STATE OF ILLINOIS
Department of Financial and Professional Regulation
Division of Professional Regulation

March 12, 2015

ANTOINETTE TRUC NGUYEN MD
MCGAW MED CTR NORTHWESTERN
DEPT OF GME
420 E SUPERIOR SUITE 12-174
CHICAGO, IL 60611

The Illinois Temporary Medical License or Permit for the resident listed above has been approved and will be forwarded to your facility as soon as office routine permits. Information regarding all licensees is available instantly on our Web site at www.idfpr.com. Simply click on the Express Access License Look-up icon to verify a license.

LICENSE DETAILS

LICENSE NUMBER:	125.062300
PROGRAM START DATE:	06/28/2015
EXPIRATION DATE:	06/27/2016
PROGRAM:	Obstetrics and Gynecology
TRAINING FACILITY:	McGaw Medical Ctr/Northwestern

Utilization of this license is limited to the training program listed above.

Temporary licenses and permits may not be used for any clinical medical practice which occurs outside of the residency program (i.e. moonlighting).

Temporary licenses and permits are **not** automatically transferred from one program/institution to another. Should the resident transfer to a different residency program within your facility or to a program in another institution, the license or permit must be updated. The resident may not begin a new program until the current temporary license or permit has been returned to the Division and a license or permit has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of temporary licenses and permits. Any violation of the Act may result in disciplinary action by this Department.

2012

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

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.
5. 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.

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

RECEIVED CASH SECTION

FEB 19 2014

IDFPR Div of Professional Regulation

PART I: Application Category Information

A. SEE **REFERENCE SHEET, CHART I, OR INSTRUCTIONS** PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Extension / Reissue	1 2 5	non examination	$ 100

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☐ This is the first time I have made application for this profession in Illinois.
- ☑ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: _____
- ☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- ☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division 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.)	3. UNITED STATES SOCIAL SECURITY NO.
Nguyen	Antoinette	Truc	MD	[redacted]

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

[redacted] _____

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

250 E. Superior, Ste 52177 Chicago, IL USA 60611-_____

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)

[redacted]

7. MOTHER'S MAIDEN NAME

[redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY

[redacted]

9. DATE OF BIRTH

[redacted]

Month Day Year

10. AGE

[redacted] ☐ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (312) 695-5544 (Area Code)

Home: (_____) _____-_____ (Area Code)

Fax: (_____) _____-_____ (Area Code)

Fax: (_____) _____-_____ (Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) [If available]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI):

SS#:

Profession:

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
Klein Forest High School	Houston, TX	05 / 2001 (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
Northwestern University	Evanston, IL	09/2001	06/2005	B.A.
Emory University School of Medicine	Atlanta, GA	08/2007	05/2012	MD., MPH

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
McGraw Medical Center of Northwestern University	Chicago, IL	07/2012	current	☐ Yes ☑ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

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	125062300	6/28/2012	Active
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

(If additional space is needed, attach a separate sheet.)

SS#:

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
USMLE Step 1	GA	1/2009	[redacted]
USMLE Step 2 CK	GA	3/2010	
USMLE Step 2 CS	GA	4/2011	
USMLE Step 3	IL	1/2014	

(If additional space is needed, attach a separate sheet.)

Profession:

NAME (Last, First, MI):

SS#:

Profession:

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		✓
2. Have you been convicted of a felony?		✓
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		✓
4. 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.*		✓
5. 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.*		✓
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		✓

PART VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes. ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐

b) CHART III - Select the examination site you desire and enter 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: ☐☐

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☑
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☑

PART IX: 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] _____ 2/2/2015

Signature of Applicant — Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and 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.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION PERSONAL HISTORY INFORMATION**	SUPPORTING DOCUMENT **PH**

NAME LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
Nguyen	Antoinette	Truc	[redacted]

