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.

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	1 2 5	Non-Examination	$100

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.
- [ ] 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.
Brown, Benjamin Patterson	MD	[redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
5841 S. Maryland Ave., M/C 1052
Chicago, IL 60637-1470 Cook

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

7. MOTHER'S MAIDEN NAME [redacted]

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

9. DATE OF BIRTH [redacted]

10. AGE [redacted]

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: (773) 702-6760 (Area Code)
Home: [redacted] (Area Code)
Fax: (773) 702-0861 (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): BROWN, BENJAMIN P

SS#: [redacted]

Profession: NEW PHYSICIAN

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 OR Received G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
WESTON HIGH SCHOOL	WESTON, MA	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
BROWN UNIVERSITY	PROVIDENCE, RI	08/2004	05/2008	BACHELOR'S
ALPERT MEDICAL SCHOOL OF BROWN UNIVERSITY	PROVIDENCE, RI	08/2008	5/12	MD (PENDING)

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): BROWN, BENJAMIN P

SS#: [redacted]

Profession: TEMP. PHYSICIAN

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	RI	04/2010	[redacted]
USMLE STEP 2 CK	RI	11/2011	
USMLE STEP 2 CS	PA	12/2011	

(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.*		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 [X]
   (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 [X]

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] 02/20/2012

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): BROWN, BENJAMIN P

SS#: [redacted]

Profession: TEMP. PHYSICIAN

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	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Brown, Benjamin	[redacted]	

4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
5841 S. Maryland Ave., MC 1052, Chicago, IL 60637	Temporary Physician (Profession Name) 1 2 5 (Profession Code)
6. MAIDEN OR GIVEN SURNAME	

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

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE	C. ENDING DATE
University of Chicago Medical Center	06 / 24 / 2012 (Month / Day / Year)	06 / 23 / 2015 (Month / Day / Year)
D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE	E. SPECIALTY / RESIDENCY NAME	
5841 S. Maryland Ave., MC 1052, Chicago, IL 60637	OBSTETRICS AND GYNECOLOGY	
F. BUSINESS TELEPHONE NUMBER	G. YEAR OF POSTGRADUATE TRAINING	
Area Code (773) 702 — 6760	I	

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

[redacted]

Anita Blanchard, M.D.
Print Name of Program Director

Program Director
Title

3/19/2012
Date

SEAL

IL486-0272 08/04 (MD)

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 FIRST MIDDLE: BROWN, BENJAMIN PATTERSON

2. DATE OF BIRTH [redacted] 3. SOCIAL SECURITY NUMBER

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.

6. MAIDEN OR GIVEN SURNAME: BROWN

TEMPORARY PHYSICIAN (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.

07/20/2012 (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: The Warren Alpert Medical School of Brown Univ.
Address: 222 Richmond St., Box G-M1
City, State, Zip: Providence, RI 02912
Phone: 401-863-5077
Fax: 401-863-5096

B. DATES OF ATTENDANCE

Start: 08 (Month) 18 (Day) 2008 (Year)
End: 05 (Month) 27 (Day) 2012 (Year)

RECEIVED MAY 09 2012 IDFPR - MEDICAL UNIT

Degree: X MD ___ DO

C.

Applicant will complete all requirements for the medical degree as of 04 (Month) 27 (Day) 2012 (Year) and will graduate on 05 (Month) 27 (Day) 2012 (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] (Signature of School Official)

Kathleen Chien (Print Name of School Official)

Associate Director, Medical School Administration & REGISTRAR (Title)

4-28-12 (Date)

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VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

BROWN, BENJAMIN PATTERSON

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

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

BROWN

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

A. NAME OF BUSINESS / INSTITUTION

ALPERT MEDICAL SCHOOL OF BROWN UNIV.

JOB TITLE

MEDICAL STUDENT

ADDRESS STREET, CITY, STATE, ZIP CODE

222 RICHMOND ST, PROVIDENCE, RI, 02903

DESCRIPTION OF DUTIES PERFORMED

STUDIED MEDICINE THROUGH CLASSROOM WORK AND CLINICAL ROTATIONS.

