



**APPLICATION FOR LICENSE TO PRACTICE MEDICINE /
OSTEOPATHIC MEDICINE IN INDIANA**

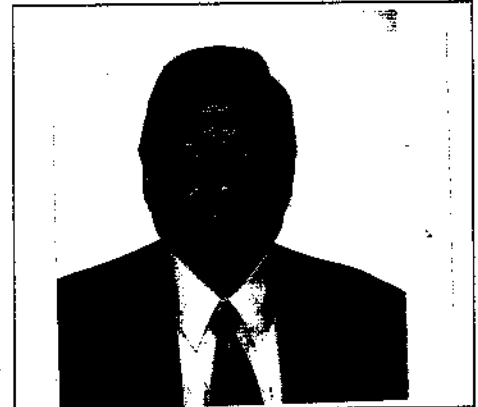
State Form 29495 (R10 / 11-01)
Approved by State Board of Accounts, 2001

Health Professions Bureau
402 W. Washington St., Room 041
Indianapolis, IN 46204
Telephone number: (317) 232-2960

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

Application fee	250.00
Date fee paid (month, day, year)	2/2/04
Receipt number	1025224
Application number	
License number	
License issuance date (month, day, year)	

Permit fee	
Date fee paid (month, day, year)	
Receipt number	
Permit number	
Permit issuance date (month, day, year)	



DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (last, first, middle, maiden)	Goyal, Vinod K.	Check one:	<input checked="" type="checkbox"/> MD <input type="checkbox"/> DO	Social Security number *	[REDACTED]
Address (number and street or Rural Route)	1640 N. Arlington Height Rd., Suite 110				
City, state, ZIP code	Arlington Heights, IL 60004				
Telephone number (daytime)	[REDACTED]	Birthdate (mo., day, yr.)	08/07/48		
		Birthplace	Amritsar, India		
E-mail address					

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit?

Yes No

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of School	Government Medical College Punjabi University	Location	Punjab, India	Date of Graduation (Month, Day, Year)	01/18/1972
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EXAMINATION

Check appropriate box(es) indicating which examination or combination of examinations you have taken.
(Please review instruction sheet for address and telephone numbers on how scores may be obtained.)

<input checked="" type="checkbox"/> FLEX EXAMINATION	<input type="checkbox"/> STATE BOARD EXAMINATION
<input type="checkbox"/> Component I <input type="checkbox"/> Component II <input type="checkbox"/> Other	Examination taken in which state?
<input type="checkbox"/> NATIONAL BOARD OF MEDICAL EXAMINERS	<input type="checkbox"/> LMCC EXAMINATION
<input type="checkbox"/> Part I <input type="checkbox"/> Part II <input type="checkbox"/> Part III	
<input type="checkbox"/> USMLE EXAMINATION	<input type="checkbox"/> NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS
<input type="checkbox"/> Step I <input type="checkbox"/> Step II <input type="checkbox"/> Step III	<input type="checkbox"/> Part I <input type="checkbox"/> Part II <input type="checkbox"/> Part III

[REDACTED]

[REDACTED]

PRE-MEDICAL / OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED
Mahendra College Punjabi University	Patiala, India	1964-1966

MEDICAL / OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED
Government Medical College Punjabi University	Patiala, Punjab, India	1966-1972

POSTGRADUATE MEDICAL / OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA (Include ALL internships, residencies and / or fellowships)			
NAME OF PROGRAM	LOCATION	FROM (month, year)	TO (month, year)
Rotating Internship	St. Elizabeth Hospital Chicago, IL	07/1972	06/1973
Obstetrics/Gynecology Residency	Mt. Sinai Hospital Chicago, IL	07/1973	06/1976

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL	
GENERAL LOCATION	DATE
Chicago, Illinois	1972-1976
Elmwood Park, Illinois	1976-1978
Wood Dale, Illinois	1978-1980
Hoffman Estates, Illinois	1980-1986
Inverness, Illinois	1986-Present

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE
Private Practice, Chicago, IL	Patient Care	1976-1979
Private Practice, Barrington, IL	Patient Care	1980-1990
Private Practice, Arlington Heights IL	Patient Care	1990-Present
Private Practice, Des Plaines, IL	Patient Care	1990-Present

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
IL	Physician & Surgeon	036-049046	03/26/1974	Active

Medical Professions Board
FEB 6 1981

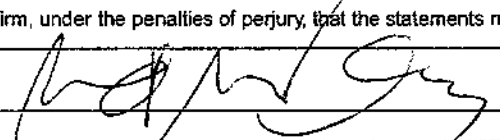
If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

- | | |
|--|---|
| 1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held? | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (including Indiana) or country? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 3. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 4. Have you ever been charged with drug addiction? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 5. Have you ever been convicted of, plead guilty or <i>nolo contendere</i> to:
A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?
B. Any offense, misdemeanor or felony in any state? (Except for minor violations of traffic laws resulting in fines.) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 8. Have you ever had a malpractice judgment against you or settled any malpractice action? | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant



Date signed (month, day, year)

1/29/2004

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for medical licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

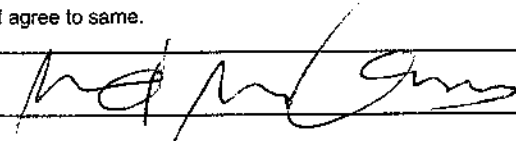
AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Date signed (month, day, year)

1/29/2004

Signature of applicant



RECEIVED
 HEALTH PROFESSIONS BUREAU OF INDIANA
 JAN 29 2004

Question 1

Vinod K. Goyal, M.D.

Date of application: January 28, 2004

1996 – Non-professional employees may have quoted the “hardship” cost for the procedure in question to patients who may not have met the hardship criteria established, thus resulting in fees that are ordinary and customary of the services rendered, but considerably higher than the quoted fee. License put on probation for two years, fined \$4,000.00.

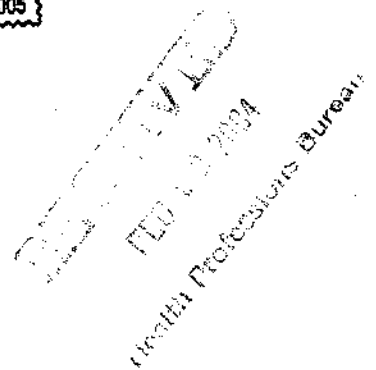
1997 – Disciplinary action for stating misleading information; license reprimanded and fine \$2,000.00.

Signed  Date: 1/29/2004

Subscribed to and sworn before me this 29 day of January, 2004.


Notary Public




RECEIVED
FEB 1 2 2004
Health Professions Bureau

Question 6

Vinod K.Goyal, M.D.