In order for your application to be evaluated, you must respond to each of the following questions:	YES	NO
1. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity? If yes, attach a separate sheet with complete and accurate explanation.		✓
2. Have you ever resigned in lieu of discipline or while under investigation that could lead to any restriction, suspension, or termination by any hospital or health care entity? *If yes, attach a separate sheet with complete and accurate explanation.*		✓
3. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended? You must answer yes if any of these actions are currently pending or if you have withdrawn or failed to proceed with an application for privileges/memberships. *If yes, attach a separate sheet with complete and accurate explanation AND request the hospital or health care facility to submit a report directly to the Department regarding the action.*		✓
4. Has your provider status ever been restricted, suspended or terminated by any insurance carrier, including but not limited to Medicare, Medicaid, Tricare or any private carrier? If yes, attach a separate sheet with complete and accurate explanation.		✓
5. Have you ever voluntarily surrendered a license to practice medicine in any state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		✓
6. Have you ever withdrawn an application for a license to practice medicine or any temporary/resident license in any other state, country, or U.S. federal jurisdiction? *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		✓
7. Have you ever been admonished, reprimanded, censured and/or disciplined in any way by any professional or medical society or association or committee thereof, or by any non-licensing governmental agency including but not limited to any governmental assistance agency? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Disclose any stipulation to informal disposition in response to this question. *If yes, attach a separate sheet with a complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.*		✓

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted]

Signature of Applicant

2/2/2015

Date

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST	FIRST	MIDDLE	3. PROFESSIONAL LICENSE NUMBER (if any)
Nguyen	Antoinette	Truc	125 - 062300
2. ADDRESS STREET, CITY, STATE, ZIP CODE			4. SOCIAL SECURITY NUMBER [redacted]

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturists
- ☐ Advanced Practice Nurses
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☒ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☒
2) Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration?	☐	☒
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☒
4) Are you currently charged with or have you been convicted of a forcible felony? *	☐	☒

*If **YES** to any of the above, 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.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted] 2/2/2015

Signature of Applicant Date

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

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 Financial and 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: Nguyen, Antoinette

2. DATE OF BIRTH: [redacted] Month Day Year

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: 240 E. Huron, Chicago IL 60611

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Temp Phys — 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: NMGaw Medical Center

B. BEGINNING DATE: 06 28 2015 (Month Day Year)

C. ENDING DATE: 06 27 2016 (Month Day Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: 240 E. Huron Ste 1-203 Chicago IL 60611

E. SPECIALTY / RESIDENCY NAME: OB/GYN

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

G. YEAR OF POSTGRADUATE TRAINING: PGY

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 Financial and Professional Regulation, the applicant is found to be eligible for licensure.

[redacted]
Signature of Program Director

Susan Gerber, MD
Print Name of Program Director

Program Director
Title

Date

SEAL

IL486-0272 08/04 (MD)

Northwestern University
Feinberg School of Medicine

Division of Graduate Medical Education
Department of Obstetrics and Gynecology
Prentice Women's Hospital
and Maternity Center
250 East Superior Street, Suite 05-2177
Chicago, Illinois 60611

Susan E. Gerber, MD, MPH
Division Head
Assistant Professor

s-gerber@northwestern.edu
Phone 312-472-4673
Fax 312-472-4687

NORTHWESTERN
UNIVERSITY

November 19, 2014

Department of Financial and
Professional Regulation
ATTN: Division of
Professional Regulation
P.O. Box 7199
Springfield, IL 62791

RE: Antoinette Nguyen, IL license: 125062300

To Whom It May Concern:

Dr. Antoinette Nguyen began her residency at Northwestern McGaw Center for Graduate Medical Education on June 28, 2012 and will complete her 4th year of residency on June 29, 2016.

Dr. Nguyen's current license will expire on June 27, 2015. In order to complete the residency training program, she will need her temporary license extended.

Please contact me should you have any questions or concerns.

Best Regards,

[redacted]

Susan Gerber, MD, MPH
Residency Program Director

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VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

Nguyen Antoinette Truc

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

5. SOCIAL SECURITY NUMBER

[redacted]

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☐ Permanent Physician License	036
☒ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

6. MAIDEN OR GIVEN SURNAME

[redacted]

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment. Also list any breaks of six (6) months or longer in medical practice since graduation from medical school.