DATE OF EMPLOYMENT/ATTENDANCE

From 08 / 18 / 2008 (Month / Day / Year)

To 05 / 27 / 2012 (Month / Day / Year)

HOURS WORKED PER WEEK

60

TYPE OF EMPLOYMENT

☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

3 YEARS 7 MONTHS AS OF TODAY

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)

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

June 4, 2012

BENJAMIN P BROWN MD
UNIV OF CHICAGO MED CTR
DEPT OF GME RM J141
5841 S MARYLAND AVE MC 1052
CHICAGO, IL 60637-1470

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:	125.061361
PROGRAM START DATE:	06/24/2012
EXPIRATION DATE:	06/23/2015
PROGRAM:	Obstetrics and Gynecology
TRAINING FACILITY:	UNIV OF CHICAGO

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.

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: 5/7/2012

Initials: DR

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:

BENJAMIN P BROWN MD
UNIV OF CHICAGO MEDICAL CENTER
DEPT OF GME RM J141
5841 S MARYLAND AVE MC 1052
CHICAGO, IL 60637-1470

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Submit official transcript(s) verifying medical education with graduation date OR 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.

265150

APPLICATION FOR LICENSURE AND/OR EXAMINATION

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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
SEP 30 2013
BY:

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
LICENSED PHYSICIAN & SURGEC	036 ___ ___	COMPUTERIZED	$ 91.00

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.
BROWN	BENJAMIN	PATTERSON	MD	[redacted]

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

[redacted]

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

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME
BROWN	[redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH Month Day Year	10. AGE
[redacted]	[redacted]	[redacted]

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED	12. PREFERRED e-MAIL ADDRESS(ES) [If available]
Work (___) ___-____ (Area Code) Home: [redacted] (Area Code)	BENJAMIN.BROWN@UCHOSPI

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
X

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
WESTON HIGH SCHOOL	WESTON MA	6 / 2004 (Month / Year)

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 8
X

Graduated? ☒ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM	DATES OF ATTENDANCE TO	TYPE OF DEGREE EARNED
		Month/Year	Month/Year	
BROWN UNIVERSITY	PROVIDENCE, RI	08/2004	05/2008	AB
ALPERT MEDICAL SCHOOL OF BRO	PROVIDENCE, RI	08/2008	05/2012	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	DATES OF ATTENDANCE TO	Did You Complete Training?
		Month/Year	Month/Year	
UNIVERSITY OF CHICAGO MEDI	CHICAGO, IL	06/2012		☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): BROWN BENJAMIN PATTERSC

SS#: [redacted]

Profession: LICENSED PHYSICIAI

NAME (Last, First, MI): BROWN BENJAMIN PATTERS

SS#: [redacted]

Profession: LICENSED PHYSICIAN

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	TEMPORARY PHYSICIAI	125061361	6/24/2012	ACTIVE
State of Current Licensure where you most recently have been practicing. IL	TEMPORARY PHYSICIAI	125061361	6/24/2012	ACTIVE
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
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USMLE STEP 2 CK	RI	11/2011	
USMLE STEP 2 CS	PA	12/2011	

(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.*		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. 0 1

b) CHART III - Select the examination site you desire and enter Test Center Code: 9 9 9 9

c) CHART IV - Find your School of Graduation and enter school code: 05/27/2012 000000

d) Record the number of times you have taken this exam in Illinois or any other state: 0

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 [X]
   (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 [X]

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.

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): BROWN BENJAMIN PATTERSON

SS#: [redacted]

Profession: LICENSED PHYSICIAN

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)
BROWN	BENJAMIN	PATTERS	___ - ___
2. ADDRESS STREET, CITY, STATE, ZIP CODE			4. SOCIAL SECURITY NUMBER
[redacted]			[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.

