

61988

DO NOT WRITE ON THIS FOLD

APPLICATION FOR REGISTRATION AS PHYSICIAN AND SURGEON

No. 36-61988

City _____
 Street and number _____
 County _____
 Preliminary Education approved _____ 19 _____
 Medical Education approved _____ 19 _____
 Diploma verified _____ 19 _____
 Diploma returned _____ 19 _____
 By _____
 Hail _____
 Express _____
 Application Fee received _____ 19 _____
 Certificate issued 4-14 1981
 Certificate forwarded 4-14 1981
 Application declined _____ 19 _____

THIS PORTION OF THE APPLICATION MUST BE COMPLETED BY THE MEDICAL COLLEGE AND FORWARDED DIRECTLY TO THIS DEPARTMENT FROM THE COLLEGE. IT WILL NOT BE ACCEPTED FROM THE APPLICANT.

CERTIFICATION OF MEDICAL EDUCATION ATTENDANCE (Give exact dates)

June 26, 19 80

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

This is to certify that Catherine S. Stika, M.D.
 was in regular attendance at the State University of New York, Upstate Medical Center
 from the 05 day of September, 1974 to the 07 day of June, 1975
 from the 04 day of September, 1975 to the 04 day of June, 1976
 from the 23 day of August, 1976 to the 25 day of June, 1977
 from the 11 day of July, 1977 to the 25 day of March, 1978
 from the _____ day of _____, 19____ to the _____ day of _____, 19____
 and was granted a diploma as Doctor of Medicine by SUNY Upstate Medical Center
 located at Syracuse State of New York
 on the 21 day of May, 1978

(Seal of College)

(Dean, Secretary or Registrar)

CERTIFICATE OF MORAL CHARACTER

This is to Certify that we, the undersigned, are personally acquainted with CATHERINE S STIKA, who is applying for registration as a Physician and Surgeon under the Illinois Medical Practice Act, and we know her to be of good moral character, and that she is the person referred to in this application; and that the attached photograph and signature are correct

Signed: _____, M.D.

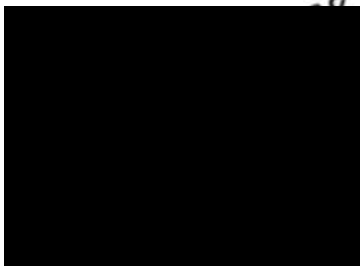
Signed: _____

Address: _____

Address: _____

Illinois License No. 36-39 217

Illinois License No. 36 47066



STATE OF ILLINOIS
 DEPARTMENT OF REGISTRATION AND EDUCATION
 320 WEST WASHINGTON STREET, 3RD FLOOR
 SPRINGFIELD, ILLINOIS 62786

RECEIVED
 REGISTRATION & EDUCATION

1980 JUL -2 AM 9:20

MAIL SECTION

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE AND SURGERY UPON
 THE BASIS OF NATIONAL BOARD EXAMINATION

I hereby make application for a license to practice Medicine and Surgery in all their branches in the State of Illinois, and submit the following statements regarding my educational qualifications:

Full name CATHERINE Susan STIKA

Present address

Intended residence Illinois

Place of birth Date of birth Age

Are you a citizen of the United States? YES

Please designate your Social Security Number : 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.

CATHERINE SUSAN STIKA
 COLLEGE OR UNIVERSITY EDUCATION

Name and location of institution attended
 At CORNELL UNIVERSITY - ITHACA, NEW YORK
 from the Sept day of 1968, to the May day of 1972

MEDICAL EDUCATION

At SUNY-UPSTATE MEDICAL CENTER - SYRACUSE, NEW YORK
(Name of Medical College)
 from the Sept day of 1974, to the May day of 1978

List any states in which you have ever written a licensure examination to practice Medicine and Surgery _____

List any states in which you have ever been licensed as a Physician and Surgeon _____

State of Illinois } ss CATHERINE SUSAN STIKA, being
 County of Racine } the duly sworn, says that she is the person referred to in this application and that
 the statements therein contained are true.

Catherine Susan Stika
 (Signature of Applicant)

Subscribed and sworn to before me this 29th day of

May A.D. 1980

 (Notary Public)

My commission expires 8/2/82

RECEIVED
 MEDICAL
 III



ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

CATHERINE SUSAN STIKA, M.D.

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

Attest: **WILLIAM B. HOLDEN**
Chairman of the Board

SEAL **EDITHE J. LEVIT**
President of the Board

Philadelphia, Pa.
07/02/79

Cert # **205011**

Direct

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of **SUNY UPSTATE MED CTR** in **MAY 1978**, whose birth date is [REDACTED], following successful completion of all examinations required for Certification by the National Board of Medical Examiners.

