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63755

RECEIPT CASH SECTION

NOV 30 1980

Misc. 7-1-81

| IMPORTANT NOTICE | RETURN APPLICATION TO: | FOR OFFICIAL USE ONLY |
|---|---|---|
| Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center. | STATE OF ILLINOIS DEPARTMENT OF REGISTRATION AND EDUCATION Attention: Medical Section 320 West Washington Street, 3rd Floor Springfield, Illinois 62786 | County Code 016<br>Graduation Date 6-6-80<br>License No. 63755<br>Certificate Issued 1-14-82<br>Certificate Mailed 1-18-82 |

# APPLICATION FOR LICENSURE UNDER THE MEDICAL PRACTICE ACT

*IN THE BLOCK BELOW, CHECK TYPE OF LICENSURE FOR WHICH YOU ARE APPLYING AND THEN THE BASIS UNDER WHICH YOU ARE APPLYING.*

| | | | |
|---|---|---|---|
| Type of Licensure: | [✓] Physician-Surgeon | [ ] Osteopath | [ ] Doctor of Chiropractic |
| Basis of Licensure: | [ ] Flex Endorsement<br>[ ] Flex Examination<br>[ ] Reciprocity | [✓] National Board Endorsement<br>[ ] LMCC Endorsement | [ ] Examination<br>[ ] National Board Diplomate<br>[ ] Reciprocity |

*All candidates for licensure must complete the following. False or misleading information may be cause for disciplinary action on the grounds of a lack of good moral character.*

| 1. PRINT NAME AS IT SHOULD APPEAR ON CERTIFICATE (Limited to 20 characters first name, middle initial and 20 characters last name) | 2. SOCIAL SECURITY NUMBER |
|---|---|
| DAVID Allen TABER | [redacted]<br>*Designation of number is not mandatory—used only to ensure identification, accessibility, and accuracy of this application.* |

| 3. HOME STREET ADDRESS | 4. CITY | 5. COUNTY | 6. STATE | 7. ZIP CODE |
|---|---|---|---|---|
| [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |

| 8. INTENDED STREET ADDRESS | 9. CITY | 10. COUNTY | 11. STATE | 12. ZIP CODE |
|---|---|---|---|---|
| SAME | | | | |

| 13. TELEPHONE NO. (Area Code) | 14. PLACE OF BIRTH | 15. DATE OF BIRTH (Month/Day/Year) | 16. AGE |
|---|---|---|---|
| [redacted] | [redacted] | [redacted] | [redacted] |

EDUCATION — Official transcripts must be submitted with this application.

17. COLLEGE EDUCATION *(Do not include medical schooling.)*

| NAME OF INSTITUTION | LOCATION (City and State) | DATES OF ATTENDANCE | CREDIT HOURS / DATE OF GRADUATION |
|---|---|---|---|
| Parkland College | Champaign IL | From 9-71<br>To 6-74 | [ ] ____ Semester<br>[ ] ____ Quarter |
| University of Illinois | Urbana IL | From 9-74<br>To 6-76 | DATE OF GRADUATION: 6-76 |

18. MEDICAL COLLEGE OR UNIVERSITY — *Exact copy of diploma of said institution must be attached.*

| NAME OF INSTITUTION | LOCATION (City and State) | DATES OF ATTENDANCE |
|---|---|---|
| University of Illinois | Urbana IL | From 9-76<br>To 6-77 |
| University of Illinois | Chicago IL | From 6-77<br>To 6-80 |

| TYPE OF DEGREE GRANTED | NAME OF INSTITUTION GRANTING DEGREE | DATE DEGREE WAS GRANTED |
|---|---|---|
| M.D. | University of Illinois | 6-80 |

19. SPECIALTY/RESIDENCY TRAINING — *For applicants desiring licensure as a physician-surgeon.*

| NAME OF INSTITUTION | LOCATION (City and State) | TYPE OF PROGRAM | DATES OF ATTENDANCE |
|---|---|---|---|
| Cook County Hospital | Chicago IL | Internship | From 7-80<br>To 7-81 |

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DEPT. OF TREAS. STATE OF IL.

