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.

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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
Visiting Physician Permit	1 D 6	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	M.D.	[redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: 4001 old Clinic Building CB 7570, Chapel Hill, NC 27599-7570 Orange

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

7. MOTHER'S MAIDEN NAME: [redacted]

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

9. DATE OF BIRTH (Month Day Year): [redacted]

10. AGE: [redacted] ☐ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (919) 843-9559 (Area Code)

Home: [redacted] (Area Code)

Fax: (919) 843-6691 (Area Code)

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

12. **REQUIRED** E-MAIL ADDRESS: antoinette_nguyen@med.unc.edu

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	9/01	6/05	B.A.
Emory University	Atlanta, GA	8/07	5/12	M.D.
Emory University	Atlanta, GA	8/10	5/12	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?
McGaw Medical Center of Northwestern University	Chicago, IL	7/12	6/16	☑ Yes ☐ No
University of North Carolina	Chapel Hill, NC	7/16	present	☐ 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 IL	Physician, temporary license	125062300	6/28/12	Lapsed
State of Current Licensure where you most recently have been practicing. NC	Physician	2016-01239	10/10/16	Active
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 (Passed, Failed, Absent)
USMLE Step 1	GA	01/09	[redacted]
USMLE Step 2 CK	TX	03/10	
USMLE Step 2 CS	GA	04/11	
USMLE Step 3	IL	01/14	

(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 personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*		✓
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		✓
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. Do you now have any disease or condition that presently limits 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? *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? *(NOTE: If you are not subject to a child support order, answer "no.")* Yes ☐ 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] 9/13/2017

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.

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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] Antoinette Nguyen — Signature of Applicant

11.15.17 — Date

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

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE
NGUYEN ANTOINETTE TRUC

3. PROFESSIONAL LICENSE NUMBER (if any)
____ - _____

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

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]
Signature of Applicant

11.15.17
Date

January 9, 2018

To:
State of Illinois
Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786

From:
Antoinette Truc Nguyen MD
Family Planning Associates Medical Group
659 W. Washington Blvd.
Chicago, IL 60661

To Whom It May Concern:

Please find the following items attached, which include the items that were listed on the application deficiency checklist.

- Personal history form (part VI of application) – with original signature of applicant
- Personal history form (PH form) – with original signature of applicant
- CCA form – with original signature of applicant

Sincerely,

[redacted]

Antoinette Nguyen MD

RECEIVED
CASH SECTION
JAN 16 2017
IDFPR
Div. of Professional Regulation

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 personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*		✓
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		✓
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. Do you now have any disease or condition that presently limits 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? *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? *(NOTE: If you are not subject to a child support order, answer "no.")* Yes [ ] 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] 01/09/2018

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): Nguyen, Antoinette, T.

SS#: [redacted]

Profession: Physician

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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] Antoinette Nguyen
Signature of Applicant

01/09/2018
Date

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

SUPPORTING DOCUMENT

CCA

1. NAME LAST: Nguyen FIRST: Antoinette MIDDLE: Truc

2. ADDRESS STREET CITY STATE ZIP CODE: [redacted]

3. PROFESSIONAL LICENSE NUMBER (if any): ____ - _____

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
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- ☐ Nursing Home Administrators
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- ☐ Occupational Therapy Assistants
- ☐ Optometrists
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- ☐ 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

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JAN 19 2018
IDFPR - MEDICAL UNIT

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] Antoinette Nguyen
Signature of Applicant

01/09/2018
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.

CERTIFICATION OF INVITATION/APPOINTMENT FOR VISITING PHYSICIAN 180-DAY PERMIT

SUPPORTING DOCUMENT

MD-VPH

NOTE: An applicant shall not commence the appointment before the program receives written notification of approval from the Department of Financial and Professional Regulation.

A Visiting Physician Permit issued pursuant to Section 18(B) of the Medical Practice Act, shall be valid for 180 days from the date of issuance or until the time the medical, osteopathic, chiropractic, or clinical studies or techniques are completed, whichever occurs first. The applicant may be required to appear before the Board for an interview prior to, and as a requirement for, the issuance of such visiting physician permit.