The grades obtained are as follows:

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

(Scale Score) *10*

*Examinations taken since June 1971 are reported with both Standard and Scale Score Equivalents.

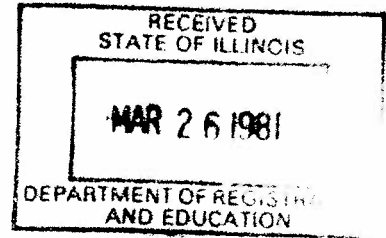
**Since 1966 National Board criteria for certification are based upon candidate's Total Grade in Part I, Part II, and Part III, and not scores of individual subjects within each Part.

[REDACTED]
Secretary for Certification
06/12/80

SEAL

Date

DEPARTMENT OF REGISTRATION AND EDUCATION
(Medical Section)



CERTIFICATION OF CLINICAL TRAINING COVERED BY THE ILLINOIS MEDICAL PRACTICE ACT

This is to CERTIFY:

(1) That CATHERINE S STIKA
(full name of physician)
has satisfactorily completed twenty (20) months in
a program of OB-Gyne ~~graduate~~ ~~specialty~~ residency
(strike out whichever is not applicable)
at Michael Reese Hospital and Medical Center
(name of hospital)
extending from July 1, 1979 to March 1, 1981;
and

(2) That the physician hereinabove named
(check and complete whichever is applicable)

presently holds Temporary Certificate of Registration No. T-10623
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:

[Signature]
(Medical Director)
Michael Reese Hospital and Medical Center
(Name of Hospital)
29th Street and Ellis Avenue, Chicago, IL 60616
(Address)

SEAL OF HOSPITAL

DATED:

March 4, 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

This is to certify that I, AARON Lifchez am personally acquainted with CATHERINE S STIKA, 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. CATHERINE S. STIKA, who graduated from SUNY-UPSTATE MEDICAL CENTER and was issued the degree and diploma of Doctor of Medicine on the ___ day of CENTER, 19 78, and that Dr. CATHERINE S. STIKA is of good moral character and professional background. I further endorse Dr. CATHERINE S. STIKA'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. CATHERINE S. STIKA and that I personally viewed the original medical diploma of this applicant.

1980 JAN -2 AM 12:41
CITY STATION



Signed

[Redacted Signature]

RECEIVED

Aaron S Lifchez MD
PRINTED NAME

State of Illinois Medical Certificate No.

036-043314
PRINT NUMBER

State of Illinois in the County of COOK

Subscribed and sworn to before me this 24th day of December, 19 80

[Redacted Name] My Commission
NOTARY PUBLIC

expires August, 1983

RECEIVED

RECEIVED

DEPARTMENT OF HEALTH
am personally

This is to certify that I, DONALD Chatman

acquainted with CATHERINE S. STIKA

1981 JAN -2 AM 11:53
who is applying

for licensure to practice medicine in all of its branches in the State of ILLINOIS

Illinois; that I hereby attest to the educational background of Dr. CATHERINE

S. STIKA, who graduate! from SUNY - UPSTATE MEDICAL

and was issued the degree and diploma of Doctor of Medicine on the ___ day of

CENTER, 19 78; and that Dr. CATHERINE S. STIKA

is of good moral character and professional background. I further endorse

Dr. CATHERINE S. STIKA'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. CATHERINE S. STIKA

and that I personally viewed the original medical diploma of this applicant.

Signed

[Redacted Signature]

DONALD Chatman

PRINTED NAME

State of Illinois Medical Certificate No.

of

36-39217

PRINT NUMBER

State of Illinois in the County of COOK

Subscribed and sworn to before me this 24th day of December, 19 80

[Redacted Name]

My Commission

NOTARY PUBLIC

expires: August, 1983

STATE OF ILLINOIS

Department of Registration and Education

JAMES D. NOWLAN, Director, ACTING DIRECTOR

Springfield, Illinois 62786

(Use typewriter or print with pressure)

Enter all applicable information.

Form with fields: E.C.F.M.G. No., Visa Type and No., DBI No., Full name before marriage (CATHERINE SUSAN STIKA), Social Security No., and a note about Social Security Number designation.

NAME: STIKA CATHERINE SUSAN

Street Address, City, Country, Place of birth, City - Province - Country

DATE OF BIRTH, Sex: Male, Female X

CITIZENSHIP: At birth: United States, Now: U.S.