Date of Application: January 28, 2004

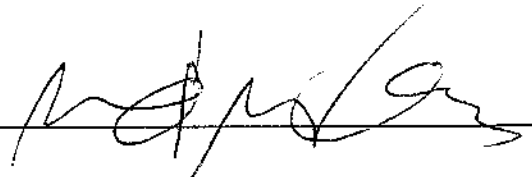
Hospital privileges not renewed for lack of clinical activity.

Gottlieb Memorial Hospital, 701 W. North Avenue, Melrose Park, IL 60160.

Privileges not renewed for lack of attendance at meetings.

Good Shepard Hospital, 450 West Highway 22, Barrington, IL 60010.

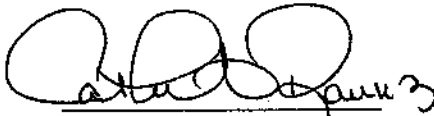
Signed: _____



Date: _____

1/29/2004

Subscribed to and sworn before me this 29 day of January, 2004.



Notary Public



ILLINOIS
JAN 29 2004
Health Professions Board

Vinod K. Goyal, M.D.
Question 8
Date of Application: January 13, 2004

Applicant Name: Goyal Vinod K
Last First MI

A. Plaintiff's Name: S D MI
Last First MI

If court case, Case Name & Case Number: _____

B. Your Involvement in the Care (Attending, Consulting, Etc.): Attending

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): Co-defendent

D. Allegations, including Patient Outcome, if Available: case of post-op pain after D& C.

E. Date of Incident (mm/yy): 1990 approx. F. Date Filed (mm/yy): _____

G. Date Case Closed (mm/yy): 1992 approx.

Resolution Case: Dismissed Judgment Arbitration Other
 Settlement out of Court Pending Mediation

H. Amount Paid on Your Behalf (if any): \$7,500

I. Professional Liability Insurer Name (if one was involved): St. Paul

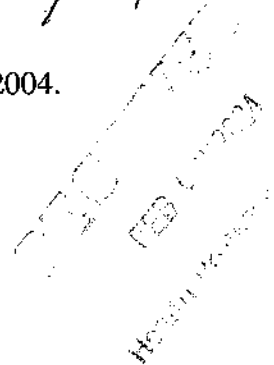
J. Insurer Telephone Number: () unknown K. Policy Number: unknown

L. Insurer Address (Street, City, State, Zip Code):
unknown

Signed: [Signature] Date: 1/29/04

Subscribed to and sworn before me this 29 day of January, 2004.

[Signature]
Notary Public



Vinod K. Goyal, M.D.

Question 8

Date of Application: January 13, 2004

Applicant Name: Goyal Vinod K
Last First MI

A. Plaintiff's Name: B N MI
Last First MI

If court case, Case Name & Case Number: _____

B. Your Involvement in the Care (Attending, Consulting, Etc.): Attending

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): Co-defendant

D. Allegations, including Patient Outcome, if Available: Case of alleged failure to diagnose ectopic pregnancy. Patient was hospitalized and underwent surgery.

E. Date of Incident (mm/yy): 1989 approx. F. Date Filed (mm/yy): _____

G. Date Case Closed (mm/yy): 1991 approx.

Resolution Case: Dismissed Judgment Arbitration Other
 Settlement out of Court Pending Mediation

H. Amount Paid on Your Behalf (if any): \$100,000

I. Professional Liability Insurer Name (if one was involved): St. Paul

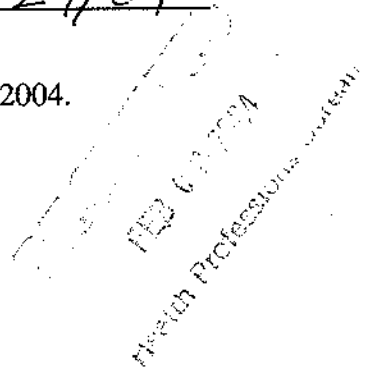
J. Insurer Telephone Number: () unknown K. Policy Number: unknown

L. Insurer Address (Street, City, State, Zip Code):
unknown

Signed: [Signature] Date: 1/29/04

Subscribed to and sworn before me this 29 day of January, 2004.

[Signature]
Notary Public



Vinod K. Goyal, M.D.
Question 8
Date of Application: January 13, 2004

Applicant Name: Goyal Vinod K
Last First MI

A. Plaintiff's Name: P J MI
Last First MI

If court case, Case Name & Case Number: _____

B. Your Involvement in the Care (Attending, Consulting, Etc.): Assistant/Co-Attending

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): Co-defendent

D. Allegations, including Patient Outcome, if Available: Case of obstetrical delivery via cesarean section by _____ assisted by Dr. Goyal. Newborn was born with low Apgar scores, fetal distress, alleged delayed cesarean section. Case settled out of court by insurance company and hospital.

E. Date of Incident (mm/yy): 1980 approx. F. Date Filed (mm/yy): _____

G. Date Case Closed (mm/yy): 1984 approx.

Resolution Case: Dismissed Judgment Arbitration Other
 Settlement out of Court Pending Mediation

H. Amount Paid on Your Behalf (if any): \$284,000 approx.

I. Professional Liability Insurer Name (if one was involved): ISMIE

J. Insurer Telephone Number: _____ K. Policy Number: unknown

L. Insurer Address (Street, City, State, Zip Code):
20 N. Michigan Avenue, Suite 700, Chicago, IL 60602.

Signed: [Signature] Date: 1/29/04

Subscribed to and sworn before me this 29 day of January, 2004.

[Signature]
Notary Public

OFFICIAL SEAL
CATHERINE RAMIREZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11-5-2005

ILLINOIS PROFESSIONAL BUREAU
FEB 1 2004

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Vinod K. Goyal, M.D.
Question 8
Date of Application: January 13, 2004

Applicant Name: Goyal Vinod K
Last First MI

A. Plaintiff's Name: M D MI
Last First MI

If court case, Case Name & Case Number: _____

B. Your Involvement in the Care (Attending, Consulting, Etc.): no clinical care for surgery

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): co-defendant

D. Allegations, including Patient Outcome, if Available: Plastic surgery case. Breast reconstruction preformed by plastic surgeon. Dr. Goyal was not involved in clinical care of the patient and was removed as a named defendant.

E. Date of Incident (mm/yy): 1996 F. Date Filed (mm/yy): _____

G. Date Case Closed (mm/yy): Dr. Goyal discharged from the case.

Resolution Case: Dismissed Judgment Arbitration Other
 Settlement out of Court Pending Mediation

H. Amount Paid on Your Behalf (if any): \$0

I. Professional Liability Insurer Name (if one was involved): Illinois Insurance Guaranty Fund

J. Insurer Telephone Number: ██████████ K. Policy Number: HCL 5972

L. Insurer Address (Street, City, State, Zip Code):
120 S. La Salle St., Suite 1910, Chicago, IL 60603

Signed: [Signature] Date: 1/29/04

Subscribed to and sworn before me this 29 day of January, 2004.

