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IDFPR

# 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 |
|---|---|---|---|
| PHYSICIAN | 036 | Endorsement | $ 700 |

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. |
|---|---|---|
| DIEDRICH, JUSTIN THOMAS | 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: (Same)

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

7. MOTHER'S MAIDEN NAME: [redacted]

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

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

10. AGE: 36

- [ ] Female
- [x] Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: ( [redacted] ) (Area Code)

Home: ( [redacted] ) (Area Code)

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

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

12. **REQUIRED** E-MAIL ADDRESS: [redacted]



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

NAME (Last, First, MI): DIEDRICH, JUSTIN T.

SS#: [redacted]

Profession: MD

## 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? [x] 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 |
|---|---|---|
| Parkway North High School | Creve Coeur, MO | 05 / 2000 (Month / Year) |

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

1 2 3 4 5 6 7 8 Graduated? [x] 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 |
|---|---|---|---|---|
| Case Western Reseve University | Cleveland Ohio | 08/00 | 05/04 | B.A. |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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? |
|---|---|---|---|---|
| Case School of Medicine | Cleveland, Ohio | 07/03 | 01/08 | [x] Yes [ ] No |
| | | | | [ ] Yes [ ] No |
| | | | | [ ] Yes [ ] No |
| | | | | [ ] Yes [ ] No |
| | | | | [ ] Yes [ ] No |

NAME (Last, First, MI): DIEDRICH, JUSTIN T.

SS#: [redacted]

Profession: MD

## 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<br>California | Physician | A114859 | 11/24/10 | Active |
| State of Current Licensure where you most recently have been practicing.<br>California | | | | |
| Other States of Licensure | | | | |
| Missouri | Physician | 2013023316 | 7/6/13 | Active |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

***(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 | FLORIDA | 8/05 | [redacted] |
| USMLE, STEP 2 CK | MISSOURI | 12/06 | |
| USMLE, STEP 2 CS | ILLINOIS | 01/07 | |
| USMLE, STEP 2 CS | ILLINOIS | 05/07 | |
| USMLE, STEP 3 | CALIFORNIA | 02/10 | |
| AMERICAN BOARD OF OBGYN | TEXAS | 11/06 | |

***(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 or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.* | | x |
| 2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.* | | 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. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.* | | 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] 1.11.18

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): DIEDRICH, JUSTIN T.

SS#: [redacted]

Profession: MD

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

# ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
## PERSONAL HISTORY INFORMATION

SUPPORTING DOCUMENT

**PH**

| NAME LAST | FIRST | MIDDLE | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| DIEDRICH, JUSTIN THOMAS | | | [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]

Signature of Applicant

1.11.18

Date

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

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

SUPPORTING DOCUMENT

**CCA**

1. NAME LAST FIRST MIDDLE

DIEDRICH, JUSTIN THOMAS

3. PROFESSIONAL LICENSE NUMBER (if any)

NPI - 1396978037

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 1.11.18

# ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## AUTHORIZATION FOR THIRD PARTY CONTACT

***Instructions to Applicant:*** Use this form to authorize individuals or companies (such as employers or credential services) to contact the Department on your behalf regarding your application.

| | |
|---|---|
| Name: Justin T Diedrich | Phone: [redacted] |
| Address: [redacted] | SSN: [redacted] |
| Profession: Gynecologist | Email: [redacted] |

I, Justin T Diedrich, hereby authorize the following person/business to communicate with the Division regarding my application for initial licensure. I understand that information received from the person or business listed below shall be binding and that I will be responsible for the accuracy of all information and documents received as part of my application for initial licensure. This authorization shall expire upon issuance of the license, referral to enforcement or expiration of the application.

Name of authorized representative: Kristina Winkelman,

Address: [redacted]

Phone:

Email:

[redacted]

Applicant Signature

10-30-17

Date

*Completed forms may be sent to the Division at:*

fpr.medicalunit@illinois.gov

**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

DIEDRICH, JUSTIN THOMAS

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

DIEDRICH

**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
UC IRVINE MEDICAL CENTER

JOB TITLE
RESIDENT PHYSICIAN, OBGYN

ADDRESS STREET, CITY, STATE, ZIP CODE
101 THE CITY DRIVE, ORANGE CA

DESCRIPTION OF DUTIES PERFORMED
RESIDENT PHYSICIAN IN GYNECOLOGY SURGICAL, CLINICAL CARE OF WOMEN

DATE OF EMPLOYMENT/ATTENDANCE
From 07/01/2009 (Month Day Year)
To 06/30/2013 (Month Day Year)