Signature of Applicant _____ Date _____

RECEIVED
JAN 03 2014
BY:

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 POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(CTS)

APPLICANT: Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
BROWN	BENJAMIN	PATTERSON	[redacted]	[redacted]

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

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

PHYSICIAN (Profession Name) — 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: BROWN

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable): 125061361

8. ISSUANCE DATE: 6/24/12

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:

Continental Testing Services, Inc.
P.O. Box 100
LaGrange, Illinois 60525-0100

This is to certify that the above-named applicant satisfactorily completed 16 months of postgraduate clinical training in Obstetrics and Gynecology
(Name of Accredited Postgraduate Clinical Training Program)

from June 24, 2012 to November 18, 2013 at the following hospital:

Hospital: University of Chicago

Number and Street: 5841 S. Maryland Ave., MC 2050

City, State and Zip Code: Chicago, IL 60637

I further certify that at the time of such training the program was accredited by:

- [X] the Accreditation Council for Graduate Medical Education;
- [ ] the Accreditation Council on Canadian Graduate Medical Education; or
- [ ] the American Osteopathic Association

Name of Postgraduate Clinical Training Program Director: Anita Blanchard, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: November 18, 2013

SEAL

Telephone No: 773-834-0598

IF THIS FILM IS NOT LEGIBLE

IN SOME PLACES IT IS DUE

GENERALLY TO THE POOR CONDITION

OF THE ORIGINAL DOCUMENT RATHER

THAN THE FILMING TECHNIQUES

RECEIVED
OCT 30 2013
BY:

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

APPLICANT: Complete the application section of this form then forward it to your employer. Upon receipt of the completed form from the employer include it with your Application for Licensure/Examination. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE
BROWN BENJAMIN PATTERSON

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

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

4. DATE OF BIRTH
[redacted]

5. SOCIAL SECURITY NUMBER
[redacted]

6. MAIDEN OR GIVEN SURNAME
BROWN

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

A. NAME OF BUSINESS / INSTITUTION
ALPERT MEDICAL SCHOOL OF BROWN UNIV.

JOB TITLE
MEDICAL STUDENT

ADDRESS STREET, CITY, STATE, ZIP CODE
222 RICHMOND ST, PROVIDENCE, RI 02903

DESCRIPTION OF DUTIES PERFORMED
STUDIED MEDICINE THROUGH CLASSROOM WORK AND CLINICAL ROTATIONS

DATE OF EMPLOYMENT/ATTENDANCE
From 08/18/2008 (Month/Day/Year)
To 05/17/2012 (Month/Day/Year)

HOURS WORKED PER WEEK
60

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
3 YEARS, 9 MONTHS

B. NAME OF BUSINESS / INSTITUTION
UNIVERSITY OF CHICAGO MEDICAL CENTER

JOB TITLE
OB/GYN RESIDENT

ADDRESS STREET, CITY, STATE, ZIP CODE
5841 S. MARYLAND AVE - MC2050 - CHICAGO, IL 60637

DESCRIPTION OF DUTIES PERFORMED
RESPONSIBLE FOR PATIENT CARE AND PROFESSIONAL DEVELOPMENT ACTIVITIES, INSTRUCT MEDICAL STUDENTS AND JUNIOR RESIDENTS

DATE OF EMPLOYMENT/ATTENDANCE
From 06/19/2012 (Month/Day/Year)
To ___/___/_____ (Month/Day/Year)

HOURS WORKED PER WEEK
80

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
1 YEAR, 4 MONTHS AS OF TODAY

IL486-1965 04/06 (MD)

Print this Listing

10/1/2013 **Illinois Division of Professional Regulation** 4:11:51 PM

SEARCH FOR LICENSE BY LICENSE NUMBER:
Profession is Medical License, Temporary

You requested license number: 125-061361

Licensee's Name	DBA/AKA	License Number	License Status	City, State	Program Name	Program Start Date	Issuance Date	Current Exprtn	Ever Discplned?
BENJAMIN P BROWN MD		125061361	ACTIVE	CHICAGO, IL	Obstetrics and Gynecology	06/24/2012	06/24/2012	06/23/2015	N

Page 1

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 POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

APPLICANT: ***Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.***

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Brown	Benjamin	P.	[redacted]	

4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
[redacted]	Physician (Profession Name) — 036 (Profession Code)
6. MAIDEN OR GIVEN SURNAME	

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)	8. ISSUANCE DATE
125-061361	6/24/2012

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed 25 months of postgraduate clinical training in Obstetrics and Gynecology (Name of Specialty Program)

from 6/24/2012 (MM/DD/YYYY) to 8/4/2014 (MM/DD/YYYY) at the following hospital:

Hospital: University of Chicago

Number and Street: 5841 S. Maryland Ave., MC 2050

City, State and Zip Code: Chicago, IL 60637

I further certify that at the time of such training the program was accredited by:

- [X] the ACGME
- [ ] the AOA
- [ ] the CFPC, RCPSC or FMLAC (Canadian Programs)
- [ ] not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: Anita Blanchard, M.D.

