000500 00103

(DO 3E THIS APPLICATION FOR RENEWAL OF AN EXISTING L)

IMPORTANT NOTICE: Completion of this form is required by 720 of the Illinois Compiled Statutes (Chap. 56 1/2, of the Ill. Rev. Stat. 1985). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application. This form has been approved by the Forms Management Center.

OPTOMETRISTS AND PHYSICIANS
APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

DO NOT SUBMIT APPLICATION UNTIL A PERMANENT PRACTITIONERS LICENSE HAS BEEN ISSUED!
CONTROLLED SUBSTANCES LICENSE WILL NOT BE ISSUED TO A TEMPORARY LICENSE-HOLDER!

1. Every person who prescribes or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Professional Regulation in accordance with the Illinois Controlled Substances Act.
2. A separate controlled substances registration is required for each place of professional practice or business where controlled substances are stored or located.
3. A State Controlled Substances Registration is prerequisite to a Federal Controlled Substances Registration.

A. Type or print legibly with black ink only.

B. The fee is $5 - Make check payable to the Department of Professional Regulation. THIS FEE IS NOT REFUNDABLE! (Separate application/fee is required for each registration.)

C. Disclosure of your U.S. mandatory. This disclosur 100/10-65. The social sec of Public Aid to assist in the days delinquent in comply

GILLIAM, MELISSA LYNN MD
3036 file# 62232 09-14-99
BY: NON-EXAM ASG: UNASSIGN
SSN: 577960834

D. Submit application and fee to:

Department of Profes l Regulation
320 West Washingtor
Springfield, Illinois 62

336061678

CHECK A BOX INDICATING THE APPROPRIATE INFORMATION REG
(Do not use this form to renew existing Regist

☑ First Time Applicant ☐ Additional Location (separate o

PART I: Application Category Information

1 PROFESSIONAL NAME	2 PROFESSIONAL CODE Check applicable box	3 LICENSURE METHOD	4 FEE
Controlled Substances	☐ 3046 (Optometrist) ☒ 336 (Physician)	Registration	$5

PART II: Applicant Identifying Information

1 NAME LAST	FIRST	MIDDLE	2 TITLE (e.g., M.D., O.D. etc.)	3 UNITED STATE SOCIAL SECURITY NO
GILLIAM	MELISSA	LYNN	MD	[redacted]

4 PERMANENT MAILING ADDRESS [redacted] CITY STATE/COUNTRY ZIP CODE COUNTY

5. NAME OF BUSINESS AND LOCATION (STREET/CITY /ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED
DEPARTMENT OF OBSTETRICS and GYNECOLOGY
UNIVERSITY of Illinois at
Chicago (MC 808)
820 South Wood
Chicago IL 60612+7313

6. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

7. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Work (312) 413-0967 (Area Code)
Home [redacted] (Area Code)

PART III: Professional Activity

Practitioner - CHECK AND COMPLETE ONE OF THE FOLLOWING

Optometrist 046 - _____ (Professional License Number)
DRUG SCHEDULES
IIN IIIN IV

Physician 336 - 036-095268 (Professional License Number)
DRUG SCHEDULES (Circle the schedules for which you are applying)
(II) (IIN) (III) (IIIN) (IV) (V)

FOR OFFICIAL USE ONLY FEE $5

BNDD Number: _____

Type: Suffix:

Schedule Codes:

Additional Function: A

Card Code: K

Issuance Date (Month/Day/Year)

IL486-1813 8/98 (LT)

REVERSE SIDE MUST BE COMPLETED

PART IV: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you ever been charged or convicted of any drug related criminal offense in any state or in federal court? *If yes, attach a statement for each conviction including dates and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.*		✓
2. 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.*		✓
3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		✓
4. 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.*		✓
5. Has any previous registration held by the applicant under the Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? *If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.*		✓

PART V: Child Support Information (*This part must be completed by all applicants.*)

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.**

You **MUST** check one of the following:

- [ ] I am not more than 30 days delinquent in complying with a child support order.
- [ ] I am more than 30 days delinquent in complying with a child support order.
- [x] I am not currently under any child support order.

PART VI: Certifying Statement

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 this application to the best of my knowledge.

MELISSA GILLIAM
Print Name of Applicant

[redacted]
Signature of Applicant

August 5, 1999
Date of Application

My signature above authorizes the Department of 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.

IL 486-1813 8/98 (LT)

Application must be completed in its entirety.

If not completed, it will be returned to the address noted on front of application.