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 Management Center.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

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 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.

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 I: Application Category Information (See REFERENCE SHEET, CHART I, prior to completing PART I.)

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physicians Licensure	1 2 5	nonexamination	$ 100.00

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., 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

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]	27

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work ( ) — Area Code
Home [redacted] Area Code

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
GEORGETOWN DAY	WASHINGTON DC	06/83 (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
Yale University	NEW HAVEN, CT	9/83	6/87	BA
OXFORD University	Oxford, England	9/87	6/89	MA
HARVARD University	BOSTON, MA	9/89	6/93	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?
				☐ Yes ☐ No
				☐ 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				
State of Current Licensure where you most recently have been practicing				
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 (Passed, Failed, Absent)
~~USMLE~~ USMLE PART I	MA	June 91	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 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.*		✓
2. Do you now suffer, have you suffered from, been diagnosed as having, or been treated for 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 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.*		✓
5. Are you a U.S. citizen **OR** a lawfully admitted alien of the United States?	✓	

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.

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

March 28, 1993
Date

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 regarding your application.

PRINTED BY THE AUTHORITY OF
THE STATE OF ILLINOIS
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 SPECIALTY / RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA - MED

J U D I O 2 7 J 1 . 8

NOTE: *An applicant shall not commence specialty/residency training before he or the hospital/institution receives 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.*

1. NAME LAST FIRST MIDDLE: Gilliam, Melissa 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 Temporary Licensure (Profession Name) 125 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

ADMINISTRATOR: *Complete the remainder of this form and return it to the applicant.*

A. HOSPITAL/INSTITUTION NAME: University of Chicago Hospitals

B. BEGINNING DATE: 06 / 24 / 93 (Month / Day / Year)

C. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE:
5841 S. Maryland Ave., MC6040
Chicago, IL 60637

D. 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 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.

[redacted]
Signature of Program Director

Bruce L. Gewertz, M.D.
Print Name of Program Director

Chairman, Dept. of Surgery
Program Dir., General Surgery Residency
Title

March 23, 1993
Date

SEAL

IL486-0272 1/89 (MD)

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.

CERTIFICATION OF EDUCATION

0 0 0 1 0 2 7 3 1 - 8

SUPPORTING DOCUMENT

ED-MED

APPLICANT: *Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.*

1. NAME LAST FIRST MIDDLE: GILLIAM MELISSA 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.
Temp. Physician Licensure (Profession Name) 125 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

7. NAME OF INSTITUTION ATTENDED: HARVARD UNIVERSITY

8. DATE OF GRADUATION/COMPLETION: 06 / 10 / 93 (Month / Day / Year)

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Professional Regulation or its designated testing service the information requested below

Melissa Gilliam March 28, 1993 [redacted]
Date Signature of Applicant

SCHOOL OFFICIAL: *Complete the bottom portion of this page and the reverse side, then return to the applicant.*

A. NAME OF INSTITUTION: Harvard Medical School

B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE
25 Shattuck Street
Boston, Massachusetts 02115

C. INDICATE YEAR BY YEAR THE DATES OF ATTENDANCE IN COLLEGE – (Both pre-medical and medical education must be included.)

From	09	07	89	To	08	31	90
From	09	01	90	To	08	31	91
From	09	01	91	To	08	31	92
From	09	01	92	To	present		
From				To			
From				To			

(Month / Day / Year)

D. Total academic years attended: 04 Years / --- Months / ---- Days
OR
Total calendar years attended: ___ Years / ___ Months / ___ Days

E. TYPE OF DEGREE OR CERTIFICATE AWARDED
Anticipated degree: M.D.

F. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET
06 / 10 / 93 (Month / Day / Year)

G. DATE THAT DEGREE ~~XXXXXXXXXXXXXXXX~~ CONFERRED is expected to be
06 / 10 / 93 (Month / Day / Year)

H. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

[ ] Applicant has graduated on ___ / ___ / ___ (Month / Day / Year)

