APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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.

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	036	Acceptance of Exam.	$ 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.

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.
Kumaraswami	Tara	Neubert	MD	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

[redacted]

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

119 Belmont St. Worcester, MA 01605-____ USA

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)

7. MOTHER'S MAIDEN NAME: Neubert

8. PLACE OF BIRTH CITY STATE/COUNTRY: [redacted]

9. DATE OF BIRTH: [redacted] (Month Day Year)

10. AGE: 29 ☒ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (508) 334-8459 (Area Code) Home: [redacted] (Area Code)

Fax: (508) 334-5371 (Area Code) Fax: (____) ____-____ (Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) [If available]: [redacted]

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

NAME (Last, First, MI): Kumaravelu, Tara, N

SS#: [redacted]

Profession: Physician

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
Acton Boxborough Regional HS	Acton, MA	06 / 1998 (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
University of Massachusetts, Amherst	Amherst, MA	08/1998	06/2002	BS
University of Massachusetts Medical School	Worcester, MA	08/2002	06/2006	MD

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?
University of Massachusetts	Worcester, MA	07/2006	06/2010	☑ Yes ☐ No will complete 6/10
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Kumaraswami, Tara, N

SS#: [redacted]

Profession: Physician

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 Massachusetts State of Current Licensure where you most recently have been practicing.	Physician	228346	5/3/2006	Active
Other States of Licensure				

(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
USMLE Step 1	MA	6/2004	[redacted]
USMLE Step 2	MA	7/2005	
USMLE Step 3	MA	10/2007	

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

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.*		NA
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] 3/9/10

Signature of Applicant 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.

NAME (Last, First, MI): Kumarowski, Tara, N

SS#: [redacted]

Profession: Physician

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VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

Kumaraswami Tara N

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

09 / 29 / 80
Month Day Year

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☑ Permanent Physician License	036
☐ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

5. SOCIAL SECURITY NUMBER

[redacted]

6. MAIDEN OR GIVEN SURNAME

[redacted]

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION

University of Massachusetts

ADDRESS STREET, CITY, STATE, ZIP CODE

119 Belmont St. J4
Worcester, MA 01605

DATE OF EMPLOYMENT/ATTENDANCE

From 07 / 01 / 2006
Month Day Year

To 06 30 2010
Month Day Year

HOURS WORKED PER WEEK

80

TYPE OF EMPLOYMENT

☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

48 months

JOB TITLE

Resident Physician

DESCRIPTION OF DUTIES PERFORMED

OB/GYN resident physician, including Labor & Delivery, surgery and outpatient clinic.

B. NAME OF BUSINESS / INSTITUTION

University of Massachusetts

ADDRESS STREET, CITY, STATE, ZIP CODE

55 Lake Ave North
Worcester, MA 0

DATE OF EMPLOYMENT/ATTENDANCE

From 08 / 01 / 2002
Month Day Year

To 06 / 04 / 2006
Month Day Year

HOURS WORKED PER WEEK

40+

TYPE OF EMPLOYMENT

☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

4 yrs

JOB TITLE

medical student

DESCRIPTION OF DUTIES PERFORMED

medical student

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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
Kumaraswami Tara Neubert	[redacted] Month Day Year	[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.	
6. MAIDEN OR GIVEN SURNAME	Physician (Profession Name)	036 (Profession Code)
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 THE APPLICANT.

This is to certify that the above-named applicant will satisfactorily completed 48 months of postgraduate clinical training in Obstetrics & Gynecology (Name of Specialty Program)

from 07/01/2006 (MM/DD/YYYY) to 06/30/2010 (MM/DD/YYYY) at the following hospital:

Hospital: University of Massachusetts Umass Memorial Health Care

Number and Street: 119 Belmont St. J4

City, State and Zip Code: Worcester, MA 01605

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

- [x] the ACGME
- [ ] the AOA
- [ ] the CFPC, RCPSC or FMLAC (Canadian Programs)
- [ ] not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: Petra H. Belady MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 12/3/10

Telephone No: [redacted]

Letterhead

IL486-1536

OK

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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: Kumarasuami — FIRST: Tara — MIDDLE: N

2. DATE OF BIRTH [redacted] (Month Day Year)

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 [redacted]

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

U. of Massachusetts Medical School
Name of Medical College

Michael F. Baker, M.A. Registrar
Type Name of Dean of Medical College

55 Lake Avenue North
Street Address

February 11, 2010
Date

Worcester — MA — 01655
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

Name of Clinical Teaching Facility

Type Name of Administrator of Clinical Teaching Facility

Street Address

Date

City — State — Zip Code