0300003408

PAGE ONE

IMPORTANT NOTICE Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes) Disclosure of this information is VOLUNTARY However failure to comply may result in this form not being processed This form has been approved by the Forms Management Center

APPLICATION FOR LICENSURE AND/OR EXAMINATION

1 0 3 1 0 3 3 2 6

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

Carefully follow all steps outlined on the INSTRUCTION SHEET In addition note the following

A Type or print legibly with black ink only

B The licensure and application fee are NOT refundable

C Disclosure of Social Security number and gender information is not mandatory It is used only to ensure identification, accuracy and to expedite processing of your application

D 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

PART I: Application Category Information

A SEE REFERENCE SHEET (PART I) PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1 PROFESSION NAME	2 PROFESSION CODE	3 LICENSURE METHOD	4 FEE
PHYSICIAN	0 3 6		$ 300

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

RECEIVED
STATE OF ILLINOIS
MAR 1 [illegible]
DEPARTMENT OF
PROFESSIONAL REGULATION

PART II: Applicant Identifying Information - You must notify the Department 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 (eg MD DDS etc)	3 SOCIAL SECURITY NUMBER
GILLIAM MELISSA LYNN	MD	[redacted]

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

5 BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
333 E. SUPERIOR Chicago, IL 6 0 6 1 1 — _ _ _ _

6 MAIDEN GIVEN SURNAME OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED (SEE D ABOVE)

7 PLACE OF BIRTH CITY STATE/COUNTRY	8 DATE OF BIRTH Month Day Year	9 AGE	
[redacted]	[redacted]	31	☑ Female ☐ Male

10 TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work ( ) _ _ _ _ _ _ _ _ _ _ Home ([redacted]
(Area Code) (Area Code)

IL486-1019 10/95 (LT)

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 GED? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION City and State	4. DATE OF GRADUATION Month / Year
Georgetown Day	Washington D.C.	06 / 84

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
Yale University	New Haven, Connecticut	9/84	6/87	BA
Oxford University	Oxford, England	09/87	06/89	MA
Harvard University	Boston, Massachusetts	9/89	6/93	MD
University of Illinois	Chicago, Illinois	9/94	6/95	MPH

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 CHICAGO	Chicago, Illinois	6/93	6/94	☐ Yes ☒ No
NORTHWESTERN UNIVERSITY	Chicago, Illinois	6/95		☒ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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: Illinois	general surgery	125029678		Active
State of Current Licensure where you most recently have been practicing: Illinois	obstetrics and gynecology	125029678	6/	Active
Other States of License:				

(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)
NMBE PART I	Massachusetts	91	PASSED
	Massachusetts	92	PASSED
USMLE Step III	Illinois	94	PASSED

(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 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 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*		✓

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 — TEST CODES

b) CHART III - Select the examination site you desire and enter Test Center Code — TEST CENTER CODE

c) CHART IV - Find your School of Graduation and enter school code — SCHOOL CODE

d) Record the number of times you have taken this exam in Illinois or any other state — EXAM ATTEMPTS

e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated? ☐ Yes ☐ No

PART VIII: 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

1/25/97 — Date

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

[illegible] 1095 (LT)

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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: Gilliam FIRST: Melissa MIDDLE: Lynn

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
Profession Name: Physician
Profession Code: 036

6 MAIDEN OR GIVEN SURNAME:

7 CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED: ☐

8 DATE FORM COMPLETED: 1/27/97

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: Northwestern Memorial hospital
JOB TITLE: Resident Physician Obstetrics and Gynecology
ADDRESS STREET CITY STATE ZIP CODE: 333 E Superior Chicago IL 60610
DESCRIPTION OF DUTIES PERFORMED: Patient Care
SUPERVISOR NAME: Sharon Dooley, MD John Scimm, MD
DATE OF EMPLOYMENT/ATTENDANCE From: 06/25/95 To: present
HOURS WORKED PER WEEK: 60
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month): 1yr and 8 months

B NAME OF BUSINESS / INSTITUTION: University of Chicago
JOB TITLE: Resident Physician - General Surgery
ADDRESS STREET CITY STATE ZIP CODE: 5812 S Maryland Ave Chicago IL 60637
DESCRIPTION OF DUTIES PERFORMED: Patient Care
SUPERVISOR NAME: Robert Baker, MD Bruce Gewertz, MD
DATE OF EMPLOYMENT/ATTENDANCE From: 06/25/93 To: 06/25/94
HOURS WORKED PER WEEK: 70
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month):

COMPLETE THE REVERSE SIDE OF THIS FORM

C NAME OF BUSINESS / INSTITUTION: University of Illinois Chicago

JOB TITLE: STUDENT

ADDRESS STREET CITY STATE ZIP CODE:

DESCRIPTION OF DUTIES PERFORMED: Masters of Public Health Student

SUPERVISOR NAME:

DATE OF EMPLOYMENT/ATTENDANCE
From 6 (Month) 6 (Day) 94 (Year)
To 6 (Month) 26 (Day) 95 (Year)

HOURS WORKED PER WEEK:

TYPE OF EMPLOYMENT
[X] Full-time [ ] Part-time

TOTAL TIME WORKED (Year/Month): days over lapped

D 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):

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):

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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: Gilliam — FIRST: Melissa — MIDDLE: Lynn

2. DATE OF BIRTH (Month Day Year): [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. ILLINOIS TEMPORARY LICENSE NUMBER (if applicable): 252767 8

8. ISSUANCE DATE: 6/24/93

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to: Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 62791

This is to certify that the above-named applicant satisfactorily completed 12 months of postgraduate clinical training in General Surgery

(Name of Accredited Postgraduate Clinical Training Program)

from 6/24/93 to 6/30/94 at the following hospital:

Hospital: University of Chicago Hospitals

Number and Street: 5841 S. Maryland Ave

City, State and Zip Code: Chgo, IL 60637

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: Robert Baker

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 2/11/97

SEAL

Telephone No: 773-702-4337

IL486-1535 4/94 (MD)

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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
Gilliam	Melissa	Lynn	[redacted]	[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 ILLINOIS TEMPORARY LICENSE NUMBER (If applicable) 125-029677

8 ISSUANCE DATE 06/22/95

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 62786

This is to certify that the above-named applicant satisfactorily completed 20 months of postgraduate clinical training in Obstetrics & Gynecology - Northwestern University
(Name of Accredited Postgraduate Clinical Training Program)

from 06/22/95 to 02/28/97 at the following hospital

Hospital McGaw Medical Center of Northwestern University

Number and Street 303 E. Chicago Avenue, Ward 9-332

City State and Zip Code Chicago, IL 60611

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 Sharon L. Dooley, MD

Signature of Postgraduate Clinical Training Program Director [redacted]

Date of this Certification 3/6/97

SEAL

Telephone No [redacted]

IL486-1535 4/96 (MD)

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

0 0 0 1 0 3 3 0 2 / 6

Diplomate Name: Melissa Lynn Gilliam, MD

Date of Birth: [redacted]

Certification Date: 07/01/1994

Certificate #: [redacted]

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat Phys	Bioc	Path	Micr Phar	Beh Sci
NBME PART I	Jun	198	176	PASS					
					Comments				
USMLE Step 2	Mar	200	167	PASS					
NBME PART III	Mar	435	315	PASS					

DATE: 02/04/1997

SEE OTHER SIDE FOR SCORE INFORMATION

FEB 10 1997

IL1060

The Federation of State Medical Boards of the United States, Inc.
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Telephone: (817) 868-4000
FAX (817) 868-4099

J u l 0 3 3 . 2 . 6

BOARD ACTION CLEARANCE REPORT

March 24, 1997

Attn: Pat Eubanks
Illinois Dept. of Reg. & Ed.
320 W. Washington Street
Springfield, IL 62786

Re: Board Action Query Dated: March 24, 1997
Your Reference Number:
FSMB Batch Number: BQ47201

The following is a final report of the search results from the Board Action Data Bank as of March 24, 1997 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of March 24, 1997

Item	Name	DOB	SSN	School	Yr/Grad	Request ID
1	Alkhayarin, Mohammed M	[redacted]		539030	1988	[redacted]
2	Alsikafi, Nejd F			014030	1997	
3	Armstrong, Jeffrey Sands			099780	1986	
4	Baluyut, Irene Dalusung			748040	1992	
6	Bardini, John Andrew			031010	1996	
5	Baronofsky, Ian David			033070	1996	
7	Betancourt, Joanna Elena			935030	1994	
8	Biesterfeld, Susan Lynn			099791	1996	
9	Bond, Michael Ian			014010	1997	
10	Boppana, Rama Swami			495530	1976	
11	Bullard, Scott Jay			014040	1990	
12	Butz, Steven Frederick			014060	1993	
13	Cunnar, James George			014080	1994	
14	Diudea, Dana Marietta			781020	1989	
15	Etter, Nancy J			099790	1979	
16	Frader, Joel Edward			022040	1974	
17	Freeman, Marlene Elizabeth			026050	1993	
18	Ghaleb, Ahmed Hussein			915050	1990	
19	Gilliam, Melissa Lynn			022020	1993	
20	Gonnella, George Ralph			014010	1997	
21	Gorski, Marie Jane			014042	1992	
22	Gupta, Rajat			495195	1983	
23	Habeeb, Baher Nazmy			915040	1992	
24	Jackson, Robyn Anne			028010	1994	