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 8/4/2014

University/Hospital SEAL

Telephone No: 773-834-0598

(If no seal, attach letter on letterhead stating no seal exists.)

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)
BROWN	BENJAMIN	PATTERSON	125 061361
2. ADDRESS STREET, CITY, STATE, ZIP CODE			4. SOCIAL SECURITY NUMBER
5841 S. MARYLAND AVE - MC2050, CHICAGO, IL 60637			[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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- ☐ Occupational Therapy Assistants
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- ☐ 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.*

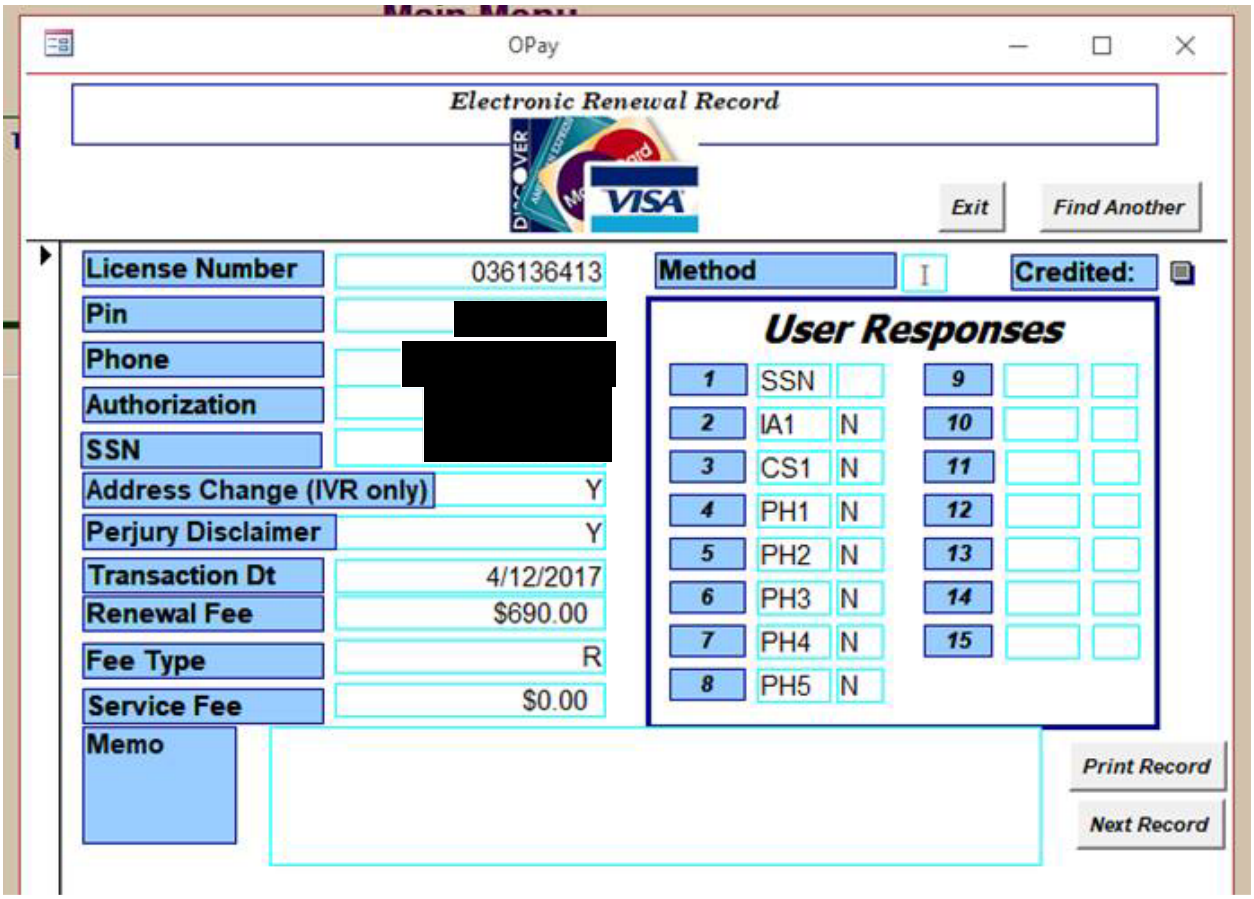
Certification Statement

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 8/14/17


OPay
Electronic Renewal Record
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License Number
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Authorization
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Y
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Method
Credited:
User Responses
1 SSN
2 IA1 N
3 CS1 N
4 PH1 N
5 PH2 N
6 PH3 N
7 PH4 N
8 PH5 N
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14
15
Print Record
Next Record

RECEIVED
CASH SECTION

JUL 09 2015

IDFPR
Div. of Professional Regulation

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

Lic#: 336.100218
BROWN, BENJAMIN PATTERSON
336 Cred #3508837 07/02/2015
By:NON-EXAM
SSN: [redacted]

8/6/15

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

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

1. PROFESSIONAL NAME	2. PROFESSIONAL CODE - Check applicable box		3. LICENSURE METHOD	4. FEE
Controlled Substances	☐ 319 Dentist	☒ 336 Physician	Registration	$5
	☐ 316 Podiatrist	☐ 390 Veterinarian		

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
BROWN	BENJAMIN	PATTERSON	MD	[redacted]

4. PERMANENT MAILING ADDRESS: [redacted]

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED

5841 S. MARYLAND AVE - MC 2050
CHICAGO, IL 60637

6. If you will ***not*** be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

☒ I will ***not*** be storing or dispensing controlled substances, including samples.

7. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

BROWN

8. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work (773) 702-1000 PAGER 3610 — FAX ( ) —
Area Code — Area Code

Home [redacted] — FAX ( ) —
Area Code — Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:

(II) (III) (IV) (V)

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 -
☒	Physician	036 - 136413
☐	Podiatrist	016 -
☐	Veterinarian	090 -

PART V: 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 VI: 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 VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

3/22/15 — [redacted]

Date of Application — Signature of Applicant

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.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

NAME (Last, First, MI): Brown Benjamin P

SS#: [redacted]

Profession: 036

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
BROWN BENJAMIN PATTERSON