HOURS WORKED PER WEEK
80

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
4 YEARS

B. NAME OF PRACTICE / WORK LOCATION
WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

JOB TITLE
FELLOW IN FAMILY PLANNING

ADDRESS STREET, CITY, STATE, ZIP CODE
4533 CLAYTON AVE, ST LOUIS MO 63110

DESCRIPTION OF DUTIES PERFORMED
SURGICAL AND CLINICAL CARE OF REPRODUCTIVE-AGED WOMEN; TEACHING RESIDENTS AND MEDICAL STUDENTS; GYNECOLOGY ON-CALL

DATE OF EMPLOYMENT/ATTENDANCE
From 07/01/2013 (Month Day Year)
To 06/30/2015 (Month Day Year)

HOURS WORKED PER WEEK
60

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
2 YEARS

NAME (Last, First, MI): DIEDRICH, JUSTIN T

SS#: [redacted]

Profession: PHYSICIAN

C. NAME OF PRACTICE / WORK LOCATION
UC RIVERSIDE

JOB TITLE
ATTENDING PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE
19330 JESSE LANE, SUITE 100
RIVERSIDE CA 92508

DESCRIPTION OF DUTIES PERFORMED
CARE OF REPRODUCTIVE-AGED WOMEN; LECTURING RESIDENTS AND MEDICAL STUDENTS; GYNECOLOGY ON-CALL

DATE OF EMPLOYMENT/ATTENDANCE
From 08/01/2015 (Month/Day/Year)
To 06/30/2017 (Month/Day/Year)

HOURS WORKED PER WEEK
40

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
1 YEAR, 11 MONTHS

D. NAME OF PRACTICE / WORK LOCATION
SELF-EMPLOYED

JOB TITLE
REPRODUCTIVE HEALTH CONSULTANT

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

DESCRIPTION OF DUTIES PERFORMED
CONSULTANT FOR FAMILY PLANNING CLINICS

DATE OF EMPLOYMENT/ATTENDANCE
From 07/01/2015 (Month/Day/Year)
To CURRENT (Month/Day/Year)

HOURS WORKED PER WEEK
50

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
4 MONTHS, CURRENT JOB

E. NAME OF PRACTICE / WORK LOCATION
PLANNED PARENTHOOD ST LOUIS

JOB TITLE
INDEPENDENT CONTRACTOR

ADDRESS STREET, CITY, STATE, ZIP CODE
4251 FOREST PARK PKWY, ST LOUIS MO 63108

DESCRIPTION OF DUTIES PERFORMED
CARE OF REPRODUCTIVE AGED WOMEN

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

HOURS WORKED PER WEEK
5

TYPE OF EMPLOYMENT
☐ Full-time ☒ Part-time

TOTAL TIME WORKED (Year/Month)
Part time 4 years, 3 months

F. 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)

Federation of STATE MEDICAL BOARDS

**Federation Credentials Verification Service (FCVS)**

400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

## Verification of Postgraduate Medical Education

Institution: University of California (Irvine) Program
Specialty: Obstetrics & Gynecology
Address: Orange, CA

Attention: Program Director
Affiliated University: University of California, Irvine

**Verification For:**

Name: Justin Thomas Diedrich
DOB: [redacted]
Individual's Name on Record (if different from above): _____

**Program Participation:**

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations

PGY: 1-4
☒ Internship
☒ Residency
☐ Chief Residency
☐ Fellowship
☐ Research
Specialty/Subspecialty: Obstetrics + Gynecology
From: 6/23/2009 To: 6/22/2013
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: _____
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research
Specialty/Subspecialty: _____
From: _____ To: _____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: _____
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research
Specialty/Subspecialty: _____
From: _____ To: _____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

**Unusual Circumstances:**

Check the correct response. Omitted responses require written explanation

If necessary, you may continue your explanation on a separate sheet of paper

ELECTRONIC SEAL VERIFIED

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

**Certification:**

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Laura Fitzmaurice, MD
Signature: [redacted]
Title: Residency Program Director
Date of Signature: 1/16/18
Tel: 714-456-5816 Fax: 714-456-8360 E-Mail: lfitzmau@uci.edu

Rev. 01/21/2016 FID: [redacted] ACGME ID: 2200521031 GME CODE: _____

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Postgraduate Training

Federation of STATE MEDICAL BOARDS

Postgraduate Training

**Accreditation ID:** **2200521031**
**Institution:** **University of California (Irvine) Program**
Location: Orange, CA
UNITED STATES

**Accreditation ID:** **None**
**Institution:** **Barnes Jewish Hospital**
Location: Saint Louis, MO
UNITED STATES

**Credentials Analysis Information for Postgraduate Training**

Issue:
The Verification of Post Graduate Training Form from Barnes Jewish Hospital dated 07/01/2013 to 06 / 30/2015 reported in the Chronology of Activities is not included in the Profile.

