[redacted] 03000004205 [redacted]

NOV 1 3 2006

APPLICATION FOR EXAMINATION

Div. of Professional Regulation

FOR OFFICIAL USE ONLY

PEIPERT, JEFFREY F
036 Cred #2261446 11/16/2006
By:ENDORSEMENT
SSN [redacted]

ecessary for consideration for licensure
ure of this information is VOLUNTARY.
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
Physician	0 3 6	Endorsement	$ 300.00

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. 1301287

RECEIVED NOV 20 2006 MEDICAL UNIT

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 changes 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.
Peipert Jeffrey F.	M.D.	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY	ZIP CODE	COUNTY
Washington Univ. Sch. of Medicine 4911 Barnes Hosp. Plaza, Campus Box 8064 Dept. of OB/GYN St. Louis, Mo	63110-____	

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY	ZIP CODE	COUNTY
Planned Parenthood 4529 N. IL (Rt 159) Lakeland Square, Fairview Hts. IL	62221-____	

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	9. DATE OF BIRTH	10.AGE
[redacted]		☐ Female ☒ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED	12. PREFERRED e-MAIL ADDRESS(ES) [If available]
Work ([redacted]) (Area Code) Home: [redacted] (Area Code)	

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

NAME (Last, First, MI): Peipert, Jeffrey F.

SS#: [redacted]

Profession: M.D.

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
Farmingdale Sr. High	Farmington, NY	06 / 19 78 (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
Brown University	Providence, Rhode Island	/1978	/1982	B.A.
Emory University School of Medicine	Atlanta, Georgia	/1982	5/1986	M.D.
Yale University School of Medicine	New Haven, Connecticut	/1990	/1992	M.P.H
University of Minnesota	Minneapolis, Minnesota	/1996	/2000	M.H.A.

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?
Pennsylvania Hospital	Philadelphia, Pennsylvania	/1986	/1987	☒ Yes ☐ No
Pensylvania Hospital	Philadelphia, Pennsylvania	/1987	/1990	☒ Yes ☐ No
Yale Univesity School of Medicine	New Haven, Connecticut	/1990	/1992	☒ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Peipert, Jeffrey F.

SS#: [redacted]

Profession: M.D.

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 R.I.	M.D.	MD08241		Exp. 6/06
State of Current Licensure where you most recently have been practicing. Missouri	M.D.	2006002063		Active
Other States of Licensure				
Connecticut	M.D.	030653, CT		Expired
Pennsylvania	M.D.	039868-E, PA		Expired

(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
			(Passed, Failed, Absent)

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

NAME (Last, First, MI): Peipert, Jeffrey T.

SS#: [redacted]

Profession: M.D.

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

11/1/06
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. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

WORK HISTORY

SUPPORTING DOCUMENT

WH

APPLICANT: Complete Work History. If you have never been employed you may stop at box 8. You are authorized to photocopy this form if additional space is required.

1. NAME LAST: Peipert FIRST: Jeffrey MIDDLE: F.

2. DATE OF BIRTH [redacted]

3. SOCIAL SECURITY NUMBER [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.
Physician (Profession Name) 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☐

8. DATE FORM COMPLETED

9. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS / INSTITUTION: Planned Parenthood of the St. Louis Region

ADDRESS STREET, CITY, STATE, ZIP CODE: 4251 Forest Park Ave., St. Louis, MO 63108

SUPERVISOR NAME: Paula M. Gianino

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 01 / 2006 (Month / Day / Year)
To ___ / ___ / _____ (Month / Day / Year)

HOURS WORKED PER WEEK: 8

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

TOTAL TIME WORKED (Year/Month)

JOB TITLE: Medical Director

DESCRIPTION OF DUTIES PERFORMED
Participates in planning process, development of new medical services; approves all medical protocols; provides oversight for training, supervising and evaluation of all clinicians, helps develop annual quality assurance program; assists in training for medical students; provide full range of medication and surgical abortion services; director of Colposcopy and Crotherapy services; oversees client testing.