[X] Applicant will graduate on 06 / 10 / 93 (Month / Day / Year)

[ ] Applicant has completed program on ___ / ___ / ___ (Month / Day / Year)

[X] Applicant will complete program on 06 / 10 / 93 (Month / Day / Year)

I. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:

Complete the Reverse Side of this Form

USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES

WHEN THIS FORM IS CERTIFIED PRIOR TO THE ACTUAL GRADUATION OF THE APPLICANT, THE SCHOOL OFFICIAL IS RESPONSIBLE FOR NOTIFYING THE DEPARTMENT OF PROFESSIONAL REGULATION OF ANY FAILURE ON THE PART OF THE APPLICANT TO COMPLETE THE REQUIREMENTS FOR GRADUATION

I certify that the information recorded herein is true and correct according to the official records of this institution

Carol A. Duffey
Print Name of School Official

[redacted]
Signature of School Official

Registrar
Title

April 1, 1993
Date

SCHOOL SEAL

OR

NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this day of 19

Date of Expiration

Signature of Notary Public

RETURN THIS FORM TO APPLICANT

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.

WORK HISTORY

0 0 0 1 0 2 7 0 1 3

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 FIRST MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
GILLIAM MELISSA LYNN	[redacted]	[redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
[redacted]	TEMP. PHYSICIAN LICENSURE (Profession Name) 125 (Profession Code)

6. MAIDEN OR GIVEN SURNAME	7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☒	8. DATE FORM COMPLETED
		MARCH 28, 1993

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: ~~BRIGHAM AND WOMEN'S HOSP.~~

ADDRESS STREET, CITY, STATE, ZIP CODE: ~~SGMB Longwood Ave Boston, MA 02115~~

SUPERVISOR NAME: ~~GEORGE TSAO~~

DATE OF EMPLOYMENT/ATTENDANCE: From ~~08/01/92~~ (Month/Day/Year) To ~~10/01/92~~ (Month/Day/Year)

HOURS WORKED PER WEEK: ~~50~~

TYPE OF EMPLOYMENT: ☐ Full-time ☒ Part-time

TOTAL TIME WORKED (Yr./Mo.): ~~2 MONTHS~~

JOB TITLE: ~~LAB RESEARCHER~~

DESCRIPTION OF DUTIES PERFORMED: ~~BASIC SCIENCE RESEARCH~~

B. NAME OF BUSINESS/INSTITUTION:

ADDRESS STREET, CITY, STATE, ZIP CODE:

SUPERVISOR NAME:

DATE OF EMPLOYMENT/ATTENDANCE: From ~~10/01/91~~ (Month/Day/Year) To ~~06/10/93~~ (Month/Day/Year)

HOURS WORKED PER WEEK:

TYPE OF EMPLOYMENT: ☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Yr./Mo.):

JOB TITLE: ~~UNEMPLOYED~~

DESCRIPTION OF DUTIES PERFORMED:

COMPLETE THE REVERSE SIDE OF THIS FORM

C. 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 (Yr./Mo.)

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 (Yr./Mo.)

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 (Yr./Mo.)

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

MAY 15, 1993

0 0 0 1 0 2 7 0 1 8

MELISSA L GILLIAM MD
[redacted]

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 06/23/96.

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

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

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 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, CHART I, PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
TEMPORARY Physician Licensure	1 2 5	NONEXAMINATION	$ 100.00

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: I AM REQUESTING TRANSFER OF PREVIOUS TEMPORARY LICENSE Reissue
- ☐ 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 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.)
GILLIAM	MELISSA	LYNN	M.D.