[Signature]
Notary Public



ILLINOIS
FEB 02 2004
Health Professions Board

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Vinod K. Goyal, M.D.
Question 8
Date of Application: January 13, 2004

Applicant Name: Goyal Vinod K
Last First MI

A. Plaintiff's Name: B [REDACTED] [REDACTED] MI
Last First MI

If court case, Case Name & Case Number: _____

B. Your Involvement in the Care (Attending, Consulting, Etc.): Co-Attending

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): Co-Defendent

D. Allegations, including Patient Outcome, if Available: Case of twin gestation, prenatal care and delivery of twins with alleged slower growth and development.

E. Date of Incident (mm/yy): 1979-1980 approx. F. Date Filed (mm/yy): _____

G. Date Case Closed (mm/yy): 1982

Resolution Case: Dismissed Judgment Arbitration Other
 Settlement out of Court Pending Mediation

**Case withdrawn by Plaintiff voluntarily for lack of expert testimony.*

H. Amount Paid on Your Behalf (if any): \$0

I. Professional Liability Insurer Name (if one was involved): ISMIE

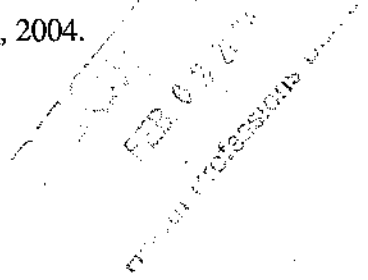
J. Insurer Telephone Number: [REDACTED] K. Policy Number: _____

L. Insurer Address (Street, City, State, Zip Code):
20 N. Michigan Avenue, Suite 700, Chicago, IL 60602

Signed: [Signature] Date: 1/29/04

Subscribed to and sworn before me this 29 day of January, 2004.

[Signature]
Notary Public



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Vinod K. Goyal, M.D.

Question 8

Date of Application: January 13, 2004

Applicant Name: Goyal Vinod K
Last First MI

A. Plaintiff's Name: I K
Last First MI

If court case, Case Name & Case Number: _____

B. Your Involvement in the Care (Attending, Consulting, Etc.): Attending

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): Co-defendent

D. Allegations, including Patient Outcome, if Available: Case of possible incomplete D&C.
Case settled by insurance company.

E. Date of Incident (mm/yy): 1989 approx. F. Date Filed (mm/yy): _____

G. Date Case Closed (mm/yy): 1991 approx.

Resolution Case: Dismissed Judgment Arbitration Other
 Settlement out of Court Pending Mediation

H. Amount Paid on Your Behalf (if any): \$7,500

I. Professional Liability Insurer Name (if one was involved): St. Paul

J. Insurer Telephone Number: () unknown K. Policy Number: unknown

L. Insurer Address (Street, City, State, Zip Code):
unknown

Signed: [Signature] Date: 1/29/04

Subscribed to and sworn before me this 29 day of January, 2004.

[Signature]
Notary Public



NOTARY
JAN 02 2004
Illinois Notations Bureau

OFFICIAL SEAL
CATHERINE RAMIREZ
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 11-5-2005

Punjabi University



Bachelor of Medicine & Bachelor of Surgery

Certified that Vinod Kumar Goyal, son/daughter of Shri Jagat Ram Goyal, and of the Government Medical College, Patiala has obtained the degree of Bachelor of Medicine & Bachelor of Surgery in this University having passed the examination for the said degree held in December 1970, and is hereby authorised to practise Medicine, Obstetrics and Surgery.

Given Under the Seal of the University.

Signed: [Signature] Date: 1/29/04

This is a true copy of the original. I have seen the original document.

Subscribed and sworn before me this 29 day of January, 2004.

Notary Public [Signature]

[Signature]
Registrar

[Signature]
Chancellor

[Signature]
Vice-Chancellor

Stamp: FEB 04 2004
PUNJABI UNIVERSITY PATIALA

St. Elizabeth's Hospital of Chicago, Inc.
U. S. A.

This Certificate is Awarded to
Winod Kumar Goyal, M.D.

and attests that the duties of the position were
satisfactorily performed in a Rotating Internship.

In Witness, whereof, we have hereunto subscribed our name and
affixed the seal of the Hospital this 13th day of June, 1973

Stanley J. Polush, M.D. F.C.P.S.
CHAIRMAN, DEPARTMENT OF SURGERY
Michael McDonald, M.D.
CHAIRMAN, DEPARTMENT OF MEDICINE
L. R. Lerman, M.D. F.A.C.P.
CHAIRMAN, DEPARTMENT OF PEDIATRICS
James H. Stegner, M.D.
CHAIRMAN, DEPARTMENT OF OBSTETRICS
Michael Marano
CHAIRMAN, MEDICAL EDUCATION
Elizabeth Goyal, M.D.
PRESIDENT, MEDICAL STAFF

178 Shornely, M.D.
DIRECTOR, MEDICAL EDUCATION
Sister M. Martiny, Admin.
ADMINISTRATOR

STANBEE - CHICAGO



Signed: *[Signature]* Date: 1/29/04

This is a true copy of the original. I have seen the original document.
Subscribed and sworn before me this 29 day of January, 2004.

[Signature]
Notary Public

Howard Simon Hospital Medical Center

Chicago, Illinois

Be it Known That

Wimod K. Goyal, M.D.

has served in the capacity of

Resident Physician

in the Department of

Obstetrics-Gynecology

for a period of 36 months ending June 30, 1976

and having satisfactorily performed all duties is granted this

Recognition

Given at Chicago, in the State of Illinois,

June 30, 1976

In Witness Whereof, the undersigned have affixed their signatures

Luch M. Cochran
Vice President and Executive Director



Richard C. Goyal
President, Board of Directors

Robert C. Goyal, M.D.
Chairman of Department

Signed: *[Signature]*

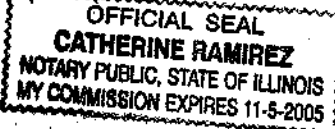
Date: 1/29/04

This is a true copy of the original. I have seen the original document.

Subscribed and sworn before me this 29 day of January, 2004.