B. NAME OF BUSINESS / INSTITUTION: Washington University School of Medicine

ADDRESS STREET, CITY, STATE, ZIP CODE: 4911 Barnes Jewish Hospital Plaza Campus Box 8064 St. Louis, MO 63110

SUPERVISOR NAME: Dr. George Macones

DATE OF EMPLOYMENT/ATTENDANCE
From ___ / ___ / 2006 (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: Professor

DESCRIPTION OF DUTIES PERFORMED
Vice Chair of Clinical Research
- perform clinical research
- obtain grant funding
- mentor junior investigators
- teach
- provide clinical care

NAME (Last, First, MI): Peipert, Jeffrey F.

SS#: [redacted]

Profession: M.D.

C. NAME OF BUSINESS / INSTITUTION: Women and Infants Hospital

JOB TITLE: Assistant/Associate Professor OB/GYN

ADDRESS STREET, CITY, STATE, ZIP CODE: 101 Dudley Street Providence, RI 02905

DESCRIPTION OF DUTIES PERFORMED:
- Perform clinical research
- Write grants
- Teach
- Provide clinical care

SUPERVISOR NAME:

DATE OF EMPLOYMENT/ATTENDANCE
From 07/01/1992 (Month/Day/Year)
To 12/31/2005 (Month/Day/Year)

HOURS WORKED PER WEEK: 50-70

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

TOTAL TIME WORKED (Year/Month): 13 years

D. NAME OF BUSINESS / INSTITUTION: Yale University

JOB TITLE: Physician

ADDRESS STREET, CITY, STATE, ZIP CODE: 333 Cedar Street New Haven, CT 06510

DESCRIPTION OF DUTIES PERFORMED: Provide outpatient and inpatient clinical (OB/Gyn) care

SUPERVISOR NAME:

DATE OF EMPLOYMENT/ATTENDANCE
From 07/01/1990 (Month/Day/Year)
To 07/01/1992 (Month/Day/Year)

HOURS WORKED PER WEEK: 10-12

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

TOTAL TIME WORKED (Year/Month):

E. NAME OF BUSINESS / INSTITUTION:

JOB TITLE:

ADDRESS STREET, CITY, STATE, ZIP CODE:

DESCRIPTION OF DUTIES PERFORMED:

SUPERVISOR NAME:

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):

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.

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE: Peipert Jeffrey F.

2. DATE OF BIRTH: [redacted]

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: Washington Univ. School of Medicine Dept. of OB/GYN, 4911 Barnes Hospital Plaza Campus Box 8064, St. Louis, MO 63110

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. Physician (Profession Name) 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: N/A

7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code: [redacted]

8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)

8b. LICENSE NUMBER (If applicable)

8c. ISSUANCE DATE OF LICENSE (If applicable)

I hereby authorize _____ (Name of Licensing Agency or Board) to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service, the information requested below.

Signature [redacted] Date 7/20/06

DO NOT RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS

A. The applicant ☐ has written ☐ is scheduled to write the following examination:

_____ (Name of Examination) _____ (Date of Examination)

B. The applicant has or will have written the above-named examination _____ number of times.

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE: Jeffrey Peipert MD

B. LICENSE NUMBER: 8241

C. ISSUANCE DATE OF LICENSE: 7-9-92

D. EXPIRATION DATE OF LICENSE: 6-30-2006

E. LICENSURE METHOD

☐ Examination (Administered in Your State)
- ☐ National (Name)
- ☐ State Constructed
- ☐ Other (Name)

☐ Endorsement of License (State)

Acceptance of Examination Results (Administered in Another State): ABMS

☐ Reciprocity with (State) _____
☐ Waiver/Grandfather
☐ Credentials
☐ Other (Describe) _____

F. CURRENT LICENSURE STATUS

☐ Active
☐ Inactive
☒ Lapsed – 6-30-2006
☐ Other (Explain) _____

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination	Score
Written	
Practical	
Other (Describe)	
Received no Grade Below	

Examination Period _____ days _____ hours

NAME (Last, First, MI): Pelpert Jeffrey F.

SS#: [redacted]

Profession: M.D.