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

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

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]	29

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (3 1 2) 9 0 8 - 7 0 0 3 Area Code

Home ([redacted] Area Code

IL488-1018 8/94 (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 G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
GEORGETOWN DAY SCHOOL	WASHINGTON, DC	06/84 (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
YALE UNIVERSITY	NEW HAVEN, CT	09/83	06/87	B.A.
OXFORD UNIVERSITY	OXFORD, ENGLAND	09/87	06/89	M.A.
HARVARD UNIVERSITY	BOSTON, MA	09/89	06/93	M.D.
UNIVERSITY ILLINOIS	CHICAGO, IL	06/94	PRESENT	M.P.H

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, IL	06/93	06/94	☐ Yes ☒ No
				☐ 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	TEMPORARY Physician Licensure		6/24/93	
State of Current Licensure where you most recently have been practicing.				
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 (Passed, Failed, Absent)
NMBE I	MA	6/90	Passed
NMBE II	MA	6/93	Passed
USMLE	IL	2/94	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.*		X
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.*		X
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.*		X
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.*		X
5. Are you a U.S. citizen **OR** a lawfully admitted alien of the United States?	X	

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] April 3, 1995

Signature of Applicant — 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.

IL468-1010 6/94 (LT)

PRINTED BY THE AUTHORITY OF
THE STATE OF ILLINOIS
12-94/60;025/REQ.# X34469
PRINTED ON RECYCLED PAPER

[redacted] 0 0 1 0 2 7 0 1 - 8

April 3, 1995

State of Illinois
Department of Professional Regulation

To whom it may concern:

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

I spent one 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,

[redacted]

Melissa Gilliam

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.

WORK HISTORY

0 0 0 1 0 2 7 0 1 - 8

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 FIRST MIDDLE: GILLIAM MELISSA LYNN

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.
TEMPORARY Physician Licen. 1 2 5
Profession Name — Profession Code

6. MAIDEN OR GIVEN SURNAME:

7. CHECK HERE IF YOU HAVE **NEVER** BEEN EMPLOYED ☐

8. DATE FORM COMPLETED: 4/3/95

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 University

ADDRESS STREET, CITY, STATE, ZIP CODE: 333 East Superior
Chicago, IL 60611

SUPERVISOR NAME: PATRICIA GARCIA, MD

DATE OF EMPLOYMENT/ATTENDANCE
From 07/01/94 (Month/Day/Year)
To 06/20/95 (Month/Day/Year)

HOURS WORKED PER WEEK: 30

TYPE OF EMPLOYMENT: ☐ Full-time ☒ Part-time

TOTAL TIME WORKED (Yr./Mo.):

JOB TITLE: LABORATORY RESEARCH TECH

DESCRIPTION OF DUTIES PERFORMED:
MOLECULAR VIROLOGY RESEARCH

B. NAME OF BUSINESS/INSTITUTION: UNIVERSITY OF CHICAGO HOSPITAL

ADDRESS STREET, CITY, STATE, ZIP CODE: 5841 S. MARYLAND AVE
CHICAGO, IL

SUPERVISOR NAME: BRUCE GEWERTZ

DATE OF EMPLOYMENT/ATTENDANCE
From 06/20/93 (Month/Day/Year)
To 06/30/94 (Month/Day/Year)

HOURS WORKED PER WEEK: 60-70

TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Yr./Mo.): 12 MONTHS

JOB TITLE: INTERN IN GENERAL SURGERY

DESCRIPTION OF DUTIES PERFORMED:
FLOOR MANAGEMENT OF PATIENTS

MINOR SURGERIES

COMPLETE THE REVERSE SIDE OF THIS FORM

C. 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 (Yr./Mo.)

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 (Yr./Mo.)

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 (Yr./Mo.)

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

MAY 15, 1993

MELISSA L GILLIAM MD [redacted] 0 1 0 2 7 0 1 8

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 06/23/96.