[Signature]

Notary Public



NOTARY PUBLIC
STATE OF ILLINOIS
Catherine Ramirez
11-5-2005

Educational Council for Foreign Medical Graduates

SPONSORED BY
 AMERICAN HOSPITAL ASSOCIATION
 AMERICAN MEDICAL ASSOCIATION
 ASSOCIATION OF AMERICAN MEDICAL COLLEGES
 ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION
 FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES
 CERTIFIES THAT

VINOD KUMAR GOYAL

HAS SATISFIED ALL THE REQUIREMENTS OF THE COUNCIL
 HAS SUCCESSFULLY PASSED ITS EXAMINATION
 AND HAS BEEN AWARDED CERTIFICATE NO. 148 820 4

SEPTEMBER 15, 1971



John G. Goyen
 PRESIDENT

Gybalsey Hunt
 EXECUTIVE DIRECTOR

This is a true copy of the original. I have seen the original document.
 Subscribed and sworn before me this 29 day of September, 2004.
 Signed: *[Signature]*
 Date: 11-29/04
 CATHERINE RAMIREZ
 NOTARY PUBLIC, STATE OF ILLINOIS
 MY COMMISSION EXPIRES 11-4-2008
 Notary Public



Illinois Department of Professional Regulation

Fernando E. Grillo
Director

Rod R. Blagojevich
Governor

CERTIFICATION OF LICENSURE

HEALTH PROFESSIONS BUREAU
402 W WASHINGTON ST ROOM 041
INDIANAPOLIS, IN 46204

RECEIVED
MAR 11 2004

Licensee:	VINOD KUMAR GOVIL
License Number:	036-049046
Profession:	PHYSICIAN AND SURGEON
Date of Issuance:	03/26/1974
Expiration Date:	07/31/2005
License Status:	ACTIVE
License Method:	ENDORSEMENT - FLEX
Disciplinary History:	HAS BEEN DISCIPLINED

DISCIPLINE IS ATTACHED.

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.



Daniel E. Bluthardt
Deputy Director, Licensing & Testing

3/8/2004
Date

Refer to the Department's Web Site at www.dpr.state.il.us to verify professional licenses via License Look-Up.

Respond to:

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800
TDD 217/524-6735

www.dpr.state.il.us

James R. Thompson Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/814-4500



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

**VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 06/04/2004**

HEALTH PROFESSIONS BUREAU
402 WEST WASHINGTON STREET, ROOM W066
INDIANAPOLIS, IN 46204

NAME: Vinod K Goyal
ADDRESS: PO Box 772
Barrington IL 60010

SSN: [REDACTED]
BIRTHDATE: 08/07/1948

TYPE: Medical Doctor
LICENSE NUMBER: 4301083203
OBTAINED BY: Endorsement - Licensed > 10 Years
STATUS: Active

ORIGINAL DATE: 03/11/2004
EXPIRATION DATE: 01/31/2005

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE


JENNIFER L. SMITH

RECORDED

JUN 14 2004

Health Information Bureau



Illinois Department of Professional Regulation

Fernando E. Grillo
Director

Rod R. Blagojevich
Governor

RECEIVED

MAR 11 2004

Health Professionals Bureau

CERTIFICATION

I, Daniel E. Bluthardt, do hereby certify that I am designated by the Director as keeper of the records and seal of the Department of Professional Regulation, a department of the State of Illinois. Such document(s) attached hereto are certified copies of the records maintained by this Department.

IN WITNESS WHEREOF, I have set my hand and Seal of the said Department of Professional Regulation at Springfield, Sangamon County, Illinois this 8th day of March, 2004.



Daniel E. Bluthardt
Deputy Director
Licensing & Testing Division

Respond to:

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800
TDD 217/524-6735

www.dpr.state.il.us

James R. Thompson Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/814-4500

STATE OF ILLINOIS

DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION)
of the State of Illinois, Complainant)
v.) No. 93-4393-LEG
VINOD KUMAR GOYAL)
License No. 036-049046, Respondent)

NOTICE OF PRELIMINARY HEARING

TO: VINOD KUMAR GOYAL
P.O. Box 772
Barrington, Illinois 60010

PLEASE TAKE NOTICE that on May 13, 1996, at 9:30 a.m., you are directed to appear before the Medical Disciplinary Board of the Department of Professional Regulation of the State of Illinois located at 100 West Randolph Street, Suite 9-300, Chicago, Illinois 60601, at which time a hearing date will be set. You are requested to then and there present any and all routine motions you may wish to have heard regarding the charges contained in the attached Complaint. Any motions presented on the above date should be served on the Adjudicative Services Unit of the Department of Professional Regulation, at 100 West Randolph Street, Suite 9-300, Chicago, Illinois 60601, at least three (3) business days in advance of the scheduled meeting.

Your appearance on the scheduled date is mandatory and failure to so appear may result in the selection of a hearing date in your absence, unless a continuance has been secured in advance of the meeting. Your appearance may be made personally or through counsel.

It is required that you file a VERIFIED ANSWER to the attached Complaint with the Department of Professional Regulation by the date of the Preliminary Hearing.

RULES OF PRACTICE IN ADMINISTRATIVE HEARINGS IN THE DEPARTMENT OF PROFESSIONAL REGULATION AND BEFORE COMMITTEES OR BOARDS OF SAID DEPARTMENT are available upon request.

DEPARTMENT OF PROFESSIONAL REGULATION of
the State of Illinois

BY: John M. Goldberg
John M. Goldberg
Attorney for the Department

John M. Goldberg
Attorney for the Department
of Professional Regulation
of the State of Illinois
100 West Randolph Street
Suite 9-300
Chicago, Illinois 60601
312/814-4564

JMG:reu

STATE OF ILLINOIS

DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION)	
of the State of Illinois,	Complainant)
v.)
VINOD KUMAR GOYAL)
License No. 036-049046,	Respondent)
		No. 93-4393-LEG

COMPLAINT

Now comes the DEPARTMENT OF PROFESSIONAL REGULATION of the State of Illinois, by its Acting Chief of Medical Prosecutions, Tommy Brewer, and as its COMPLAINT against Vinod Kumar Goyal, Respondent, complains as follows:

COUNT I

1. Vinod Kumar Goyal is presently the holder of a Certificate of Registration as a Physician and Surgeon in the State of Illinois, License No. 036-049046, issued by the Department of Professional Regulation of the State of Illinois. Said license is presently in active status.
2. At all times contained herein the Respondent was practicing medicine in the Chicago-land Area utilizing the names of The Center for Family Health Care, Dimensions Medical Center, American Health Center, Access Health Center, and others.
3. On August 7, 1992 the Respondent entered into a Physician-patient relationship with Felicia Feldman for the purpose of performing a therapeutic abortion.
4. Prior to learning that Felicia Feldman had medical insurance the patient was advised that the total cost

for the procedure would be Three Hundred Forty (\$340.00) Dollars.