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination — Date of Examination _____

(Record all available information)

Scaled Score		Raw Score	
Standard Deviation		Corrected Score	
National Mean		Percent Score	

A 2

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

A. Is there now or has there ever been any formal action commenced against the applicant? ☐ Yes ☒ No

B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? **(If yes, attach a certified copy of disciplinary action.)** ☐ Yes ☒ No

PART V - RECIPROCAL REGISTRATION

This state ☐ does ☒ does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

Lauren Sivon

Print Name

[redacted]

Title

SEAL

RHODE ISLAND DEPARTMENT OF HEALTH
BOARD OF MEDICAL LICENSURE AND DISCIPLINE
Agency/Board Street Address
ROOM 205, THREE CAPITOL HILL
PROVIDENCE, RI 02908-5097
City, State, ZIP Code

9-11-2006
Signature

401-222-3855
Date

Area Code ( )
Telephone Number

RETURN NONEXAM CT TO: **Department of Financial and Professional Regulation**
ATTN: Division of Professional Regulation
320 West Washington, L & T-1
Springfield, Illinois 62786

[redacted] [redacted] 34-6294

Matt Blunt
Governor
State of Missouri

David T. Broeker, Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
W. Dale Finke, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
website: www.pr.mo.gov/healingarts.asp

Tina Steinman
Executive Director

To:

Illinois Depart of Prof Regulation
320 West Washington, L&T-1
Springfield, IL 62786

This is to certify that the records of the Missouri Board of Healing Arts indicate the following information regarding Jeffrey F Peipert, M.D..

LICENSE TYPE:	Medical Physician & Surgeon
DATE OF BIRTH:	11/7/1960
LICENSE NUMBER:	2006002063
DATE ISSUED:	2/1/2006
STATUS:	Active
EXPIRATION DATE:	1/31/2007
LICENSE METHOD:	Natl Bd of Medical Examiners
MEDICAL SCHOOL:	Emory University
DISCIPLINARY ACTION:	None

[redacted]
NOV 0 8 2006
[redacted]

[redacted]

Rose Evers
Verifications Clerk

11/01/2006
Date

This is the only form that will be used by the Missouri State Board of Registration for the Healing Arts for the purpose of license verification.

[redacted]

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.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

APPLICANT: Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Peipert	Jeffrey	F.		[redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE
Washington Univ. School of Medicine, Dept. of OB/GYN, 4911 Barnes Hospital Plaza, Campus Box 8064, St. Louis, MO 63110

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Physician (Profession Name) — 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)

8. ISSUANCE DATE

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
320 West Washington - MED-1
Springfield, Illinois 62786

This is to certify that the above-named applicant satisfactorily completed 48 months of postgraduate clinical training in Obstetrics and Gynecology
(Name of Accredited Postgraduate Clinical Training Program)
from 6/18/86 to 6/30/90 at the following hospital:

Hospital: Pennsylvania Hospital
Number and Street: 800 Spruce St. - 2 Pine East
City, State and Zip Code: Philadelphia, PA 19107

I further certify that at the time of such training the program was accredited by:

- [x] the Accreditation Council for Graduate Medical Education;
- [ ] the Accreditation Council on Canadian Graduate Medical Education; or
- [ ] the American Osteopathic Association

Name of Postgraduate Clinical Training Program Director: Stephanie Evans MD
Signature of Postgraduate Clinical Training Program Director: [redacted]
Date of this Certification: 8/29/06
Telephone No: 215-829-8000

SEAL

IL486-1535 08/04 (MD)

Since 1986
Medilert-IRIS™
Your *complete* source for credentialing
P.O. Box 42930
Phoenix, AZ 85080-2930

Ph 1-800-846-1351
Fax 1-800-765-4814

NAPCEN ™ CREDENTIALING REPORT

NAME: PEIPERT , JEFFREY F, MD **DOB:** [redacted] **SPECIALTY:** OBSTETRICS & GYNECOLOGY
AKA: **SSN:** [redacted] **DATE:** 08/09/2006
ADDRESS: 4911 BARNES HOSPITAL PLAZA, CAMPUS BOX 8064, ST. LOUIS, MO 63110 **FAC CODE:** MO-126