| 20. PERSONAL HISTORY — *If any of the following questions are answered "YES" a detailed explanation must be [illegible]* | | YES | NO |
|---|---|---|---|
| A. | Do you hold a license in any of the other healing arts? | | X |
| B. | Have you ever been denied a certificate, or the privilege of taking an examination, before any State Medical Board? *If yes, the State Medical Board must submit a certified statement of the charge and its disposition.* | | X |
| C. | Are you now, or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or habit-forming drugs? | | X |
| D. | *If the answer is yes to either of the following, attach a statement from the treating psychiatrist and a copy of his board certification or, if he is not board-certified, his curriculum vitae.* 1. Have you ever been a patient (voluntarily or otherwise) in any institution for the treatment of mental or emotional illness, drug addiction, or inebriety? | | X |
| | 2. Have you ever been treated, but not hospitalized, for mental or emotional illness, drug addiction, or inebriety? | | X |
| E. | Have you ever been convicted of any criminal offense(s) in Illinois or in another state or in federal court (other than minor traffic violations)? | | |
| F. | Have you ever been denied hospital staff privileges? *If yes, please attach an explanation from the hospital administrator.* | | X |
| G. | Do you have any physical impairment or disability that could interfere with your ability to practice your profession? | | X |
| H. | Have you ever applied for a certificate of registration as a physician-surgeon or chiropractor? | | X |
| I. | Have you ever written a licensure examination to practice medicine and surgery or chiropractic in Illinois or any other state? *If yes, complete the following:* | | X |

| List state(s) in which you took examination | Type of Examination Taken | Date of Examination |
|---|---|---|
| | | |
| | | |
| | | |

| J. | Have you ever been licensed as a physician-surgeon or chiropractor in Illinois or in another state? *If yes, complete the following and attach a certification of original licensure, with state seal affixed.* | YES | NO |
|---|---|---|---|
| | | | X |

| List state(s) in which you have ever been licensed. | License Number | Dates of Licensure From | Dates of Licensure To | Is license current? | Has license ever been revoked or otherwise disciplined? |
|---|---|---|---|---|---|
| | | | | [ ] YES [ ] NO | [ ] YES [ ] NO |
| | | | | [ ] YES [ ] NO | [ ] YES [ ] NO |
| | | | | [ ] YES [ ] NO | [ ] YES [ ] NO |

STATE OF Illinois )

COUNTY OF COOK )

I hereby certify that I personally completed this application and that the answers appearing hereon are true and correct to the best of my knowledge and belief.

Signature (in full—no initials)

Subscribed and sworn to before me this 16 day of November 1981. NOTARY SEAL

Signature of Notary Public Comm expires 5/8/85

IL 486–0279 7/81 (MD)



DEC 2 81

DEPARTMENT OF REGISTRATION AND EDUCATION

## MEDICAL SECTION CHECKLIST

NAME David C Allen Taber

DATE APPLICATION RECEIVED 11-30-81

| | CHIRO. EXAM | PHYS. ASSIST. | LMCC | FLEX EXAM | FLEX ENDORSE. | NATIONAL BOARD | RECIPRO-CITY | RESTORA-TION | TEMP CERT. |
|---|---|---|---|---|---|---|---|---|---|
| 1. Basis of Application | | | | | | X | | | |
| 2. Fee—Amount Received | | | | | | X | | | |
| 3. Pers. History Statement | | | | | | X | | | N/A |
| 4. Application Notarized | | | | | | X | | | |
| 5. Work Experience | | | | | | X | | | |
| 6. Name Change Papers | | | | | | N/a | | | |
| 7. Photographs | | | | | | X | | | |
| 8. Identity Statements | N/A | | [illegible] | OK | | X | | N/A | N/A |
| 9. 3 Physician Affidavits | | | | | | N/a | | N/A | |
| 10. College Transcript | | | | | | X | | N/A | |
| 11. Prof. Transcript | | | | | | X | | N/A | |
| 12. Prof. Diploma--Copy | | | | | 6-6-80 | X | | N/A | |
| 13. Translations | | | | | | N/a | | N/A | |
| 14. Completed by Hospital | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | |
| 15. AMA/AOA Hospital | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | |
| 16. AMA/Dept. Hospital | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | |
| 17. Clinical Training – 4 | N/A | N/A | | | | N/a | | N/A | N/A |
| 18. Clinical Training – 12 | N/A | N/A | | | | X | | N/A | N/A |
| 19. Clinical Training Waiver | N/A | N/A | | | | N/a | | N/A | N/A |
| 20. American Board Spec. | N/A | N/A | | N/A | N/A | N/a | | N/A | N/A |
| 21. Curriculum Vitae | N/A | N/A | N/A | N/A | N/A | N/A | | N/A | N/A |
| 22. Request for 2 c | N/A | N/A | N/A | N/A | N/A | N/A | | N/A | N/A |
| 23. 100 CME Hours | N/A | N/A | N/A | N/A | N/A | N/A | N/A | | N/A |
| 24. Current License | N/A | | | N/A | 1 | N/A | | N/A | N/A |
| 25. Cert. of Original State | N/A | | | N/A | | | | N/A | |
| 26. Certificate of Health | N/A | | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 27. National P.A. Cert. | N/A | | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 28. P.A. Exam Accepted | N/A | | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 29. Exam Grades | | | | | | X | | N/A | N/A |

