PAGE ONE

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter III of the Illinois Revised Statutes. This form has been approved by the Forms

APPLICATION FOR LICENSURE AND/OR EXAMINATION

Management Center.		URE AND/OR EKAMIN	
for Licensure and/or Examination	on in Stantors:	Carefully follow all steps outlined SHEET. In addition, note the foll	on the INSTRUCTION owing:
Four page APPLICATION I OR EXAMINATION.		distribution and increasing the control of the	
2. INSTRUCTION SHEET, was application instructions for your profess. 3. REFERENCE SHEET, which information for your profess. 4. SUPPORTING DOCUMENT documentation you may be your application.	ich gives detailed coding ion. TS, forms, and/or any other	C. Disclosure of Social Security no It is used only to ensure identic expedite processing of your ap D. If the name shown on your so different from that shown on your submit proof of legal name chalicense, divorce decree, affiday	umber is not mandatory. fication, accuracy and to eplication. supporting documents is our application, you must hange - copy of marriage
CHECK BOX INDICATION	NG THE APPROPRIATE I	NFORMATION REGARDING YOU	R APPLICATION.
This is the first time I had this profession in Illinois. I have previously made applying Illinois. However, my present I am now reapplying. Other:	ication for this profession	 My application for this profess denied in Illinois. I am reapply additional requirements. I have previously made application. Illinoisa However, I am no statutory language. 	ring since I have fulfilled attion for this profession
Professional Control of the Control			
PART I: Application Category	Information (See REFERE	NCE SHEET, CHART I, prior to c	ompleting PART I.)
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PAGE TWO

PART III: Education information		0			
1. PRELIMINARY EDUCATION (Elementary and High Sci	hool or G.E.D. Circle number of years	completed)			
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HARVARD University	BOSTON N	IA 9	189	6 93	MD
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7 SPECIALIZED TRAINING (Residency, Professional T	raining, Vocational Training, Practical	or Clinical Training)			
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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, trainly 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	(Active, Lapsed, etc.)
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(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	MONTHYEAR	EXAM RESULTS
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PAGE FOUR

	FAGE FOOR	YES	NO
STORAGE S	Personal History Information (This part must be completed by all Applicants)	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 statement for each conviction including date and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.		V
	Do you now suffer, have you suffered from, been diagnosed to any disease or condition which is generally regarded by the medical community as chronic, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance and (3) physical disease or condition that presently interferes with your ability to practice your proposition? If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.		V
	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 litensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.		J
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.	١,	/
5.	Are you a U.S. citizen OR a lawfully admitted alien of the United States?		
P	RT VII: Examination Coding Information (This part is for Examination Applicants only)	11.11.11.11.11	a particular
Charles of			
Re	fer 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.		\blacksquare
	CHART III - Select the examination site you desire and Test Center Code. CHART IV - Find your School of Graduation and enter school code. Record the number of times you have taken this exam in Illinois or any other state. Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated? TEST CENTER CODE TEST CENTER CODE 1131 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
P	ART VIII: Certifying Statement		1000
U	nder penalties of perjury, I declare that I have examined the application and all supporting documents subminection therewith, and to the best of my knowledge, they are true, correct, and complete.		ne in
١,	ou must notify the Department of Professional Regulation and/or Continental Testing Servicing, of any address changes after you file this application in order to receive any further on regarding your application.	rice <u>in</u> r infor	ma-

PRINTED BY THE THE STATE OF ITLINOIS
05-92/58,975/P.O. #X19808
PRINTED ON RECYCLED PAPER

important Notice: 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.

