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

January 12, 2016

Rachel Cannon MD
McGaw Med Ctr-Northwestern
Dept of GME
240 E Huron Ste 1-203
Chicago, IL 60611-2909

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:	125.063039
PROGRAM START DATE:	06/23/2016
EXPIRATION DATE:	06/22/2017
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.

2013

APPLICATION FOR LICENSURE AND/OR EXAMINATION

RECEIVED
CENTRAL INTAKE
DEC 08 2015
IDFPR
Div. of Professional Regulation

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.

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	125	NON examination	$ 100.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☐ This is the first time I have made application for this profession in Illinois.
- ☒ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: _____
- ☐ 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.
CANNON	RACHEL		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. Superia St Chicago IL USA 60611-____

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
[redacted]
Month Day Year

10. AGE [redacted]
☒ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: (312) 921-6185 (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): CANNON RACHEL

SS#: [redacted]

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
ROCKVILLE HIGH SCHOOL	VERNON CT	06 / 2004 (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
BOSTON UNIVERSITY	BOSTON MA	9/2004	5/2008	B.S
UMASS MEDICAL SCHOOL	WORCESTER MA	8/2009	6/2013	MD

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
NORTHWESTERN MEMORIAL HOSPITAL	CHICAGO, IL	7/2013	12/2015	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): RACHEL CANNON

SS#: [redacted]

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 ILLINOIS	OBGYN RESIDENT	125.063039	7/2013	ACTIVE
State of Current Licensure where you most recently have been practicing. ILLINOIS	OBGYN RESIDENT			
Other States of Licensure				

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

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)

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

NAME (Last, First, MI): RACHEL CANDAU

SS#: [redacted]

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.*		X
2. Have you been convicted of a felony?		X
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.*		X
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.*		X
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.*		X
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.*		X

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

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

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

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] 11/30/2014

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
CANNON	RACHEL		[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.		X
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.*		X
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.*		X
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.		X
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.*		X
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.*		X
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.*		X

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] 11/30/2015

Signature of Applicant Date

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

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE
CANNON RACHEL

3. PROFESSIONAL LICENSE NUMBER (if any)
125 . 063039

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

Date 11/30/2015

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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: CANNON — FIRST: RACHEL — MIDDLE:

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

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

Temporary Physician Extension — 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: NCGaw Medical Center

B. BEGINNING DATE: 06/23/2016 (Month Day Year)

C. ENDING DATE: 06/22/2017 (Month Day Year)

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

E. SPECIALTY / RESIDENCY NAME: Obstretic and Gynecology

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

G. YEAR OF POSTGRADUATE TRAINING: PGY4

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
Print Name of Program Director

MD Program Director
Title

12/1/2015
Date

SEAL

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
Associate Professor

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

NORTHWESTERN
UNIVERSITY

December 1, 2015

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

RE: CANNON, Rachel, IL License 125063039

To Whom It May Concern:

Dr. Rachel Cannon began her residency at Northwestern McGaw Center for Graduate Medical Education on June 24, 2013 and will complete her 4th year of residency on June 29, 2017.

Dr. Cannon's current license will expire on June 22, 2016. 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

CANNON RACHEL

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

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
Northwestern Memorial Hospital

JOB TITLE
Resident Physician

ADDRESS STREET, CITY, STATE, ZIP CODE
250 E Superior St Chicago IL 60611

DESCRIPTION OF DUTIES PERFORMED
patient care

DATE OF EMPLOYMENT/ATTENDANCE
From 07 / 01 / 2013 (Month / Day / Year)
To __ / __ / ____ (Month / Day / Year)

HOURS WORKED PER WEEK
80

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
current

B. NAME OF PRACTICE / WORK LOCATION

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)

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

May 17, 2013

Rachel Cannon MD
McGaw Medical Center/Northwestern
Dept of GME
420 E Superior St Ste 12-174
Chicago, IL 60611-4494

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:	125.063039
PROGRAM START DATE:	06/23/2013
EXPIRATION DATE:	06/22/2016
PROGRAM:	Obstetrics and Gynecology
TRAINING FACILITY:	McGaw/Northwestern

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

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BUSINESS SERVICES
MAR 29 2013
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Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

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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.