A. NAME OF PRACTICE / WORK LOCATION Mccraw Medical Center of Northwestern

ADDRESS STREET, CITY, STATE, ZIP CODE

250 Superior St 52177 Chicago, IL 60611

DATE OF EMPLOYMENT/ATTENDANCE

From 06/24/2012 (Month Day Year)

To current (Month Day Year)

HOURS WORKED PER WEEK

80

TYPE OF EMPLOYMENT

☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

2.5 years

JOB TITLE

Resident

DESCRIPTION OF DUTIES PERFORMED

Resident duties as assigned

B. NAME OF PRACTICE / WORK LOCATION

ADDRESS STREET, CITY, STATE, ZIP CODE

DATE OF EMPLOYMENT/ATTENDANCE

From ___ / ___ / ____ (Month Day Year)

To ___ / ___ / ____ (Month Day Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

JOB TITLE

DESCRIPTION OF DUTIES PERFORMED

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION

June 28, 2012

ANTOINETTE TRUC NGUYEN MD
MCGAW MED CTR NORTHWESTERN
DEPT OF GME
420 E SUPERIOR SUITE 12-174
CHICAGO, IL 60611

The Illinois Temporary Medical License or Permit for the resident listed above has been approved and will be forwarded to your facility as soon as office routine permits. Information regarding all licensees is available instantly on our Web site at www.idfpr.com. Simply click on the Express Access License Look-up icon to verify a license.

LICENSE DETAILS

LICENSE NUMBER:	125.062300
PROGRAM START DATE:	06/28/2012
EXPIRATION DATE:	06/27/2015
PROGRAM:	Obstetrics and Gynecology
TRAINING FACILITY:	MCGAW/NORTHWESTERN

Utilization of this license is limited to the training program listed above.

Temporary licenses and permits may not be used for any clinical medical practice which occurs outside of the residency program (i.e. moonlighting).

Temporary licenses and permits are **not** automatically transferred from one program/institution to another. Should the resident transfer to a different residency program within your facility or to a program in another institution, the license or permit must be updated. The resident may not begin a new program until the current temporary license or permit has been returned to the Division and a license or permit has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of temporary licenses and permits. Any violation of the Act may result in disciplinary action by this Department.

RECEIVED
Bureau of Services

APR 10 2012

APPLICATION FOR LICENSURE AND/OR EXAMINATION

Div. of Professional Regulation

FOR OFFICIAL USE ONLY

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5. 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.

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Licensure	~~035~~	Nonexamination	$ 100.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [x] 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.
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PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division 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.)	3. UNITED STATES SOCIAL SECURITY NO.
Nguyen	Antoinette	Truc	M.D. / M.P.H.	[redacted]

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

[redacted]

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

n/a

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)

n/a

7. MOTHER'S MAIDEN NAME [redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY [redacted]

9. DATE OF BIRTH [redacted] Month Day Year

10. AGE [redacted] Female Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: ( ) (Area Code)

Home: [redacted] (Area Code)

Fax: ( ) (Area Code)

Fax: ( ) (Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) [If available] [redacted]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI):

SS#:

Profession:

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
Klein Forest High School	Houston, TX	05 / 2001 (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
Northwestern University	Evanston, IL	9/2001	6/2005	B.A.
Emory University	Atlanta, GA	8/2007	5/2012	M.D. 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?
n/a				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

SS#:

Profession:

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
USMLE Step 1	GA	1/2009	[redacted]
USMLE Step 2 CK	GA	3/2010	
USMLE Step 2 CS	GA	4/2011	

(If additional space is needed, attach a separate sheet.)

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		✓
2. Have you been convicted of a felony?		✓
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		✓
4. 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.*		✓
5. 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.*		✓
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		✓

PART VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes. [ ] [ ] [ ] [ ] [ ] [ ]

b) CHART III - Select the examination site you desire and enter 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: [ ] [ ]

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes [ ] No [✓]
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes [ ] No [✓]

PART IX: 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] 3/29/2012

Signature of Applicant — Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and 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.

NAME (Last, First, MI):

SS#:

Profession:

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.

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 form.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Nguyen, Antoinette, Truc	[redacted] Month Day Year	[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 Physician License_____ __1__ _2___ _5___
Profession Name Profession Code

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
McGaw Medical Center of Northwestern University	6/23/12 Month Day Year	06/22/2015 Month Day Year

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE	D. SPECIALTY / RESIDENCY NAME
420 East Superior Street, Rubloff 12th floor Chicago, IL 60611	Obstetrics and Gynecology

F. BUSINESS TELEPHONE NUMBER	G. YEAR OF POSTGRADUATE TRAINING
(312) 503-7975	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

Magdy Milad
Print Name of Program Director

Program Director
Title

3/19/12
Date

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 ILCS 60/1 et.seq. Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF GRADUATION

(Current Year Graduates of LCME and COCA-Accredited Programs Only)

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: Nguyen — FIRST: Antoinette — MIDDLE: Truc

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.