5. Felicia Feldman's insurance company was billed Three Thousand Seven Hundred and Ninety One (\$3791.00) Dollars for the aforesaid Three Hundred Forty (\$340.00) Dollars procedure.
6. The foregoing acts and/or omissions are grounds for revocation or suspension of a Certificate of ~~Registration pursuant to 225 Illinois Compiled Statutes~~ (1992), paragraph(s) 60/22 (a) (6) and (25).

WHEREFORE, based on the foregoing allegations, the DEPARTMENT OF PROFESSIONAL REGULATION of the State of Illinois, by Tommy Brewer, its Acting Chief of Medical Prosecutions, prays that the Physician and Surgeon license of Vinod Kumar Goyal be suspended, revoked, or otherwise disciplined.

COUNT II

1. The Department re-alleges paragraph 1 of Count I as paragraph 1 of Count II.
2. The Department re-alleges paragraph 2 of Count I as paragraph 2 of Count II.
3. On September 21, 1991 the Respondent entered into a Physician-patient relationship with Tina Lamb for the purpose of performing a therapeutic abortion.
4. Prior to the procedure Tina Lamb and her mother, Debra Lamb, were told that the total cost for the procedure would be Three Hundred Fifty (\$350.00) Dollars.
5. Tina Lamb's insurance company was billed Three Thousand Four Hundred and Thirty (\$3430.00) Dollars

for the aforesaid Three Hundred Fifty (\$350)⁰⁰ Dollars procedure.

6. The foregoing acts and/or omissions are grounds for revocation or suspension of a Certificate of Registration pursuant to 225 Illinois Compiled Statutes (1992), paragraph(s) 60/22 (a) (6) and (25).

WHEREFORE, based on the foregoing allegations, the DEPARTMENT OF PROFESSIONAL REGULATION of the State of Illinois, by Tommy Brewer, its Acting Chief of Medical Prosecutions, prays that the Physician and Surgeon license of Vinod Kumar Goyal be suspended, revoked, or otherwise disciplined.

COUNT III

1. The Department re-alleges paragraph 1 of Count I as paragraph 1 of Count III.
2. The Department re-alleges paragraph 2 of Count I as paragraph 2 of Count III.
3. On December 30, 1992 the Respondent entered into a Physician-patient relationship with Vicki Cuiert for the purpose of performing a therapeutic abortion.
4. Prior to the procedure Vicki Cuiert was told that the total cost for the procedure would be Six Hundred (\$600.00) Dollars.
5. Vicki Cuiert's insurance company was billed Three Thousand Five Hundred and Twenty-Four (\$3524.00) Dollars for the aforesaid Six Hundred (\$600.00) Dollars procedure.
6. The foregoing acts and/or omissions are grounds for revocation or suspension of a Certificate of

Registration pursuant to 225 Illinois Compiled Statutes (1992), paragraph(s) 60/22 (a) (6) and (25).

WHEREFORE, based on the foregoing allegations, the DEPARTMENT OF PROFESSIONAL REGULATION of the State of Illinois, by Tommy Brewer, its Acting Chief of Medical Prosecutions, prays that the Physician and Surgeon license of Vinod Kumar Goyal be suspended, revoked, or otherwise disciplined.

COUNT IV

1. The Department re-alleges paragraph 1 of Count I as paragraph 1 of Count IV.
2. The Department re-alleges paragraph 2 of Count I as paragraph 2 of Count IV.
3. On March 16, 1993 the Respondent entered into a Physician-patient relationship with Eleanor Buckles for the purpose of performing a therapeutic abortion.
4. Prior to the procedure Eleanor Buckles was told that the total cost for the procedure would be Three Hundred Ninety (\$390.00) Dollars.
5. Eleanor Buckles's insurance company was billed Three Thousand Seven Hundred and Eighty Six (\$3786.00) Dollars for the aforesaid Three Hundred Ninety (390.00) Dollars procedure.
6. The foregoing acts and/or omissions are grounds for revocation or suspension of a Certificate of Registration pursuant to 225 Illinois Compiled Statutes (1992), paragraph(s) 60/22 (a) (6) and (25).

WHEREFORE, based on the foregoing allegations, the DEPARTMENT OF PROFESSIONAL REGULATION of the State of Illinois, by

Tommy Brewer, its Acting Chief of Medical Prosecutions, prays that the Physician and Surgeon license of Vinod Kumar Goyal be suspended, revoked, or otherwise disciplined.

DEPARTMENT OF PROFESSIONAL REGULATION of
the State of Illinois

BY:  MAB

TOMMY BREWER
ACTING CHIEF OF MEDICAL PROSECUTIONS

John M. Goldberg
Attorney for the Department
of Professional Regulation
of the State of Illinois
100 West Randolph Street
Suite 9-300
Chicago, Illinois 60601
312/814-4564

TB:JMG:reu

STATE OF ILLINOIS

DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION)	
of the State of Illinois,)	Complainant
v.)	
VINOD GOYAL, M.D.)	
License No. 036-049046,)	Respondent

No. 93-4393-LEG

STIPULATION AND RECOMMENDATION FOR SETTLEMENT

The Department by John M. Goldberg, its attorney, and Vinod Goyal, M.D., Respondent, by Dennis Tobin, his attorney, submit the following Stipulation and Recommendation for Settlement to the Medical Disciplinary Board for its approval and favorable recommendation to the Director.

STIPULATION OF FACTS

1. THAT on April 5, 1996, the Department filed a Complaint against Respondent, alleging that the Respondent violated the Medical Practice Act by quoting a charge for a procedure that was substantially lower than the ultimate cost for the procedure to four (4) named patients.
2. Respondent has been advised that he has the right to be represented by counsel and has retained Dennis Tobin as his attorney. Respondent has fully discussed the allegations made in the Complaint with his counsel. Respondent has been advised that he has a right to a formal evidentiary hearing and waives such right to a hearing if this Recommendation is approved.
3. Respondent admits that at all times pertinent to the Complaint, he was a licensed Physician and Surgeon practicing in the State of Illinois.

4. Respondent admits that non-professional employees may have quoted the "hardship" cost for the procedure in question and the patients in question may not have met the hardship criteria established by the Respondent, resulting in fees that are ordinary and customary for the services rendered, but considerably higher than the quoted fee.
5. Respondent has procedures in place to prevent a re-occurrence of these complaints, which occurred in 1992 and 1993.
6. Respondent is fully aware that this Recommendation must be approved by the Medical Disciplinary Board. By submission of this Recommendation for approval, Respondent expressly waives any objection based upon prejudice should the Medical Disciplinary Board refuse to accept this Recommendation.
7. For purposes of settlement only, Respondent acknowledges that a violation of the Medical Disciplinary Act of 1987 may be found by the Medical Disciplinary Board following review of the Stipulation.
8. The parties stipulate that these admissions are made for purposes of this Recommendation only. In the event that this Recommendation is not approved by the Medical Disciplinary Board, these admissions shall not be admissible in any proceeding and the matter will be set for an evidentiary hearing on the merits as if this Recommendation had not been submitted. In addition,

upon approval of this Recommendation, these admissions may not be utilized in any other proceeding except one to enforce this agreement.