[ ] Not Eligible ______
[X] Eligible [ ] Committee Review
Initials CR Date 12-31-81

[ ] Not Eligible ______
[ ] Eligible [ ] Comm. Review
Initials ______ Date ______

[ ] Not Eligible ______
[ ] Eligible [ ] Comm. Review
Initials ______ Date ______

EXAMINATION DATE

COMMITTEE DATE

RETAKE REQUIREMENTS:

[ ] Fee – Amount Received $ ______
[ ] Eligible to retake examination
Date scheduled ______
[ ] Not eligible to retake examination – Reason
[ ] Needs Further Education
[ ] Other ______

Required to retake days/subjects:

______

______

______

Initials ______

Date ______

IL 486–0269 7/81 (MD)

# 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. [redacted]

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

NAME: TABER, DAVID ~~[illegible]~~ ALLEN

[redacted]

City — Province — Country

[redacted] Sex: Male X Female ______

CITIZENSHIP: At birth: USA Now: USA

MEDICAL DEGREE: Title of degree (M.D., M.B.-B.S., D.O., other) MD Date conferred 1980

MEDICAL SCHOOL: (School(s) attended) (Location) (Dates) (No. of school yrs.)
(Precise name) University of Illinois Chicago IL '76 – '80 4

SECONDARY SCHOOL, COLLEGE, UNIVERSITY University of Illinois

HOSPITAL TRAINING: Hospital(s) Location Position(s) Dates
Cook County Hospital Chicago Resident 7-80 – 6-83

Are you a Diplomate of the National Board of Medical Examiners? Yes X 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).) none

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 David Allen Taber 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 16th day of November A.D. 19 81

[redacted] (Seal)
My Commission Expires ______ Notary Public

NOTE: Accompanying this preliminary application must be two photographs taken within the past six months. They should be at least passport size (2½ x 3½) and be signed on the reverse by the applicant.

[redacted]
Signature of Applicant

11-16-81
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 ( )

**IMPORTANT NOTICE**

Completion of this form is required for applicant to be considered for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

**DEPARTMENT OF**

**REGISTRATION AND EDUCATION**

# STATEMENTS OF IDENTITY

*TO BE COMPLETED FOR APPLICANTS APPLYING FOR REGISTRATION AS A PHYSICIAN-SURGEON ONLY.*

INSTRUCTIONS TO APPLICANT: Please attach a photograph in the space provided on this form. This form must be completed by two licensed physicians who can attest to your identity and submitted with your application.

**FIRST STATEMENT**

This is to certify that I, DONALD JOSEPH STINAR (Print name), am personally acquainted with DAVID ALLEN TABER, who is applying for licensure as a physician-surgeon in the State of Illinois, and I hereby attest that the attached photograph is a true likeness of him/her.

Donald Joseph Stinar — Signature of Physician

Dec 13 / 1981 — Date

State of Licensure

**SECOND STATEMENT**

This is to certify that I, Martin M. Mass (Print name), am personally acquainted with David Allen Taber, who is applying for licensure as a physician-surgeon in the State of Illinois, and I hereby attest that the attached photograph is a true likeness of him/her.