Temporary Physician License — Profession Name: 125 — Profession Code

6. MAIDEN OR GIVEN SURNAME: [redacted]

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

3/29/2012 — Date

[redacted] — Signature

SCHOOL OFFICIAL: Complete the bottom portion of this page and return **ALONG** with a current official medical school transcript. **DO NOT** certify this form more than **30 days** prior to the graduation date.

A. MEDICAL SCHOOL INFORMATION

Name: EMORY UNIVERSITY
Address: 1648 PIERCE DR. NE
City, State, Zip: ATLANTA, GA 30322
Phone: 404. 727. 5655
Fax: 404. 727. 6045

B. DATES OF ATTENDANCE

Start: 07 / 24 / 2008 (Month / Day / Year)
End: 05 / 14 / 2012 (Month / Day / Year)
Degree: X MD ____ DO

RECEIVED BUSINESS SERVICES MAY 31 2012 IDFPR Div. of Professional Regulation

C.

Applicant will complete all requirements for the medical degree as of 05 / 14 / 2012 (Month / Day / Year) and will graduate on 05 / 14 / 2012 (Month / Day / Year).

When this form is certified prior to the actual graduation of the applicant, the school official is responsible for notifying the Department of Financial and 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.

RECEIVED JUN 01 2012 IDFPR-MEDICAL UNIT

[redacted]
Signature of School Official

SCHOOL SEAL

TRISH SHAWVER
Print Name of School Official

ACADEMIC SERVICES COORDINATOR
Title

5/16/2012
Date

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

Nguyen Antoinette True

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

5. SOCIAL SECURITY NUMBER

[redacted]

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☐ Permanent Physician License	036
☑ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

6. MAIDEN OR GIVEN SURNAME

[redacted]

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION

n/a

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

B. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

125 TEMPORARY CHECKLI
TRANSFER – EXTENSION – REISSUE

FILES SET-UP IN THIS ORDER (Some exceptions) DO NOT KEEP BLANK OR DUPLICATE DOCUMENTS

APPLICATION FINDINGS 2/2/15

✓ Application Complete

SS# if not provided on initial app_____

_____ PH Form _____ CCA Form

~~Fingerprint~~ _____ ~~Clear~~ _____ ~~HIT~~

_____ Name Change

___PPH not previously addressed

ITD _____ MLB _____

TEMPORAY LICENSE HISTORY INFO

Transfer/extend within initial 3-yrs _____ $20

Extension after 3-yrs to complete program ✓ $100

Reissue after leaving program or to new program____$100

LIC # & History 125- 062300

Original Dates & Program

06/28/12 - 06/27/15 OB GYN

Be sure the following has been completed before approving. *DO NOT* make any changes to UDL's or address until ready to issue the new license:

___ Program start date changed
(Training date only changes if license was never used)

___ Update program, hospital name, address

___ Applicant Name Correct and SS #

==========

TRANSFER DOCUMENTATION

_____ CA-MED with NEW Dates

Hospital _____

Start _____ (must be current year)
End _____ (cannot exceed 3-yrs total)

Accredited program _____

OR

Non-Accredited program _____

Outline – see worksheet _____

Interview Required _____

MLB approved in past 3 yrs _____

_____ License returned if not expiring

EXTENSION DOCUMENTATION

✓ CA-MED with NEW Dates

Start 06/28/15 (must be current year)
End 06/27/16 (cannot exceed accredited length of training)

Accredited Length of Training 4

Letter of request & reason for the extension <u>if time requested is less than 1 year</u> **or** if <u>beyond ACGME/AOA accredited time</u> from:

Program/GME Office_____
Applicant if medical, personal or LOA _____
***Letters need to be specific regarding LOA

REISSUE DOCUMENTATION

(left the program, beginning new program after completion of another – license is expired/cancelled)

_____ CA-MED with NEW Dates

Hospital _____

Start _____ (must be current year)
End _____ (can have up to 3-yrs)

Accredited program _____

Letter of request & reason for the reissue from:

Program/GME Office_____ Applicant _____

May also need to submit:

___ VE-PC to verify Professional Capacity
_____CME required

___TN-MED - If a full year was not completed in an out-of-state program; left IL program prior to completion of a full year; or other questionable training

___CT from Other Jurisdiction, if applicable

___Federation Check

++

NOTES:

125 TEMPORARY APPLICATION CHECKLIST

APPLICATION FINDINGS
X Application Complete

POSITIVE PERSONAL HISTORY INFO
Yes#_____ See Worksheet for documents
OK VE-PC from Grad to Present for PPH_____
MLB _____ ITD_____

LICENSE INFORMATION McGaw/NW
X CA-MED(125)
Start 6/23/12
End 6/22/15
Program Ob/Gyn

Non-approved Program – MLB Interview
_____Outline which includes but not limited to: staff info; description; pre-requisites; clinical goals, activities & responsibilities; educational goals, research info; evaluations; venue

EDUCATIONAL DOCUMENTATION

DOMESTIC GRADUATES
___Premedical Transcripts
___ED-MED or Roster **CURRENT YEAR GRADUATES ONLY**
___Medical Transcripts w/degree date Degree date 5/14/12
EMORY UNIV (Atlanta, GA)

FOREIGN GRADUATES
___ECFMG _____5th Pathway _____Social Service
___Premedical Transcripts ___Translations
___Medical Transcripts ___Translations Degree date _____

___AF-MED Part A

AF-MED Part B DOCUMENTATION:
Int Med Hosp: _____
Evaluation: _____
AF-MED B_____ and Agreement_____
OR
Verbal Affidavits: Hospital ___School___

Psych Hosp: _____
Evaluation: _____
AF-MED B_____ and Agreement_____
OR
Verbal Affidavits: Hospital ___School___

Ob/Gyn Hosp:_____
Evaluation: _____
AF-MED B_____ and Agreement_____
OR
Verbal Affidavits: Hospital ___School___

Surgery Hosp: _____
Evaluation: _____
AF-MED B_____ and Agreement_____
OR
Verbal Affidavits: Hospital ___School___

Peds Hosp: _____
Evaluation: _____
AF-MED B_____ and Agreement_____ OR Verbal Affidavits: Hospital ___School ___

___**ED-NON** _____Total months -must be minimum of 36 w/premed; 54 combined
Minimum 4-weeks: IM ___ Ob/Gyn ___ Peds ___ Psych ___Psych Affidavit ___ Surgery ___

SUPPORTING DOCUMENTS
___X___Verification of Professional Capacity (VE-PC) - active practice in 2-years preceding app
Last Active Practice_____over 5 yrs-VE-PC Graduation to present ___150 hours Cat 1 & MLB
_____50 hours CME out 2-3 years
_____100 hours CME out 3-4 years
_____150 hours CME out 4-5 years
___ CT- Original Licensure State & Number_____ Discipline?_____
___ CT - Current Jurisdiction of Practice & Number_____ Discipline?_____
___Name Change N/A Federation Check

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 6/5/2012

Initials: SI

License No: 125 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

ANTOINETTE TRUC NGUYEN MD
MCGAW MED CTR NORTHWESTERN
DEPT OF GME
420 E SUPERIOR SUITE 12-174
CHICAGO, IL 60611

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Submit official final transcript(s) verifying medical education with school seal/signature to the attention of the Medical Unit.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 5/29/2012

Initials: DO

License No: 125 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

ANTOINETTE TRUC NGUYEN MD
MCGAW MED CTR NORTHWESTERN
DEPT OF GME
420 E SUPERIOR SUITE 12-174
CHICAGO, IL 60611

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Submit official final transcript(s) verifying medical education with school seal/signature to the attention of the Medical Unit with conferral date.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 5/3/2012

Initials: DO

License No: 125 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

ANTOINETTE TRUC NGUYEN MD
MCGAW MEDICAL CENTER/NORTHWESTERN
DEPT OF GME
420 E SUPERIOR SUITE 12-174
CHICAGO, IL 60611

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Submit official transcript(s) verifying a minimum of 2-years liberal arts education with school seal/signature affixed to the attention of the Medical Unit.

Official medical transcripts verifying education completed to date along with completed ED-MED form certified not more than 30 days prior to graduation.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.