9. Respondent has been advised that he has the right to file for a rehearing of the matter within 20 days of the Medical Disciplinary Board's action in this case. Respondent hereby waives such a right to a rehearing if this Recommendation is approved.
10. Respondent has been advised that he has a right to Administrative Review of the Order entered by the Director in this case. Respondent hereby waives such right to review if this Recommendation is approved.

RECOMMENDATION FOR SETTLEMENT


11. In the interest of a prompt and just settlement in this matter in a manner consistent with the public interest and in light of the responsibilities of the Medical Disciplinary Board, the Department and the Respondent offer the following proposal for approval by the Medical Disciplinary Board. This Recommendation shall be considered to be an integrated package such that approval of this Recommendation without change is necessary.
12. Upon notification that the Recommendation has been approved and that the Director has entered an Order adopting the Recommendation of the Medical Disciplinary Board, Respondent agrees:
 - A. Respondent's license to practice medicine as a Physician and Surgeon shall be placed on Probation for two (2) years:

- 1) During the period of Probation the Respondent shall ensure that any patient who may have been quoted a "hardship" fee who does not qualify for a "hardship" fee acknowledges, in writing, their understanding of the fees and costs charged by the Respondent; and
- 2) Respondent will cease any efforts to collect any moneys in addition to the "hardship" fee for any patient who was quoted a "hardship" fee, unless there is evidence that the patient was aware of the additional costs and fees resulting from their failure to qualify for a "hardship" fee.

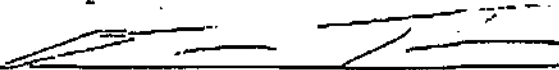
B. Respondent shall pay a fine in the amount of Four Thousand (\$4000.00) Dollars to the Department within thirty (30) days of the effective date of an Order adopting this Recommendation.

I have read this Stipulation and Recommendation for Settlement and have fully discussed it with my attorney. I agree to be bound by its terms.

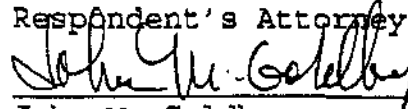
10-14-96
DATE


Vinod Goyal, M.D.
Respondent

10-14-96
DATE


Dennis Tobin
Respondent's Attorney

10-30-96
DATE


John M. Goldberg
Attorney for the Department

The foregoing Stipulation and Recommendation for Settlement is approved by the Medical Disciplinary Board as its decision this 20th day of November, 1996. The Medical Disciplinary Board concludes that Respondent has violated the Medical Practice Act of 1987 and hereby recommends that the Director approve the Recommendation set forth herein by issuing an appropriate Order.

11/20/96
DATE

DATE

DATE

DATE

DATE

DATE

[Signature]
CHAIRMAN OF THE MEDICAL DISCIPLINARY BOARD

[Signature]
Member

[Signature]
Member

[Signature]
Member

[Signature]
Member

Member

JMG:reu

STATE OF ILLINOIS

DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION)	
of the State of Illinois,)	
)	Complainant
)	v.
VINOD GOYAL, M.D.)	
License No. 036-049046,)	Respondent
)	

NO. 93-4393-LEG

ORDER

This matter having come before the Medical Disciplinary Board of the Department of Professional Regulation of the State of Illinois, and the Medical Disciplinary Board, having approved a Stipulation and Recommendation for Settlement submitted by the parties;

NOW, THEREFORE, I, NIKKI M. ZOLLAR, DIRECTOR OF THE DEPARTMENT OF PROFESSIONAL REGULATION of the State of Illinois, do hereby adopt the Stipulation and Recommendation for Settlement approved by the Medical Disciplinary Board in this matter.

IT IS THEREFORE ORDERED that the Certificate of Registration, License No. 036-049046, heretofore issued to Vinod Goyal, M.D. to practice medicine as a Physician and Surgeon in the State of Illinois is placed on Probation for a period of two (2) years and the Respondent is fined in the amount of Four Thousand (\$4,000.00) Dollars in accordance with the Stipulation and Recommendation for Settlement which is attached hereto and incorporated herein.

IT IS FURTHER ORDERED that the Respondent immediately surrender said wall and wallet sizes of said Certificate of Registration to the Department (Prosecution Division) to be marked with the term of probation and returned. Upon failure to do so, the Department shall seize the same.

DATED THIS 9th DAY OF December, 1996.

DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

Nikki M. Zollar
NIKKI M. ZOLLAR
DIRECTOR

NMZ:reu

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION)
of the State of Illinois, Complainant)

v.)

No. 93 -4393)

VINOD KUMAR GOYAL Respondent)

NOTICE

TO: VINOD KUMAR GOYAL
P.O. BOX 772
BARRINGTON, IL 60010

PLEASE TAKE NOTICE that the Director of the Department of Professional Regulation did sign the attached Order-

YOU ARE FURTHER NOTIFIED that you have a right to judicial review of all final administrative decisions of this Department, pursuant to the provisions of the "ADMINISTRATIVE REVIEW ACT," approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto.

The order of the Director of the Department of Professional Regulation will be implemented as of the date of the Order unless the Order states otherwise.

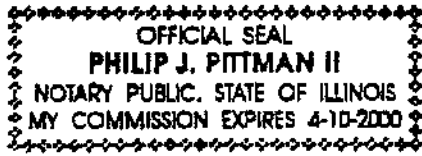
DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

BY: Thomas J. Ondrey
Clerk for the Department

All inquiries should
be directed to the
Prosecutions Unit
312/814-4477

STATE OF ILLINOIS)
)
 COUNTY OF SANGAMON) SS:

The undersigned, being duly sworn on oath, if a non-attorney, or certified, if an attorney, states that on the date hereinafter set out, I caused copies of the foregoing NOTICE AND ORDER, to be placed in the United States mail at 320 West Washington St., Springfield, Illinois 62786, to all parties at the addresses listed above:



 Trace J Orndey
 AFFIANT
 December 9, 1996
 DATE

(If not an attorney) Signed and sworn to before me this

9th day of December, 1996
 Philip J Pittman, II
 NOTARY PUBLIC

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION)
of the State of Illinois, Complainant)

v.)

No. 93 -4393)

VINOD KUMAR GOYAL Respondent)

NOTICE

TO: DENNIS TOBIN, ESQUIRE
18-3 EAST DUNDEE ROAD
BARRINGTON, IL 60010

PLEASE TAKE NOTICE that the Director of the Department of Professional Regulation did sign the attached Order.