CERTIFICATE OF ACCEPTANCE FOR

CA-MED

SUPPORTING DOCUMENT

been approved by the Forms Manage- ment Center.	SPECIALTY / RE	ESIDENCY PROGRAM	
NOTE: An applicant shall not commen of his application from the De		ining before he or the hospital/institution legulation.	receives written notice of the approval
APPLICANT: Complete the Applicant section training, for completion of the		rd it to the hospital/institution that has ac	cepted you for specialty/residency
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6. MAIDEN OR GIVEN SURNAME		Temporary Licensure	Profession Code
ADMINISTRATORS Compiled the remains	ler of this form and return	It to the applicant.	
A. HOSPITAL/INS. ITUTION NAME		B. BEGINNING DATE	
University of Chicago	Hospitals	06 / 24 / 93 Month Day Year	
C. BUSINESS ADDRESS STREET, CIT 5841 S. Maryland Ave., Chicago, IL 60637	Y, STATE, ZIP CODE MC6040	O. ENDING DATE 06 30 96 Month Day Year	
E. BUSINESS TELEPHONE NUMBER Area Code (312) 702 _	6337	F. SPECIALTY / RESIDENCY NAME Surgery	G. YEAR OF POSTGRADUATE TRAINING PGY I
I do hereby declare that the above nar to the evaluation of medical education eligible for licensure.	med applicant will be ac n and/or clinical skills b	scepted for specialty/residency training by the Department of Professional Residence of Bruce L. Gew	gulation, the applicant is found to be
SEAL		Chairman, De	pt. of Surgery pt. of Surgery , General Surgery Residence Title

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.	CERTIFICATION	OF EDUCATION	ED-MED
APPLICANT: Complete the applicant section	on of this form, then forward it to	the school for completion of the remu	under of the form.
1. NAME LAST FIRST			3. SOCIAL SECURITY NUMBER
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or its designated testing service the info	- March 28, 1993	A STREET OF THE STREET	of Applicate
A. NAME OF INSTITUTION	20/	B. ADDRESS OF INSTITUTION	STREET, CITY, STATE, ZIP CODE
Harvard Medical Schoo		25 Shattuck Street Boston, Massachusetts	s 02115
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	OB ZEVE SCHOOF
NOTE: If the institution does not have a school seal, this form must be notarized.	100405
April 1, 1993	Registrar
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SOUR THE SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE REPLICANCES

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been ap- proved by the Forms Management Center.	WORK	HISTORY 0 2 7)	WH
APPLICANT: Complete Work His photocopy this form	story. If you have never be If additional space is requ		box 8. You are authorized to
I. NAME LAST FIRST		2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
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6. MAIDE : OF GIVEN SURNAME		7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED	MARCH 28, 1993
9. RECORD WORK HISTORY CHRONO with graduation. You must account	DLOGICALLY - Complete W nt for the entire time perio	Vork History beginning with pr d including periods of unemplo	esent employment and concluding yment and volunteer work, etc.
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MAY 15, 1993

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DEAR MELISSA I GILLIAM MD

Your application for temporary licensure in Illinois has been approved and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 06/24/93. Assuming you remain in the training program listed below, this license will be valid until 06/23/96.

PROGRAM: SURGERY TRAINING
TRAINING FACILITY: UNIV OF CHICAGO HOSPS

Please note that utilization of this license is limited to only the training program listed above. It may not be used for any clinical medical practice which occurs outside the residency program; i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferable from one program/institution to another.

Applications for temporary licensure transfers must be filed with the Department at least 60 days prior to commencement of the new program. You are not eligible to begin a new training program until your current temporary license has been returned to the Department and a license has been issued for the new program.

Please be aware that the Medical Practice Act sets forth the appropriate use of the temporary license and any violation of that Act may result in disciplinary action by this Department.

If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department of Professional Regulation, 320 West Washington Street, Springfield, Il 62786.