3. PROFESSIONAL LICENSE NUMBER (if any)
036-136413

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
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- ☐ Physical Therapy Assistants
- ☑ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
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- ☐ Podiatrists
- ☐ Professional Counselors
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- ☐ Registered Nurses
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- ☐ 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

3/22/15
Date

IDFPR

Credit Card Renewal Question Codes, Definitions and Response/Direction (updated 01/26/2014)

Question Code	Question	Response/Direction
This is the default perjury question for all licensees and is not coded.	If the information you will be asked to give is not truthful, disciplinary action may be taken against your license. Do you affirm that the information you are about to give or answer is true and correct?	If yes, then Processing continues. If no, then processing stops and Person must contact department.
CE1	Have you fully complied with the continuing education requirement for the renewal of your license?	If yes, no other CE question should be asked. Processing continues. If no then person must contact the department.
CE2	Have you fully complied with the continuing education requirement for the renewal of your license?	If yes, no other CE question should be asked and processing continues. If no then question CE4 should be asked.
CE4	Are you exempt from the continuing education requirement?	If yes, continue to CE6. If no then person must contact the department.
CE6	Are you at least 62 years of age?	If yes, no other CE question should be asked and processing continues. If no then question CE7 should be asked.
CE7	Have you been licensed as a cosmetologist, cosmetology teacher or cosmetology clinic teacher for at least 25 years?	If yes, no other CE question should be asked and processing continues. If no then person must contact the department.
CE1C	Have you fully complied with the continuing education requirement for the renewal of your license?	If yes, no other CE question should be asked. If no then CE5 question should be asked.
CE5	Are you exempt from the continuing education because you have actively been licensed for 40 years?	If yes, processing continues. If no then person must contact department.
CS1	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.)	Must respond if asked. If no process continues. If yes then person must contact the department.
IA1	Would you like to place your license on inactive status?	If yes, and expiration date has not passed, then note and end phone. If after expiration date, then person must pay late renewal fee amount. No other questions should be asked. If no, continue to next question.
IA3	Would you like to place your license on inactive status?	If yes, and expiration date has not passed, **inactive fee is required** and no other questions should be asked. If after expiration date then person must pay late renewal fee amount plus inactive fee amount. If no, continue to next question.