YOU ARE FURTHER NOTIFIED that you have a right to judicial review of all final administrative decisions of this Department, pursuant to the provisions of the "ADMINISTRATIVE REVIEW ACT," approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto.

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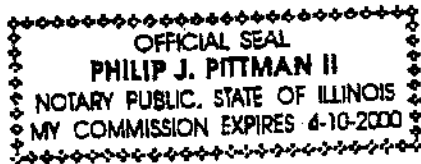
DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

BY: Traci J. Orndy
Clerk for the Department

All inquiries should
be directed to the
Prosecutions Unit
312/814-4477

STATE OF ILLINOIS)
)
 COUNTY OF SANGAMON) SS:

The undersigned, being duly sworn on oath, if a non-attorney, or certified, if an attorney, states that on the date hereinafter set out, I caused copies of the foregoing NOTICE AND ORDER, to be placed in the United States mail at 320 West Washington St., Springfield, Illinois 62786, to all parties at the addresses listed above:



Trace J. Orndey
 AFFIDANT
December 9, 1996
 DATE

(If not an attorney) Signed and sworn to before me this
9th day of December, 1996
Philip J. Pittman II
 NOTARY PUBLIC

STATE OF ILLINOIS

DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION)	
of the State of Illinois, Complainant)	
v.)	NO. 93-4393-LEG
VINOD GOYAL, M.D.)	
License No. 036-049046, Respondent)	

STIPULATION AND RECOMMENDATION FOR SETTLEMENT

The Department by John M. Goldberg, its attorney, and Vinod Goyal, M.D., Respondent, by Dennis Tobin, his attorney, submit the following Stipulation and Recommendation for Settlement to the Medical Disciplinary Board for its approval and favorable recommendation to the Director.

STIPULATION OF FACTS

1. THAT on April 5, 1996, the Department filed a Complaint against Respondent, alleging that the Respondent violated the Medical Practice Act by quoting a charge for a procedure that was substantially lower than the ultimate cost for the procedure to four (4) named patients.
2. Respondent has been advised that he has the right to be represented by counsel and has retained Dennis Tobin as his attorney. Respondent has fully discussed the allegations made in the Complaint with his counsel. Respondent has been advised that he has a right to a formal evidentiary hearing and waives such right to a hearing if this Recommendation is approved.
3. Respondent admits that at all times pertinent to the Complaint, he was a licensed Physician and Surgeon practicing in the State of Illinois.

upon approval of this Recommendation, these admissions may not be utilized in any other proceeding except one to enforce this agreement.

9. Respondent has been advised that he has the right to file for a rehearing of the matter within 20 days of the Medical Disciplinary Board's action in this case. Respondent hereby waives such a right to a rehearing if this Recommendation is approved.
10. Respondent has been advised that he has a right to Administrative Review of the Order entered by the Director in this case. Respondent hereby waives such right to review if this Recommendation is approved.

RECOMMENDATION FOR SETTLEMENT

11. In the interest of a prompt and just settlement in this matter in a manner consistent with the public interest and in light of the responsibilities of the Medical Disciplinary Board, the Department and the Respondent offer the following proposal for approval by the Medical Disciplinary Board. This Recommendation shall be considered to be an integrated package such that approval of this Recommendation without change is necessary.
12. Upon notification that the Recommendation has been approved and that the Director has entered an Order adopting the Recommendation of the Medical Disciplinary Board, Respondent agrees:
 - A. Respondent's license to practice medicine as a Physician and Surgeon shall be placed on Probation for two (2) years:

The foregoing Stipulation and Recommendation for Settlement is approved by the Medical Disciplinary Board as its decision this 20th day of November, 1996. The Medical Disciplinary Board concludes that Respondent has violated the Medical Practice Act of 1987 and hereby recommends that the Director approve the Recommendation set forth herein by issuing an appropriate Order.

11/20/96
DATE

[Signature]
CHAIRMAN OF THE MEDICAL
DISCIPLINARY BOARD

DATE

[Signature]
Member

DATE

[Signature]
Member

DATE

[Signature]
Member

DATE

[Signature]
Member

DATE

Member

JMG:reu

STATE OF ILLINOIS

DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION)	
of the State of Illinois,)	
v.)	NO. 96-14723-LEG
VINOD GOYAL, M.D.)	
License No. 036-049046,)	
Respondent)	

CONSENT ORDER

The Department of Professional Regulation by John M. Goldberg, one of its attorneys, and Vinod Goyal, M.D., Respondent, hereby agree to the following:

STIPULATIONS

Vinod Goyal, M.D. is licensed as a Physician and Surgeon in the State of Illinois, holding license No. 036-049046. At all times material to the matter set forth in this Consent Order, the Department of Professional Regulation of the State of Illinois had jurisdiction over the subject matter and parties herein.

Information has come to the attention of the Department that Respondent made misleading statements regarding the physical condition of the facility he was practicing medicine at during a hearing before the Illinois Health Facilities Planning Board.

The allegation(s) as set forth herein, if proven to be true would constitute grounds for suspending or revoking Respondent's license as a Physician and Surgeon, on the authority of 225 Illinois Compiled Statutes (1994), 60/22(A)(5).

As a result of the foregoing allegation(s), the Department held an Informal Conference at the offices of the Department, 100 West Randolph Street, Suite 9-300, Chicago, Illinois 60601 on June 11, 1997. Respondent appeared in person on that date, represented

by Dennis Tobin. Virgil Wikoff appeared as a member of the Medical Disciplinary Board of the State of Illinois and John M. Goldberg appeared as an attorney for the Department.

Respondent admits that the statements that he made were misleading.

Respondent has been advised of the right to have the pending allegation(s) reduced to written charges, the right to a hearing, the right to contest any charges brought, and the right to administrative review of any Order resulting from a hearing. Respondent knowingly waives each of these rights, as well as any right to administrative review of this Consent Order.

Respondent and the Department have agreed, in order to resolve this matter, that Vinod Goyal, M.D. be permitted to enter into a Consent Order with the Department, providing for the imposition of disciplinary measures which are fair and equitable in the circumstances and which are consistent with the best interests of the people of the State of Illinois.

CONDITIONS

WHEREFORE, the Department, through John M. Goldberg, its attorney, and Vinod Goyal, M.D., agree:

- A. Respondent shall be Reprimanded by operation of this Consent Order.
- B. Respondent shall pay a fine in the amount of Two Thousand (\$2,000.00) Dollars within ten (10) business days after the effective date of this Consent Order. Said fine shall be made payable to the Illinois Department of Professional Regulation and sent to:

Illinois Department of Professional Regulation, Fiscal
Section, 320 West Washington Street, Springfield,
Illinois 62786.