APPLICANT: **Complete the applicant section of this form. Forward the form to the dean or program director of the school or hospital at which the invitation/appointment has been established. Return the completed form with the Application for Licensure/Examination at least 60 days prior to the beginning date of the invitation/appointment.**

1. NAME (LAST, FIRST, MIDDLE): Nguyen, Antoinette Truc

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. MAIDEN OR GIVEN SURNAME: [redacted]

Visiting Physician Permit — Profession Name

1 0 6 — Profession Code

DEAN OR PROGRAM DIRECTOR OF SCHOOL OR HOSPITAL: Complete the remainder of this form, then return the form to the applicant.

A. NAME OF MEDICAL, OSTEOPATHIC, CHIROPRACTIC SCHOOL OR HOSPITAL: Family Planning Associates Medical Group Ltd.

B. THE TERM OF CONTRACT NOT TO EXCEED 180 DAYS: From 03/01/2018 (Month Day Year) To 03/31/2018 (Month Day Year)

C. NAME OF DEPARTMENT OF SCHOOL OR HOSPITAL: Family Planning

D. TELEPHONE NUMBER (Include Area Code): 312-707-8988

E. LOCATION OF SCHOOL OR HOSPITAL (Street, City, State, Zip Code): 659 W. Washington Blvd Chicago, Il. 60661

F. FAX NUMBER (Include Area Code): 312-707-9223

G. DESCRIBE IN DETAIL THE NATURE OF CLINICAL SUBJECT OR TECHNIQUE THAT APPLICANT HAS BEEN INVITED/APPOINTED TO STUDY, DEMONSTRATE, OR PERFORM.

Dr. Nguyen has been invited for a month long rotation to perform abortion procedures and contraceptive care in our facility under the direction of our medical staff.

I do hereby declare that the above-named applicant has been invited/appointed to study, demonstrate or perform a specific clinical subject or technique as a visiting physician for 180 days or until such time as the clinical studies or techniques have been completed, whichever occurs first.

OFFICIAL SEAL
KATHRYN R PHIPPS
Notary Public - State of Illinois
My Commission Expires Mar 11, 2019

9/19/17
Date

[redacted]
Signature of Dean or Program Director

Allison A Cowett MD
Print or Type Name of Dean or Program Director

IL486-1501 10/04 (MD-VPH)

[redacted]

FAMILY PLANNING ASSOCIATES MEDICAL GROUP
659 W. Washington St., Chicago, Illinois 60661
(312) 707-8988

Allison A. Cowett, MD MPH
Director of Visiting Physicians Program
Associate Medical Director
Family Planning Associates Medical Group
659 West Washington Blvd.
Chicago, IL 60661
aacowett@gmail.com

September 19, 2017

Department of Financial and Professional Regulation
Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, IL 62786

Dear Sir or Madam:

Family Planning Associates Medical Group does not have a seal to affix to Antoinette Nguyen's MD-VPH Form as part of her Visiting Physician 180-day permit. Please find the included MD-VPH Form, which has been notarized with my signature.

Please contact me with any questions.

Sincerely,

[redacted]

Allison Cowett, MD MPH

Alger, Joseph

From: Verifications <Verifications@NCMEDBOARD.ORG>
Sent: Thursday, November 16, 2017 1:32 PM
To: FPR.MedicalUnit
Cc: Nguyen, Antoinette Truc
Subject: [External] FW: North Carolina License Verification for Dr. Antoinette Truc Nguyen

Please let me know if this verification is received. I have been informed by the physician that It was not received the first time. We did not get it back undeliverable.

Janice Fowler
Operations Assistant
North Carolina Medical Board
P 919.326.1109 x251 **E** janice.fowler@ncmedboard.org
F 919-326-1130 **A** 1203 Front St, Raleigh, NC 27609
Website | Facebook | Twitter

From: verifications@ncmedboard.org [mailto:verifications@ncmedboard.org]
Sent: Thursday, September 14, 2017 1:15 PM
To: FPR.medicalunit@illinois.gov
Subject: North Carolina License Verification for Dr. Antoinette Truc Nguyen

North Carolina Medical Board

09/14/2017

Name	Antoinette Truc Nguyen, MD
Renewal Date	12/19/2017
Public Action	No

License Number	License Type	Issue Date	Current Status	Expire Date
2016-01239	MD	06/07/2016	Active	

Public Actions can be found at www.ncmedboard.org.
To receive certified copies of Public Actions, please email PublicDocuments@ncmedboard.org.
If you have questions regarding a pending investigation, please email investigations@ncmedboard.org.