Sincerely,

Pat Eubanks, Manager Medical Unit IMPORTANT NOTICE: Completion of this form is necessary for consideration for Scaneure under 225 of the litinois Complied Statutes (Chapter 111 of the litinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been compared by the Forms Management. Center.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

in this form not being processed. This form has been approved by the Forms Management. Center.		ENSURE AND/OR EXAM	INATION
The following materials are required Licensure and/or Examination in Illinois 1. Four page APPLICATION FOR EXAMINATION. 2. INSTRUCTION SHEET, which application instructions for your profession. 3. REFERENCE SHEET, which information for your profession. 4. SUPPORTING DOCUMENTS, it documentation you may be required application.	gives step by ste ofession. gives detailed codin forms, and/or any other ared to submit with you	In addition, note the following: A. Type or print legibly with black in the licensure and application for the licensure and application for the licensure of Social Security nursed only to ensure identification processing of your application. D. If the name shown on your support from that shown on your application.	nk only. see are NOT refundable. mber is not mandatory. It is n, accuracy and to expedite orting documents is different tion, you must submit proof
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4. PERMANENT MAILING ADDRESS	STREET C	ITY STATE/COUNTRY ZIP CODE	COUNTY
5. BUSINESS ADDRESS STREET		CORTING DOCUMENTS WILL BE SUBMITTED.	COUNTY

DATE OF BIRTH

Home

Area Code

Section 1975

(SEE D ABOVE)

7. PLACE OF BIRTH

CITY

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ON□ S⊖Y[Receivi D RO d	Graduated High School? ☑ Yes ☐ No	21 11 01 6 8 7 9 3 4 5 5 1
			rool or G.E.D. Circle number of years completed)	1 PRELIMINARY EDUCATION (Elementary and High Sci
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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 everyheld a temporary, trainage 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	(Active, Lapsed, etc.)
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State of Current Ucensure where you most recently have been practicing.	1 1 3			
Other States of Liganeurs				
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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	MONTHYEAR	EXAM RESULTS
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(If additional space is needed, attach a separate sheet.)

ı	equirec	My signature above authorizes the Department of Professional Regulation to reduce the amount of this check if amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the reconder, but in no event shall such reduction be made in an amount greater than \$50.
	041	Signature of Applicant Department of Professional Beautation to reduce the amount of this check if
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ni e	q pì we	Under penalties of perjury, I declare that I have examined the application and all supporting documents submitte connection therewith, and to the best of my knowledge, they are true, correct, and complete.
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		Ousqnsueq; □ Les □ No
		e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you
		or any other state.
		d) Record the number of times you have taken this exam in Illinois
		equooj code:
		c) CHART IV - Find your School of Graduation and enter
		b) CHART III - Select the examination site you desire and enter Test Center Code.
		TEST CENTER CODE
	\Box	and enter Test Codes.
		a) CHART II - Select examination(s) you desire
		Refer to the REFERENCE SHEET enclosed with this application package and complete the following:
		PART VII: Examination Coding Information (This part is for Examination Applicants only)
	×	5. Are you a U.S. citizen OR a lawfully admitted alien of the United States?
		federal position? If yes, attach a detailed explanation.
X		4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or
X		professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.
X		3. Have you been denied a protessional license or permit, or privilege of taking an examination, or had a
		If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.
X		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?
^		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
	1	offense and date of discharge, if applicable, as well as a statement from the probation or parole office.
Χ		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
ON	KES	PART VI: Personal History Information (This part must be completed by all Applicants)
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PRINTED BY THE AUTHORITY OF TALLINGIS 12-94/603025/REQ.# X34469 PRINTED ON RECYCLED PAPER

(1.3) 100 0101-000.E

April 3, 1995

State of Illinois Department of Professional Regulation

To whom it may concern:

Tam writing to request reactivation and transfer of my temporary license for the state of l'linois. It was issued with a beginning date of 6/24/93 for surgery training at the University of Chicago Hospitals.

I specifione year at the University of Chicago from June of 1993 until June of 1994. Having decided to change specialties, I will begin a program in obstetrics and gynecology in June of 1995 at Northwestern University In the intervening year, I have earned a Masters in Public Health at the University of Illinois and have been employed as a molecular virology researcher at Northwestern University.

Thank you for your time and consideration.