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1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Licensure	1 2 5	Nonexamination	$ 230.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☒ This is the first time I have made application for this profession in Illinois.
- ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: _____
- ☐ 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.
CANNON	RACHEL		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

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
[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
Rockville High School	Vernon, CT	06 / 2004 (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
Boston University	Boston, MA	09/2004	05/2008	B.S.
University of Massachusetts Medical School	Worcester, MA	08/2009	06/2013	M.D.

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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	Rhode Island	06/2011	[redacted]
USMLE Step 2	MA	11/2012	[redacted]

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

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		X
2. Have you been convicted of a felony?		X
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.*		X
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.*		X
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.*		X
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.*		X

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

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

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

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] 03/20/2013

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 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
CANNON RACHEL

3. PROFESSIONAL LICENSE NUMBER (if any)
[redacted]

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

3/20/2013
Date

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: Cannon, Rachel

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three Digit profession code for which you are making Illinois application.
Temporary Physician / 125
Profession Name Profession Code

6. MAIDEN OR GIVEN SURNAME

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

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

B. BEGINNING DATE: 06/23/2013 Month Day Year

C. ENDING DATE: 06/22/2016 Month Day Year

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE
420 East Superior Street, Rubloff 12th floor
Chicago, IL 60611

D. SPECIALTY / RESIDENCY NAME: OB/Gyn

F. BUSINESS TELEPHONE NUMBER
(312) 503-7975

G. YEAR OF POSTGRADUATE TRAINING: PGY 1

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Professional Regulation, the Applicant is found to be eligible for licensure.

[redacted]
Signature of Program Director

Magdy Milad
Print Name of Program Director

Program Director
Title

3/28/13
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

CANNON RACHEL

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

CANNON

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

A. NAME OF BUSINESS / INSTITUTION (Cutaneous Biology Research Center)

Massachusetts General Hospital

ADDRESS STREET, CITY, STATE, ZIP CODE 02129

Bldg 149 East 13th St Charlestown, MA

DATE OF EMPLOYMENT/ATTENDANCE

From 05 / 27 / 2008 (Month / Day / Year)

To 07 / 24 / 2009 (Month / Day / Year)

HOURS WORKED PER WEEK: 40

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

TOTAL TIME WORKED (Year/Month): 1 year 2 months

JOB TITLE: lab technician

DESCRIPTION OF DUTIES PERFORMED:

- assisted with lab experiment
- maintained lab stock
- ordered lab supplies

B. NAME OF BUSINESS / INSTITUTION

Cold Stone Creamery

ADDRESS STREET, CITY, STATE, ZIP CODE 02215

201 Brookline Ave Boston, MA

DATE OF EMPLOYMENT/ATTENDANCE

From 09 / 05 / 2005 (Month / Day / Year)

To 05 / 02 / 2008 (Month / Day / Year)

HOURS WORKED PER WEEK: 20

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

TOTAL TIME WORKED (Year/Month): 2 years 8 months

JOB TITLE: ice cream scooper

DESCRIPTION OF DUTIES PERFORMED:

made ice cream for customers
cleaning
opening and closing store.

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: CANNON — FIRST: RACHEL — MIDDLE:

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

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 Licencure — Profession Name: 125 — Profession Code

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.

3/20/2013 — 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: U. of Massachusetts Medical School

Address: 55 Lake Avenue North

City, State, Zip: Worcester, MA 01655

Phone: 508-856-2267

Fax: 508-856-1899

B. DATES OF ATTENDANCE

Start: 08 / 12 / 2009 (Month / Day / Year)

End: 06 / 02 / 2013 (Month / Day / Year)

Degree: X MD ____ DO

C.

Applicant will complete all requirements for the medical degree as of 06 / 02 / 2013 (Month / Day / Year) and will graduate on 06 / 02 / 2013 (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.

SCHOOL SEAL

[redacted]

Michael F. Baker, M.A.
Print Name of School Official

Registrar
Title

5/8/2013
Date

IL486-1426 02/12 (L&T)

RECEIVED
ED-MED CERTIFICATION OF EDUCATION
MAY 14 2013
IDPR MEDICAL UNIT

Direct Inquiries to the
IDFPR Call Center

Telephone No.: 1-800-560-6420

Attn:

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

Date: 4/15/2013

Initials: LB

License No: 125

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:

Rachel Cannon 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

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

OR

Submit final transcript upon graduation.

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