VERIFICATION AREAS	*VERIFICATION DATES*
MEDICAL EDUCATION: N/A **DEGREE:** N/A **DATE GRADUATED:**	N/A
1. RESIDENCIES/ADDITIONAL TRAINING: N/A **TYPE:** **DATES:** **2. RESIDENCIES/ADDITIONAL TRAINING:** N/A **TYPE:** **DATES:**	N/A N/A
BOARD CERTIFICATION: THE AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY **DATES:** 1992 - 2006 **SUB-SPECIALTY:** NONE **DATES:**	07/27/2006
STAFF AFFILIATION(S): 1. BARNES JEWISH HOSPITAL **STATUS:** ACTIVE **DATES:** 01/2006 - PRESENT 2. RHODE ISLAND HOSPITAL **STATUS:** ATTENDING **DATES:** 09/1994 - PRESENT 3. WOMEN AND INFANTS HOSPITAL **STATUS:** LOA **DATES:** 1997 - PRESENT	07/28/2006 08/08/2006 07/31/2006
MALPRACTICE LIABILITY INSURANCE: WASHINGTON UNIVERSITY **AMOUNTS:** 2 MIL/10 MIL **ISSUED:** 02/01/2006 **EXPIRES:** 06/30/2007 **CLAIMS?** NO	08/02/2006
LICENSURE: **LICENSURE ACTION(S):** 1. STATE: MO **LICENSE #:** 2006002063 **ISSUED:** 02/01/2006 **EXPIRES:** 01/31/2007 NO 2. STATE: RI **LICENSE #:** MD08241 **ISSUED:** 07/09/1992 **EXPIRES:** 06/30/2006 NO 3. STATE: N/A **LICENSE #:** **ISSUED:** / / **EXPIRES:** / / N/A	07/27/2006 07/27/2006 N/A
DEA CERTIFICATION: RECORD OF CURRENT CERTIFICATION? YES **DEA NUMBER:** BP1121564 **EXPIRATION DATE:** 03/31/2008	07/27/2006
DHHS MEDICARE/MEDICAID SANCTIONS? NO	07/28/2006
NATIONAL PRACTITIONER DATABANK SETTLEMENT/DISCIPLINARY ACTION? N/A	N/A

DISCREPANCIES/COMMENTS:

BARNES JEWISH HOSPITAL -- CONFIRMED APPOINTMENT DATE AS 3/2006.
RHODE ISLAND HOSPITAL -- CONFIRMED AS INACTIVE; ON STAFF FROM 9/1994-3/2006.
WOMEN AND INFANTS HOSPITAL -- CONFIRMED APPOINTMENT DATE AS 8/1992; ENDED 1/2006.
RHODE ISLAND STATE LICENSE -- CONFIRMED AS EXPIRED 6/30/2006.

MEDILERT ORIGINAL SEAL CASTLEMARK CORP.

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.

CERTIFICATION OF AFFILIATION

SUPPORTING DOCUMENT

AF-MED

APPLICANT: Complete the applicant section of this form, then forward it to the appropriate official for completion of A or B.

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Peipert	Jeffrey	F.	[redacted]	

4. ADDRESS STREET, CITY, STATE, ZIP CODE
Washington Univ. School of Medicine, Dept. of OB/GYN, 4911 Barnes Hospital Plaza, Campus Box 8064, St. Louis, MO 63110

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
N/A

Physician — Profession Name
036 — Profession Code

DEAN OR ADMINISTRATOR OF CLINICAL TEACHING FACILITY

Read A and B below, then complete either A or B and return form to the applicant.

A. MEDICAL COLLEGE: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was **owned or operated** by the medical college from which he graduated, sign the certification below.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility **owned or operated** by the medical college from which he graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

SEAL OF COLLEGE

[redacted] — Signature of Dean of Medical College

J. William Gilley — Type Name of Dean of Medical College

October 27, 2006 — Date

Emory University SOM — Name of Medical College

1440 Clifton Rd WHSCAB — Street Address

Atlanta GA 30322 — City State Zip Code

B. CLINICAL TEACHING FACILITY: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was **formally affiliated or contracted** with the medical college from which he graduated, sign the certification below. Further, you must **submit a copy of the affiliation agreement** between the hospital and the medical college which conferred the degree and **a copy of an evaluation form** for each core clerkship rotation, which was completed by the supervising physician of that rotation.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility **formally affiliated or contracted** with the medical college from which the applicant graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

SEAL OF INSTITUTION

Signature of Administrator of Clinical Teaching Facility

Type Name of Administrator of Clinical Teaching Facility

Date

Name of Clinical Teaching Facility

Street Address

City State Zip Code