Sincerely,

Melissa Gilliam

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Till to	Sec. 3.4	17.5	1.3	1	1

MPORTANT NOTICE: Completion of this form is nec-teary for consideration for licensure under 225 of the lines Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is SUPPORTING DOCUMENT WORK HISTORY VOLUNTARY, However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management. Center. wн 0010270 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. MIDDLE 2. DATE OF BIRTH SOCIAL SECURITY NUMBER GILLIAM MELISSA LYNN ADDRESS STREET, CITY, STATE, ZIP CODE REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. TEMPORARY Physician Licen. 1 2 5 6. MAIDEN OR GIVEN SURNAL CHECK HERE IF YOU DATE FORM COMPLETED HAVE NEVER BEEN EMPLOYED 4/3/95 RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including pariods of unemployment and volunteer work, etc. A. NAME OF BUSINESS/INSTITUTION JOB TITLE ADDRECT STREET, CITY, STATE, ZIP CODE UniversiT LABORATORY RESEARCH DESCRIPTION OF DUTIES PERFORMED 333 East Superior MOLECULAR YIROLOGY Chicago, IL 60611 SUPERVISOR NAME PATRICIA GARCIA, MD RESEARCH DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK 30 From 0 7 20 1 29 4 TYPE OF EMPLOYMENT 0 6 /2 0 /9 5 Month Day Year TOTAL TIME WORKED (Yr/Mo.) B. NAME OF BUSINESS/INSTITUTION JOB TITLE INTERN IN GENERAL SURGER'DESCRIPTION OF DUTIES PERFORMED UNIVERSITY OF CHICAGO HOSPITAL 58415. MARYLAND FLOOR MANAGEMENT OF CHILAGO , IL PATIENTS SUPERVISOR NAME BRUCE GEWERT?

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STATE OF ILLINOIS DEPARTMENT OF PROFESSIONAL REGULATION NIKKI M. ZOLLAR DIRECTOR

MAY 15, 1993

MELISSA I CILITAN OD U 0 1 0 2 7 0 1 2 8

DEAR MELISSA D GILLIAM MD

Your application for temporary licensure in Illinois has been approved and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 06/24/93. Assuming you remain in the training program listed below, this license will be valid until 06/23/96.

PROGRAM: SURGERY TRAINING TRAINING FACILITY: UNIV OF CHICAGO HOSPS

Please note that utilization of this license is limited to only the training program listed above. It may not be used for any clinical medical practice which occurs outside the residency program; i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferable from one program/institution to another.

Applications for temporary licensure transfers must be filed with the Department at least 60 days prior to commencement of the new program. You are not eligible to begin a new training program until your current temporary license has been returned to the Department and a license has been issued for the new program.

Please be aware that the Medical Practice Act sets forth the appropriate use of the temporary license and any violation of that Act may result in disciplinary action by this Department.

If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department of Professional Regulation, 320 West Washington Street, Springfield, Il 62786.

Sincerely,

Pat Eubanks, Manager Medical Unit

IMPORTANT NOTICE: 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.

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY / RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

NOTE: An applicant shall not commence specialty (residency training helpse he) the hospital /intitution relives written notice of the approval of his application from the Department of Professional Regulation. APPLICANT: Complete the Applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the remainder of the form. 2. DATE OF BIRTH 3. SOCIAL SECURITY NUMBER 1. NAME LAST FIRST MIDDLE GILLIAM MELISSA LYNN 4. ADDRESS STREET, CITY, STATE, ZIP CODE REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Hilnols application, 6. MAIDEN OR GIVEN SURNAME TEMPORARY LICENSURE Profession Code Profession Name ADMINISTRATOR: Complete the remainder of this form and return it to the applicant. A. HOSPITAL/INSTITUTION NAME B BEGINNING DATE McGaw Medical Center of Northwestern Univ. 0 6 / 2 0 / 9 5 Month Day Year D. ENDING DATE C. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE 303 E. Chicago Ave. Ward 9-332 0 6 / 1 9 / 9 8 Month Day / Year Chicago, Il 60611 F. SPECIALTY / RESIDENCY G. YEAR OF POSTGRADUATE E. BUSINESS TELEPHONE NUMBER TRAINING OBSTETRICS-Area Code (3 1 2) 5 0 3 - 7 9 7 5 GYNECOLOGY PGY 1 I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Professional Regulation, the applicant is found to be eligible for licensure. Signature of Program Director Sharon Dooley, MD SEAL Residency Program Director 4/10/95 Date