MEDICAL DEGREE: Title of degree (M.D., M.B.-B.S., D.O., other) M.D. Date conferred May, 78

MEDICAL SCHOOL: (School(s) attended) SUNY-UPSTATE Medical Center (Location) SYRACUSE NY (Dates) 74-78 (No. of school yrs.) 4

SECONDARY SCHOOL, COLLEGE, UNIVERSITY CORNELL UNIVERSITY ITHACA, NY 68-72 4

HOSPITAL TRAINING: Hospital(s) Location Position(s) Dates. 1. ST. JOSEPHS HOSPITAL SYRACUSE NY rotating intern 7/78-6/79. 2. MICHAEL REESE HOSPITAL CHICAGO, ILL PG2 OB-GYN 7/79 - current

Are you a Diplomate of the National Board of Medical Examiners? Yes [checked] No

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.

[Signature] a Notary Public, DO

HEREBY CERTIFY, that Catherine S. Stika appeared before me this day in person and acknowledged that she 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 29th day of May A.D. 19 80

NOTE: Accompanying this preliminary application must be two photographs taken within the past six months. They should be at least passport size (2 1/2 x 2 1/2) and be signed on the reverse by the applicant.

Catherine S. Stika Signature of Applicant, May 29, 1980 Date

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

RECEIVED

MA 08/11/11

my commission expires 8/2/82

RECEIVED

DEPARTMENT OF REGISTRATION AND EDUCATION
(Medical Section)

RECEIVED
REGISTRATION & EDUCATION

1980 JUN 12 AM 11:14

MEDICAL SECTION

CERTIFICATION OF CLINICAL TRAINING COVERED BY THE ILLINOIS MEDICAL PRACTICE ACT

This is to CERTIFY:

(1) That CATHERINE SUSAN STIKA
(full name of physician)

has satisfactorily completed Twelve (12) months in
a program of Obstetrics and Gynecology ~~general internal medicine~~ - residency
(strike out whichever is not applicable)
at Michael Reese Hospital and Medical Center
(name of hospital)
extending from July 1, 1979 to _____;
and

(2) That the physician hereinabove named
(check and complete whichever is applicable)

presently holds Temporary Certificate of Registration No. T- 10623
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 Signature]

Antonio Scommegna, M. D.

(Medical Director)

Michael Reese Hospital and Medical Center

(Name of Hospital)

29th Street & Ellis Avenue, Chicago, Illinois 60616

(Address)

SEAL OF HOSPITAL

DATED: June 4, 1980

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

DEPARTMENT OF REGISTRATION AND EDUCATION
MEDICAL SECTION
320 WEST WASHINGTON STREET
SPRINGFIELD, IL. 62786

PERSONAL HISTORY

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

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

IMPORTANT:

Any false or misleading information in or in connection with any application, may be cause for debarment on the grounds 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 Wisconsin
COUNTY OF Lacine

CATHERINE SUSAN STIKA being
duly sworn, says that she is the person
referred to in this application and that
the statements therein contained are
true.

SIGNATURE OF APPLICANT

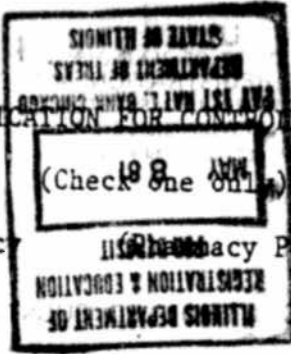
Subscribed and sworn to before me this
29th day of May, 1982.

NOTARY PUBLIC SEAL

NOTARY PUBLIC

(MD 130) My commission expires 8/2/82

APPLICATION FOR CONTROLLED SUBSTANCES LICENSE



1. Professional Activity:

B. Retail Pharmacy (Pharmacy Permit No.)

C. Practitioner

1. Physician (Professional License No. 036-061988)

2. Dentist (Professional License No.)

3. Podiatrist (Professional License No.)

4. Veterinarian (Professional License No.)

E. Hospital (Pharmacy Permit No.)

*Hospitals with Drug Rooms, use Drug Enforcement Administration Number.

F. *Teaching Institution (Drug Enforcement Administration No.)

2. Drug Schedules: (Check all applicable)

II IIN III IIN IV V

3. Have you ever been convicted of a felony under any State or Federal law relating to controlled substances? yes no

4. Has any previous registration held by the applicant, under the Controlled Substances Act been surrendered, revoked, denied or is it pending action? yes no

If answer to questions 3 or 4 is yes, attach a letter explaining.

036-061988

STATE OF ILLINOIS