DEPARTMENT OF REGISTRATION AND EDUCATION
(Medical Section)

CERTIFICATION OF CLINICAL TRAINING COVERED BY THE ILLINOIS MEDICAL PRACTICE ACT

This is to CERTIFY:

(1) That ROBERT PAUL CERVENKA
(full name of physician)

has satisfactorily completed 9 months in

a program of Obstetrics and Gynecology graduate - specialty - residency
(strike out whichever is not applicable)

at University of Chicago Hospitals and Clinics
(name of hospital)

extending from June 25, 1980 to March 24, 1981;

and

(2) That the physican hereinabove named

(check and complete whichever is applicable)

✓ presently holds Temporary Certificate of Registration No. T- 11140 issued under the provisions of Section 11a of the Illinois Medical Practice Act.

_____ previously held Temporary Certificate of Registration No. T- _____ issued under the provisions of Section 11a of the Illinois Medical Practice Act

_____ does not hold a Temporary Certificate of Registration issued under the provisions of Section 11a of the Illinois Medical Practice Act insofar as can be determined from the records of this hospital.

SIGNED: [redacted]
Executive Director
(Medical Director)
University of Chicago Hospitals and Clinics
(Name of Hospital)
950 East 59th Street, Chicago, Illinois 60637
(Address)

SEAL OF HOSPITAL

DATED: 3-31-81

THIS CERTIFICATION MUST INDICATE SATISFACTORY COMPLETION OF AT LEAST FOUR (4) MONTHS OF APPROVED CLINICAL TRAINING BEFORE THE PHYSICAN MAY BE ELIGIBLE FOR THE NEXT ILLINOIS FLEX EXAMINATION.

IF THE PHYSICIAN HAS SATISFACTORILY COMPLETED TWELVE (12) MONTHS OF APPROVED CLINICAL TRAINING AT THE TIME OF HIS/HER EXAMINATION, AND IS SUCCESSFUL IN THE EXAMINATION, HE/SHE MAY BE ISSUED A LICENSE UNDER THE PROVISIONS OF THE ILLINOIS MEDICAL PRACTICE ACT. HOWEVER, IF THE PHYSICIAN HAS NOT SATISFACTORILY COMPLETED TWELVE (12) MONTHS OF APPROVED TRAINING AS HEREINBEFORE PROVIDED AT THE TIME OF HIS/HER EXAMINATION (BUT IS ELIGIBLE FOR THE EXAMINATION BY REASON OF HAVING COMPLETED AT LEAST FOUR (4) MONTHS OF APPROVED TRAINING) AND IS SUCCESSFUL IN THE EXAMINATION, NO LICENSE SHALL BE ISSUED UNTIL THE DEPARTMENT SHALL HAVE RECEIVED PROOF OF SUCH PHYSICIAN'S SATISFACTORY COMPLETION OF THE REQUIRED TWELVE (12) MONTHS OF SUCH APPROVED TRAINING.

When completed, this form must be forwarded directly to: Medical Section
Department of Registration and Education
Springfield, Illinois 62786

(MD 108)

UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE
OFFICE OF STUDENT AFFAIRS
BALTIMORE, MARYLAND 21201

April 8, 1981

Medical Section
Department of Registration & Education
320 W. Washington Street
Springfield, Illinois 62786

TO WHOM IT MAY CONCERN:

This is a letter to certify that Robert Paul Cervenka, M.D. completed all the requirements for a M.D. Degree on May 23, 1980. His degree was conferred on May 29, 1980.

Sincerely,

[redacted]

Bernice Sigman, M.D.
Associate Dean for Student Affairs

BS:vds

U U 5 U U 0 0 0 9 0 3 0

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
ATTENTION: CONTROLLED SUBSTANCES SECTION
320 West Washington, 3rd Floor
Springfield, Illinois 62786

OCT 13 1981

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

Controlled Substances Registration – Every person who manufactures, distributes, prescribes or dispenses any controlled substances within the State must obtain annually a registration issued by the Department of Registration and Education in accordance with the Illinois Controlled Substances Act.

A State Controlled Substances Registration is a prerequisite to a Federal Controlled Substances Registration.

Applicant's Name Robert P. Cervenka M.D. (Cervenka)

Business Name University of Chicago Department of OB-GYN
Include Department, If Applicable

Business Address 5841 South Maryland Ave.
Number and Street

Chicago, Illinois 60637 Cook County
City ZIP Code County

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on the reverse side of this application to the best of my knowledge.

[redacted]
Signature of Applicant

✓ Fee: $ 5.00 Practitioner

$ _____ Non Practitioner

Make check or money order payable to:

Department of Registration and Education

OFFICIAL USE ONLY

State No. 36-62915-1 ok

Receipt No. _____

OFFICIAL USE ONLY

Edp 10/20/81

CT–20a (Revised 4/80)

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
ATTENTION: CONTROLLED SUBSTANCES SECTION
320 West Washington, 3rd Floor
Springfield, Illinois 62786

DEPT. OF REGS. STATE OF IL.

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

Controlled Substances Registration – Every person who manufactures, distributes, prescribes or dispenses any controlled substances within the State must obtain annually a registration issued by the Department of Registration and Education in accordance with the Illinois Controlled Substances Act.

A State Controlled Substances Registration is a prerequisite to a Federal Controlled Substances Registration.

Applicant's Name Robert P. Cervenka MD

Business Name University of Chicago Department of OB-GYN
Include Department, if applicable

Business Address 5841 South Maryland Ave.
Number and Street

Chicago, Illinois 60637 Cook County
City ZIP Code County

DEPT. OF REG. & ED. FOR DEPOSIT
DEPT. OF REGS. STATE OF IL.

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on the reverse side of this application to the best of my knowledge.

[redacted]
Signature of Applicant

✓ Fee: $ 5.00 Practitioner

$ _____ Non Practitioner

Make check or money order payable to:

Department of Registration and Education

OFFICIAL USE ONLY

State No. _____

Receipt No. _____

OFFICIAL USE ONLY

CT–20a (Revised 4/80)