Question Code	Question	Response/Direction
PH1	Since MMDDYYYY, have you been convicted of any criminal offense in any state or federal court other than minor traffic violations?	If no, continue to next question. If yes then person must contact the department.
PH2	Since MMDDYYYY, have you had or do you now have any disease or condition that impairs or impaired your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community?	If no, continue to next question. If yes then person must contact the department.
PH3	Since MMDDYYYY, 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 no, continue to next question. If yes then person must contact the department.
PH4	Since MMDDYYYY, have your clinical, hospital or practice privileges relating to patient care been involuntariuly restricted, suspended or revoked other than for noncompletion of medical records?	If no, continue to next question. If yes then person must contact the department.
PH5	Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act?	If no, continue to next question. If yes then person must contact the department.
PH6	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?	If no, continue to next question. If yes then person must contact the department.
PH7	Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act?	If no, continue to next question. If yes then person must contact the department.
PH8	Are you currently charged with or have you been convicted of a forcible felony?	If no, continue to next question. If yes then person must contact the department.
PR1	Are you subject to a Peer Review?	If Yes, continue to next question. If No skip question PR2.
PR2	If you are subject to a Peer Review has it satisfactorily been completed?	If Yes, continue to next question. If No then person must contact the department.

Question Code	Question	Response/Direction
SP1	Do you have a current Basic Life Support certificate?	If yes, continue to next question. If no then person must contact department.
SP2	Is the barber school for which you are renewing actually providing instruction and maintaining the equipment required by the Barber, Cosmetology, Esthetics and Nail Technology Act of 1985?	If yes, continue to next question. If no then person must contact department.
SP3	Have you fully complied with the seismic education requirements?	If yes, continue to next question. If no then person must contact department.
SP4	Is the Supervising Physician of Record correct?	If yes, continue to next question. If no then person must contact department.
SP5	Do you have current public liability and property damage insurance with the minimum of $100,000 per occurrence of property damage and $300,000 per occurrence of personal injury or bodily harm?	If yes, continue to next question. If no then person must contact department.
SP6	Do you have a current Surety Bond with a $5,000 minimum?	If yes, continue to next question. If no then person must contact department.
SP7	Are you currently Certified as a Pharmacy Technician?	Record Answer and proceed to next question
SP8	Are you currently a Student enrolled in an ACPE Approved PharmD Program?	Record Answer and proceed to next question
SP9	Have you attended a class or seminar within the past 5 years that teaches techniques or guidelines, or both, for humane animal euthanasia?	Record Answer and proceed to next question
SPA	Have you maintined current national certification (CNM, CRNA, etc.) used to qualify for licensure as an APN?	Record Answer and proceed to next question
SSN	Please Enter your Social Security Number	Please enter your Social Security Number. Nine Digits must be entered.
ISAC	Are you more than 30 days in arrears on a student loan acquired through the Illinois Student Assistance Commission?	If no continue to next question. If yes then person must contact department.
CMP1	Are you in compliance with the Home Inspector License Act, Administrative Section 1410.110?	If yes, continue to next question. If no then person must contact department.
AC1	Has your address changed from the one shown on your renewal notice?	If yes, then Address change phone recording will be made at end of renewing.
AC2	Has your address changed from the one shown on your renewal notice?	If yes, then ask question AC2A. If no, do not ask question AC2A and use the fees identified in first renewal fee areas.
AC2A	Is your new address in Illinois?	If yes, the use fees identified in Illinois fee area. If no then use fees identified in non-Illinois fee areas.
Contact The Department	We are unable to renew your license based on the information provided. For additional information contact the department at ###-###-####	Use the Support Phone Field in the Renewal Record. Please enunciate phone # slowly and repeat phone # if possible.