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 before he or the hospital/institution receives 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.***

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
GILLIAM	MELISSA	LYNN	[redacted]	

4. ADDRESS STREET, CITY, STATE, ZIP CODE
[redacted]

6. MAIDEN OR GIVEN SURNAME

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

TEMPORARY LICENSURE (Profession Name) — 1 2 5 (Profession Code)

ADMINISTRATOR: ***Complete the remainder of this form and return it to the applicant.***

A. HOSPITAL/INSTITUTION NAME
McGaw Medical Center of Northwestern Univ.

B. BEGINNING DATE
06 / 20 / 95 (Month / Day / Year)

C. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE
303 E. Chicago Ave. Ward 9-332
Chicago, Il 60611

D. ENDING DATE
06 / 19 / 98 (Month / Day / Year)

E. BUSINESS TELEPHONE NUMBER
Area Code (312) 503-7975

F. SPECIALTY / RESIDENCY NAME
OBSTETRICS-GYNECOLOGY

G. YEAR OF POSTGRADUATE TRAINING
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.

[redacted]
Signature of Program Director

Sharon Dooley, MD
Print Name of Program Director

SEAL

Residency Program Director
Title

4/10/95
Date

IL486-0272 1/89 (MD)

Northwestern University Medical School

Graduate Medical Education
Ward Building 9-332
303 East Chicago Avenue
Chicago, Illinois 60611-3008
(312) 503-7975
Fax (312) 503-5230

Robert M. Vanecko, MD
Associate Dean

Leon J. Gordon, MD
Assistant Dean

0 1 0 2 7 1 1 8

April 10, 1995

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

RE: Melissa Gilliam, MD
SS# [redacted]

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,

[redacted]

Sharon Dooley, M.D.
Residency Program Director
Department of Obstetrics/Gynecology
McGaw Medical Center

THE
UNIVERSITY
OF CHICAGO
HOSPITALS

0 0 0 1 0 2 7 0 1 8

OFFICE OF
HOUSESTAFF
AFFAIRS

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

312/702-6760

BERNARD
MITCHELL
HOSPITAL

CHICAGO
LYING-IN
HOSPITAL

WYLER
CHILDREN'S
HOSPITAL

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 [redacted]

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

[redacted]
Amy Baker
Program Coordinator

MAY 30 1995

THE
UNIVERSITY
OF CHICAGO
HOSPITALS

0 0 0 1 0 2 7 [redacted] 8

OFFICE OF
HOUSESTAFF
AFFAIRS

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

312/702-6760

BERNARD
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HOSPITAL

CHICAGO
LYING-IN
HOSPITAL

WYLER
CHILDREN'S
HOSPITAL

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 [redacted]

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

[redacted]

Amy Baker
Program Coordinator

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.

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
WILLIAM	MELISSA	L.	[redacted]	[redacted]

4. ADDRESS: [redacted]

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

Physician — Profession Name: 125 — Profession Code

6. MAIDEN OR GIVEN SURNAME: —

7. ILLINOIS [illegible] LICENSE NUMBER (If applicable): 239613

8. ISSUANCE DATE: 6/23/93

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the [illegible] below on 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 7/1/93 to 6/30/94 at the following hospital

Hospital: UNIVERSITY OF CHICAGO

Number and Street: 5841 S MARYLAND AVE MC6040

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: Bruce Degenhardt, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certificate: 6/9/95

SEAL

Telephone No: 312 702 [illegible]

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.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
GILLIAM	MELISSA	L.	[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: 125 — Profession Code

6. MAIDEN OR GIVEN SURNAME:

7. ILLINOIS TEMPORARY LICENSE NUMBER (if applicable): 125-029678

8. ISSUANCE DATE: 6/23/93

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 7/1/93 to 6/30/94 at the following hospital:

Hospital: UNIVERSITY OF CHICAGO

Number and Street: 5841 S. MARYLAND AVE MC6040

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: Bruce Qawerth, M.D

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 6/9/95

SEAL

Telephone No: 312 702 0687

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

JUNE 23, 1995

0 0 0 1 0 2 7 1 1 8

MELISSA L GILLIAM MD

[redacted]

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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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