IL 486-0267 7/81 (MD)

| IMPORTANT NOTICE | |
|---|---|
| Completion of this form is required for applicant to be considered for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center. | DEPARTMENT OF REGISTRATION AND EDUCATION<br>**CERTIFICATION OF CLINICAL TRAINING** |

| NAME OF APPLICANT | ILLINOIS TEMPORARY CERTIFICATE NUMBER (If applicable) |
|---|---|
| DAVID Allan TAlen | T-11958 |

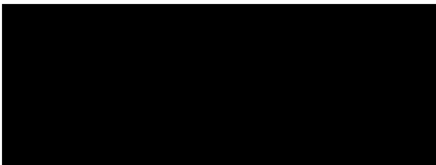
This is to certify that the above-named applicant has satisfactorily completed 12 months in a program of specialty/residency training from July '80 to June '81 at the following hospital.

| | |
|---|---|
| NAME OF HOSPITAL<br>Cook County Hospital | SEAL OF HOSPITAL |
| NUMBER AND STREET<br> | |
| CITY, STATE, AND ZIP CODE<br> | |

| DATE | SIGNATURE OF MEDICAL DIRECTOR |
|---|---|
| 11/16/81 | Conrad Tasche, M.D. |

IL 486-0265 7/81 (MD)

DAVID TAber



Work experiance

Since my graduation from College in 1976 I've been pursuing my career.
I was in medical school untill 6'80.
Since then I've been a resident in Internal Medicine At Cook County Hospital.

This is to certify that I, ______________________ am personally acquainted with DAviD Taber ______________________, 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. ______ Taber ______________, who graduated from University of Illinois and was issued the degree and diploma of Doctor of Medicine on the 6 day of June, 19 80; and that Dr. Taber ______________ is of good moral character and professional background. I further endorse Dr. Taber ______________________'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. Taber ______________ and that I personally viewed the original medical diploma of this applicant.

Signed ______________________

______________________
PRINTED NAME

State of Illinois Medical Certificate No.

36-047731
PRINT NUMBER

State of Illinois in the County of ______________________

Subscribed and sworn to before me this 16 day of ______________, 19 81

______________________ My Commission
NOTARY PUBLIC

expires: ______________________.

My Commission Expires July 15, 1983

(MD 154)

| IMPORTANT NOTICE | |
|---|---|
| Completion of this form is required for applicant to be considered for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center. | DEPARTMENT OF<br>REGISTRATION AND EDUCATION |

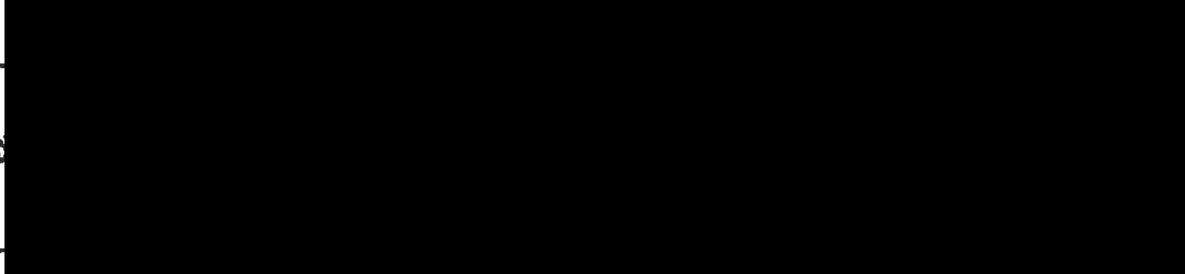
## STATEMENTS OF IDENTITY

*TO BE COMPLETED FOR APPLICANTS APPLYING FOR REGISTRATION AS A PHYSICIAN-SURGEON ONLY.*

INSTRUCTIONS TO APPLICANT: Please attach a photograph in the space provided on this form. This form must be completed by two licensed physicians who can attest to your identity and submitted with your application.

### FIRST STATEMENT

This is to certify that I, Gail Shiomoto (Print name), am personally acquainted with David Taber, who is applying for licensure as a physician-surgeon in the State of Illinois, and I hereby attest that the attached photograph is a true likeness of him/her.



### SECOND STATEMENT

This is to certify that I, ALTON WONG (Print name), am personally acquainted with DAVID TABET, who is applying for licensure as a physician-surgeon in the State of Illinois, and I hereby attest that the attached photograph is a true likeness of him/her.