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Northwestern University Medical School



Graduate Medical Education

Ward Building 9-332 303 East Chicago Avenue Chicago, Illinois 60611-3008 (312 : 503-7975 Eax : 312) 503-5230 Robert M. Vanecko, MD Associate Dean

Leo Gotton, D | U 2 7) | 8

April 10, 1995

Ms. Patricia Eubanks
Unit Manager
Illinois Department of Professional Regulation
Modical Unit
320 W Washington Street, 3rd Flr.
Springfield, Illinois 62786

RE:

Melissa Gilliam, MD

SS#

Dear Ms. Eubanks:

I am writing to request that the Illinois temporary medical license for Melissa Gilliam, MD be reactivated and transferred to the Obstetrics/Gynecology program at McGaw Medical Center of Northwestern University, effective June 20, 1995. Dr. Gilliam's original temporary medical license was issued to the University of Chicago, Surgery program. A letter from Dr. Gilliam requesting the reactivation is enclosed along with the other documents required by your office to process this request.

If you have any questions or need additional information, please contact Sarah Curtin at (312) 503-4536.

Sincerely,

Sharon Dooley, M.D.

Residency Program Director

Department of Obstetrics/Gynecology

McGaw Medical Center

THE UNIVERSITY OF CHICAGO HOSPITALS

00010270138

OFFICE OF HOUSESTAFF AFFAIRS

State of Illinois
Department of Professional Regulation
320 W. Washington
Medical Unit #1
Springfield, IL 62786

May 23, 1995

To whom it may concern:

Attached is a copy of Melissa L. Gilliams temporary license. She had requested for us to forward a copy to your office. If you need to contact Melissa, her phone number is

If you have any questions, please contract our office at (312) 702-6760. Sincerely,

The second secon

Amy Baker Program Coordinator

Room B-126 MC 1052 5841 South Maryland Aven Chicago, LLnois 60637-1470 312/702-6760

BERNARD MITCHELL HOSPITAL

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THE UNIVERSITY OF CHICAGO HOSPITALS

OFFICE OF HOUSESTAFF AFFAIRS

State of Illinois
Department of Professional Regulation
320 W. Washington
Medical Unit #1
Springfield, IL. 62786

May 23, 1995

Room B-126 MC 1052 5841 South Maryland Avenue Chicago, Illinois 60637-1470

312/702-6760

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If you have any questions, please contract our office at (312) 702-6760. Sincerely,

Amy Baker Program Coordinator

BERNARD MITCHELL HOSPITAL

CHICAGO LYING-IN HOSPITAL

WYLER CHILDREN'S HOSPITAL



IMPORTANT NOTICE: Compressor of this form is necessary for consideration for iconsular under 225 of the litting Compiled Statistics (Chapter 111 of the litting Revised Statistics). Disclosure of this information is VOLUNTARY, however, feature to comply may result in the form not being processed. This form has been expressed to the Scotter.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

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SUPPORTING DOCUMENT

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CERTIFICATION OF POSTGRADUATE GLINICAL TRAINING

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DEPARTMENT OF PROFESSIONAL REGULATION NIKKI M. ZOLLAR DIRECTOR

JUNE 23, 1995

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MELISSA L GILLIAM MD

DEAR MELISSA L GILLIAM MD

Your application for temporary licensure in Illinois has been approved and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 06/24/93. Assuming you remain in the training program listed below, this license will be valid until 06/21/97.

PROGRAM: OBSTETRICS GYNECOLOGY TRAINING TRAINING FACILITY: MCGAW MED CTR/NORTHWESTERN

Please note that utilization of this license is limited to only the training program listed above. It may not be used for any clinical medical practice which occurs outside the residency program; i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferable from one program/institution to another.

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If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department of Professional Regulation, 320 West Washington Street, Springfield, Il 62786.

Sincerely,

Pat Eubanks, Manager Medical Unit