61988

DO NOT WRITE ON THIS FOLD

No. 36-61988

APPLICATION FOR REGISTRATION AS PHYSICIAN AND SURGEON

City

Street and number

County

Preliminary Education approved 19

Medical Education approved 19

Diploma verified 19

Diploma returned 19

By Mail 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, 1980

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.

[redacted]

(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 true.

[redacted]

Signed: , M.D.

Address:

Illinois License No. 36-39217

[redacted]

Signed:

Address:

Illinois License No. 36 47066 CHICAGO

(MD 104)b

[redacted]

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
LICENSE SECTION

LICATION 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 [redacted]

Intended residence Illinois

Place of birth [redacted] Date of birth [redacted] Age [redacted]

Are you a citizen of the United States? YES

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.

→ CATHERINE Susan [illegible] STIKA

COLLEGE OR UNIVERSITY EDUCATION

Name and location of institution attended

At CORNELL UNIVERSITY - ITHACA, NEW YORK

from the _____ day of Sept, 1968, to the _____ day of May, 1972

MEDICAL EDUCATION

At SUNY - UPSTATE MEDICAL CENTER - SYRACUSE, NEW YORK
(Name of Medical College)

from the _____ day of Sept, 1974, to the _____ day of May, 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 Wisconsin)
County of Racine) ss

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.

Catherine Susan Stika
(Signature of Applicant)

Subscribed and sworn to before me this 29th day of May, A.D. 1980.

[redacted]
(Notary Public)

My commission expires 8/3/82

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

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

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of S U N Y 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
PART I passed [redacted]		
Anatomy, incl. histology and embryology		
Physiology		
Biochemistry		
Pathology		
Microbiology, incl. immunology		
Pharmacology and Materia Medica		
Behavioral Sciences		
(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**		[redacted]
Part II passed [redacted]		
Internal medicine and the medical specialties		
Surgery and the surgical specialties		
Obstetrics and Gynecology		
Public Health and Preventive Medicine		
Pediatrics		
Psychiatry		
(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**		
PART III passed [redacted]		
A General Test of Clinical Competence		
(Minimum Passing Grade 290/75) · AVERAGE		[redacted]
GENERAL AVERAGE (Parts I, II, and III)		(Scale Score)

*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

SEAL

06/12/80
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 physican hereinabove named

(check and complete whichever is applicable)

X 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]
(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 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.

[redacted]

Signed [redacted]

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, 1980

[redacted]
NOTARY PUBLIC My Commission expires August, 1983

(MD 154)

This is to certify that I, DONALD Chatman 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, 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.

[redacted]

Signed [redacted]

DONALD Chatman
PRINTED NAME

State of Illinois Medical Certificate No.

36-39217
PRINT NUMBER

State of Illinois in the County of COOK

Subscribed and sworn to before me this 24th day of December, 1980

[redacted]
NOTARY PUBLIC

My Commission expires: August, 1983

(MD 154)

STATE OF ILLINOIS

Department of Registration and Education

JAMES D. NOWLAN, Director
ACTING DIRECTOR
320 West Washington
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 [redacted] CATHERINE SUSAN STIKA
Social Security No. [redacted]

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

NAME: STIKA, CATHERINE SUSAN
All other names (spell out completely)

Street Add: [redacted] St.
City: C[redacted]
Countr[redacted]
Place of birth: [redacted]
City — Province — Country

DATE OF BIRTH: [redacted] Yea[redacted] 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: (Precise name)	(School(s) attended)	(Location)	(Dates)	(No. of school yrs.)
	SUNY-UPSTATE Medical Center	Syracuse NY	74-78	4
SECONDARY SCHOOL, COLLEGE, UNIVERSITY	CORNELL University	ITHACA, NY	68-72	4

HOSPITAL TRAINING:	Hospital(s)	Location	Position(s)	Dates
①	St. Joseph's Hospital	Syracuse NY	rotating intern	7/78-6/79
②	Michael Reese Hospital	Chicago, Ill	PGY OB-GYN	7/79 → current

Are you a Diplomate of the National Board of Medical Examiners? Yes ✓ 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.

I, [redacted], 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

[redacted] (Seal)
Notary Public

My commission expires 8/2/82

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.

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 ( ) REPROCITY ( )

DEPARTMENT OF REGISTRATION AND EDUCATION
(Medical Section)

RECEIVED
REGISTRATION & EDUCATION
1980 JUN 12 AM 11: 14
MEDICAL SECTION

RECEIVED

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 ~~graduate~~ - 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 physican hereinabove named

(check and complete whichever is applicable)

X 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] 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

(MD 129)

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?	___	X
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?	___	X
3.	Have you ever been convicted of a felony or misdemeanor other than minor 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, territory or district 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

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 Racine

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.

[redacted]

SIGNATURE OF APPLICANT

Subscribed and sworn to before me this 27th day of May, 1982.

[redacted]

NOTARY PUBLIC

NOTARY PUBLIC SEAL

My commission expires 8/2/82

(MD 130)

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

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 CATHERINE S. STIKA

Business Name OB-Gyne dept Michael Reese Hospital
Include Department, if Applicable

Business Address 29th & ~~Ellis~~ Ellis Streets
Number and Street

CHICAGO — City
60616 — ZIP Code
Cook — 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. 36-61988-1

Receipt No. _____

ok

OFFICIAL USE ONLY

Ed 5/8/81

CT-20a (Revised 4/80)

APPLICATION FOR CONTROLLED SUBSTANCES LICENSE

1. Professional Activity: (Check one only)

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 IIIN 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.