For general Verification questions, email verifications@ncmedboard.org.

Sincerely,

[redacted]

R. David Henderson
Chief Executive Officer

Antoinette T. Nguyen, MD, MPH

[redacted]

antoinette_nguyen@med.unc.edu

[redacted]

EDUCATION AND TRAINING

Fellowship	
7/2016-present	Fellow in Family Planning Clinical Instructor in Department of Obstetrics and Gynecology University of North Carolina Chapel Hill, North Carolina
Residency	
7/2012-6/2016	Categorical Residency Department of Obstetrics and Gynecology McGaw Medical Center of Northwestern University Chicago, Illinois
Medical School	
8/2007-5/2012	Doctor of Medicine Emory University School of Medicine Atlanta, Georgia
Graduate	
8/2010-5/2012	Master of Public Health in Epidemiology Emory University School of Public Health Atlanta, Georgia
Undergraduate	
9/2001-6/2005	Bachelor of Arts in History Northwestern University Evanston, Illinois
8/2003-12/2003	Universidad de Salamanca Salamanca, Spain

MEDICAL LICENSURE

7/2016-present	North Carolina Medical License (2016-01239)

HONORS AND AWARDS

2013	Excellence in Student Teaching Department of Obstetrics and Gynecology Northwestern University Feinberg School of Medicine
2011	Global Field Experience Award, Research Grant Emory University School of Public Health
2011	Global Elimination of Maternal Mortality Award, Research Grant Emory University School of Public Health

MEMBERSHIP IN PROFESSIONAL SOCIETIES

2015-present	Physicians for Reproductive Health
2013-present	Society of Family Planning
2011-present	American College of Obstetricians and Gynecologists
2011-present	Association of Reproductive Health Professionals

RESEARCH INTERESTS

2016-present	The relationship between contraceptive insurance coverage and subsequent abortion for primary fellowship project. An additional secondary analysis is currently ongoing that explores the non-use of contraceptive insurance for immediate post-abortion contraception.
2017-present	Safety of contraceptive implant in adolescents and young women. Systematic review in collaboration with the World Health Organization and Centers for Disease Control and Prevention.
2017-present	Cost effectiveness analysis on utilization of postpartum sterilization at University of North Carolina.
2017-present	Decision analysis on utilization of laparoscopic bilateral salpingectomy for sterilization.
2014-2016	Interventions to improve postpartum care in an urban prenatal care clinic. Developed study protocol for retrospective chart review and prospective enrollment in postpartum patient navigation program.
2010-2012	Knowledge, attitudes and practices of contraception and family planning among women in Central Plateau of Haiti. Developed study protocol and implemented survey in May 2012.
2010-2012	Clinical burden of pertussis in early pregnancy and prevalence of pertussis in rural Guatemala. Master's thesis completed.
2010-2011	Accuracy and performance of point of care devices to measure capillary blood glucose or hemoglobin A1C and possible use as diagnostic tool in low and middle income countries. Completed data abstraction for systematic review and meta-analysis with Dr. Justin Tcheugui.
2005-2007	Clinical outcomes of carotid angioplasty and stenting versus carotid endartarectomy. Managed research database for the Department of Vascular Surgery at Northwestern University.

PUBLICATIONS

Bhatti KZ, **Nguyen AT**, Stuart GS. Medical Abortion Reversal, Science and Politics Meet. Submitted to Viewpoints August 2017 for Am J Obstet Gynecol.

Nguyen AT, Stuart GS. The Global Gag Rule: When Politics Trumps Science. Submitted to Viewpoints September 2017 for Am J Obstet Gynecol.