- C. Any violation by Respondent of the terms and conditions
of this Consent Order shall be grounds for the
Department to immediately file a Complaint to revoke
the Respondent's license to practice as a Physician and
Surgeon in the State of Illinois.
- D. This Consent Order shall become effective upon approval
by the Director of the Department.

<u>09-14-97</u> DATE	DEPARTMENT OF PROFESSIONAL REGULATION of the State of Illinois <u>John M. Goldberg</u> John M. Goldberg Attorney for the Department
<u>7-2-97</u> DATE	<u>Vinod Goyal</u> Vinod Goyal, M.D. Respondent
<u>7-2-97</u> DATE	<u>Dennis Tobin</u> Dennis Tobin Attorney for the Respondent
<u>August 20, 1997</u> DATE	<u>Member, Medical Disciplinary Board</u> Member, Medical Disciplinary Board

The foregoing Consent Order is approved in full.

DATED THIS 16th day of September, 1997.

DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

Nikki M. Zollar
NIKKI M. ZOLLAR
DIRECTOR

NMZ:JMG:reu

REF: License No. 036-049046
Case No. 96-14723-LEG

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION)
of the State of Illinois, Complainant)
v.) No. 96-14723
)
VINOD GOYAL Respondent)

NOTICE

TO: VINOD GOYAL
P.O. BOX 772
HARRINGTON, ILLINOIS 60010

PLEASE TAKE NOTICE that the Director of the Department of Professional Regulation did sign the attached Consent Order.

The Order of the Director of the Department of Professional Regulation will be implemented as of the date of the Order unless the Order states otherwise.

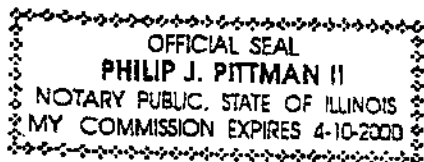
DEPARTMENT OF PROFESSIONAL REGULATION
of the State of Illinois

BY: Trace S. Ondrey
Clerk for the Department

All inquiries should be directed
to the Prosecutions Unit
312/814-4477

STATE OF ILLINOIS)
) ss:
COUNTY OF SANGAMON)

The undersigned, being duly sworn on oath, if a non-attorney, or certified, if an attorney, states that on the date hereinafter set out, I caused copies of the foregoing NOTICE AND ORDER, to be placed in the United States mail, by CERTIFIED mail at 320 W. Washington, Springfield, Illinois 62786, to all parties at the addresses listed above:



Trace S. Ondrey
AFFIANT
September 16 1997
DATE

(If not an attorney) Signed
and sworn to before me this
16th day of September, 1997

Philip J. Pittman II
NOTARY PUBLIC



VERIFICATION OF STATE LICENSURE

State Form 7143 (R2 / 10-91)

* PRIVACY NOTICE *

This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1. Disclosure is mandatory, and this form will not be processed without it.

HEALTH PROFESSIONS BUREAU
Indiana Government Center South
402 W. Washington St., Rm 041
Indianapolis, Indiana 46204
Telephone: (317) 232-2960

INSTRUCTIONS: Type and complete the top section. Make copies to send to each state that you hold or have held a license. Have the state(s) send this directly to our office.

Name (Last, first, middle, maiden) Goyal, Vinod K.		Health Profession License Held Physician & Surgeon		Social Security Number *	
Address (Number, street, or / rural route) P.O. Box 772		City Barrington	State IL	ZIP code 60010	
License number 036-049046		Date of Issuance (month, day, year) 03/26/1974		Date of Birth (month, day, year) 08/07/1948	
I hereby authorize the State of _____, to furnish the Health Profession Bureau of Indiana with the information below.					
Signature					

* Required pursuant to IC 4-1-8-1

DO NOT WRITE BELOW THIS LINE

License number	Date of Issuance (month, day, year)	Licensed by <input type="checkbox"/> Exam <input type="checkbox"/> Endorsement <input type="checkbox"/> Other		
Type of Examination	Date of Administration (month, day, year)	Please Affix Board Seal		
Attach subjects, scores, date of examination and average.				
License is current and in good standing <input type="checkbox"/> Yes <input type="checkbox"/> No	License is or has been invalid <input type="checkbox"/> Yes <input type="checkbox"/> No	Any derogatory information? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If license has been encumbered in any way, please provide certified copies of all related documents.				
FORM COMPLETED BY:				
Name	Title			
Signature	State Board		Date (month, day, year)	



VERIFICATION OF STATE LICENSURE

State Form 7143 (R2 / 10-91)

* PRIVACY NOTICE *

This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1. Disclosure is mandatory, and this form will not be processed without it.

HEALTH PROFESSIONS BUREAU
Indiana Government Center South
402 W. Washington St., Rm 041
Indianapolis, Indiana 46204
Telephone: (317) 232-2960

INSTRUCTIONS: Type and complete the top section. Make copies to send to each state that you hold or have held a license. Have the state(s) send this directly to our office.

Name (Last, first, middle, maiden)		Health Profession License Held		Social Security Number *	
Address (Number, street, or / rural route)		City	State	ZIP code	
License number		Date of Issuance (month, day, year)		Date of Birth (month, day, year)	
I hereby authorize the State of _____, to furnish the Health Profession Bureau of Indiana with the information below.					
Signature					

* Required pursuant to IC 4-1-8-1

DO NOT WRITE BELOW THIS LINE

License number	Date of Issuance (month, day, year)	Licensed by <input type="checkbox"/> Exam <input type="checkbox"/> Endorsement <input type="checkbox"/> Other		
Type of Examination	Date of Administration (month, day, year)	Please Affix Board Seal		
Attach subjects, scores, date of examination and average.				
License is current and in good standing <input type="checkbox"/> Yes <input type="checkbox"/> No	License is or has been invalid <input type="checkbox"/> Yes <input type="checkbox"/> No	Any derogatory information? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If license has been encumbered in any way, please provide certified copies of all related documents.				
FORM COMPLETED BY:				
Name	Title			
Signature	State Board		Date (month, day, year)	

1



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

**VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 07/02/2004**

HEALTH PROFESSIONS BUREAU
402 WEST WASHINGTON STREET, ROOM W066
INDIANAPOLIS, IN 46204

NAME: Vinod K Goyal
ADDRESS: PO Box 772
Barrington IL 60010

SSN: [REDACTED]
BIRTHDATE: 08/07/1948

TYPE: Medical Doctor
LICENSE NUMBER: 4301083203 **STATUS:** Active
OBTAINED BY: Endorsement - Licensed > 10 Years

ORIGINAL DATE: 03/11/2004
EXPIRATION DATE: 01/31/2005

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

Jennifer L Smith
JENNIFER L SMITH

RECEIVED

JUL 16 2004

Health Professions Bureau