Yee LM, Martinez N, **Nguyen AT**, Hajjar N, Chen MJ, Simon M. Using a Patient Navigator to Improve Postpartum Care in an Urban Women's Health Clinic. Obstet Gynecol. 2017 May;129(5): 925-933.

Tang GL, Matsumura JS, Morasch MD, Pearce WH, **Nguyen AT**, Amaranto D, Eskandari MK. Carotid angioplasty and stenting vs carotid endarterectomy for treatment of asymptomatic disease: single-center experience. Arch Surg. 2008 Jul; 143(7): 653-658.

ORAL AND POSTER PRESENTATIONS

Nguyen AT. *Ryan Fellows Showcase Emerging Research in Contraception: Non-use of contraception insurance coverage at the time of abortion.* Oral presentation at: 73rd American Society for Reproductive Medicine Scientific Congress and Expo; San Antonio, TX; October 2017.

Martinez NG, **Nguyen AT**, Hu F, Strohbach A, Hajjar N, Yee LM. *Effect of Introduction of a Lactation Counselor on Breastfeeding Uptake and Satisfaction in an Urban Perinatal Clinic.* Poster presented at: American College of Obstetricians and Gynecologists 2017 Annual Clinical and Scientific Meeting; San Diego, CA; May 2017.

Yee LM, Martinez NG, **Nguyen AT**, Hajjar N, Chen MJ, Simon MA. *Navigating New Motherhood: Interventions to Improve Postpartum Care in an Urban Women's Health Clinic.* Poster presented at: Society for Maternal-Fetal Medicine's 37th Annual Pregnancy Meeting; Las Vegas, NV; January 2017.

Nguyen AT. *The Story of the Pill: An Update on Combined Oral Contraceptives*. Grand Rounds presentation to: Northwestern University Department of Obstetrics and Gynecology; Chicago, IL; May 2016.

Nguyen AT, Martinez N, Hajjar N, Yee LM. *Navigating New Motherhood: Evaluation of Postpartum Care and Contraceptive Uptake in an Urban Women's Health Clinic.* Oral Presentation at: Northwestern University Resident Research Day; Chicago, IL; June 2016.

Nguyen AT. *Fertility Preference, Contraceptive Knowledge, and the Role of Long-Acting Reversible Contraception in the Haitian Central Plateau*. Poster presented at: International Conference on Family Planning; Addis Ababa, Ethiopia; November 2013.

Harrell C, **Nguyen AT**. *Influence of Family Planning Counseling on Knowledge Acquisition and Unwanted Pregnancy in the Haitian Central Plateau.* Oral Presentation at: 3rd International Conference on Family Planning; Addis Ababa, Ethiopia; November 2013.

Mikulich M, **Nguyen AT**. *Misperceptions in Family Planning Knowledge Among Women in the Central Plateau of Haiti*. Oral Presentation at: 3rd International Conference on Family Planning; Addis Ababa, Ethiopia; November 2013.

EDUCATIONAL PRESENTATIONS

Ectopic pregnancy and extended use of long-acting reversible contraceptives. UNC Campus Health Services; Chapel Hill, NC; September 2017.

First trimester bleeding and abortion. UNC medical students during OB/Gyn rotation; Chapel Hill, NC; August 2016, September 2016, October 2017.

Introduction to abortion. UNC chapter of Medical Students for Choice; Chapel Hill, NC; November 2016.

Ectopic pregnancy and early pregnancy loss. UNC OB/Gyn residents; Chapel Hill, NC; September 2016.

Contraception Simulation. Interactive simulation with: UNC OB/Gyn residents; Chapel Hill, NC; September 2016, September 2017.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	Illinois Division of Professional Regulation	As of Date:11/8/2017

PRACTITIONER INFORMATION

Name:	Nguyen, Antoinette Truc
DOB:	12/19/1982
Medical School:	Emory University School of Medicine Atlanta, Georgia, UNITED STATES
Year of Grad:	2012
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
NORTH CAROLINA	2016-01239	6/7/2016	12/19/2017	10/3/2017

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	Illinois Division of Professional Regulation	As of Date:11/8/2017
Practitioner Name:	Nguyen, Antoinette Truc	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099