Solution:
FCVS does not obtain verification of non-accredited training programs.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

# Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

## Graduate Medical Education

| | |
|---|---|
| Medical Professional Name: | Diedrich, Justin Thomas |
| Accreditation ID: | 2200521031 |
| Institution: | University of California (Irvine) Program |
| Specialty: | Obstetrics & Gynecology |

## Unusual Circumstances

**Training Period: 7/1/2009 - 6/30/2013** **Internship/Residency**

| | |
|---|---|
| **Did you have any interruption(s) or extension(s) in your medical education?** | **No** |
| **Were you ever placed on probation?** | **No** |
| **Were you ever disciplined or placed under investigation?** | **No** |
| **Were any negative reports for behavioral reasons ever filed by instructors?** | **No** |
| **Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?** | **No** |

End of Applicant Reported Unusual Circumstances report for: Diedrich, Justin Thomas

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

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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.

IDFPR
Division of Professional Regulation

# 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 Month Day Year | 3. SOCIAL SECURITY NUMBER |
|---|---|---|
| DIEDRICH, JUSTIN THOMAS | [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. | |
| 6. MAIDEN OR GIVEN SURNAME DIEDRICH | Physician (Profession Name) | 036 (Profession Code) |
| 7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable) | 8. ISSUANCE DATE | |

## 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 48 months of postgraduate clinical training in Obstetrics and Gynecology Residency Program (Name of Specialty Program)

from 06/23/2009 (MM/DD/YYYY) to 06/22/2013 (MM/DD/YYYY) at the following hospital:

Hospital: University of Californica, Irvine (Medical Center)

Number and Street: 101 The City Drive

City, State and Zip Code: Orange, CA 92868



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: Laura Fitzmaurice

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 1/10/18

Telephone No: 714/456-5616

University/Hospital SEAL

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

J. DIEDRICH [redacted]



N 1/19

# MEDICAL BOARD OF CALIFORNIA
**Licensing Program**

January 16, 2018

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION
SPRINGFIELD OFFICE
PO BOX 7007
SPRINGFIELD IL 62791

RECEIVED
FEB 06 2018
IDFPR - MEDICAL UNIT

To Whom It May Concern:

This is to certify that on the date of this letter the records of the Medical Board of California (Board) indicate the following information:

| | |
|---|---|
| Physician: | JUSTIN THOMAS DIEDRICH |
| License Number: | A114859 |
| Issued Date: | 11/24/2010 |
| Exam Type: | A written examination |
| Expiration Date: | 10/31/2018 |
| License Status: | CURRENT |
| Board Discipline and/or Administrative Action: | No |

If Board Discipline and/or Administrative Action is indicated, public records may be available at http://www.mbc.ca.gov; or you may contact the Board's Enforcement Program, Central File Room by email at central.fileroom@mbc.ca.gov, by fax at (916) 263-2420 or by mail at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain information concerning the action.

[redacted]

Kimberly Kirchmeyer
Executive Director

## Licensure / Examinations

Exam: USMLE

## Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

## PRACTITIONER PROFILE

Prepared for: FCVS As of Date:2/13/2018

### PRACTITIONER INFORMATION

| | |
|---|---|
| Name: | Diedrich, Justin Thomas |
| DOB: | [redacted] |
| Medical School: | Case Western Reserve University School of Medicine<br>Cleveland, Ohio, UNITED STATES |
| Year of Grad: | 2008 |
| Degree Type: | MD |
| NPI: | 1396978037 |

### BOARD ACTIONS

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

### LICENSE HISTORY

| Jurisdiction | License Number | Issue Date | Expiration Date | Last Updated |
|---|---|---|---|---|
| CALIFORNIA | A-114859 | 11/24/2010 | 10/31/2018 | 2/7/2018 |
| MISSOURI | 2013023316 | 7/6/2013 | 1/31/2019 | 2/2/2018 |

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

## PRACTITIONER PROFILE

Prepared for: FCVS As of Date:2/13/2018

Practitioner Name: Diedrich, Justin Thomas

### ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Obstetrics and Gynecology
Certificate: Obstetrics and Gynecology
Certification Type: General
Certification Status: Certified
Participating in MOC: Yes

| Status | Duration | Effective Date | Expiration Date | Reverification Date | Occurrence | Last Reported |
|---|---|---|---|---|---|---|
| Active | Time Limited | 12/31/2017 | 12/31/2018 | | Recertification | 1/25/2018 |
| Active | Time Limited | 12/31/2016 | 12/31/2017 | | Recertification | 1/25/2018 |
| Expired | Time Limited | 11/06/2015 | 12/31/2016 | | Initial | 1/25/2018 |





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# WASHINGTON UNIVERSITY SCHOOL OF MEDICINE

## DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

**HEREBY CERTIFIES THAT**

# JUSTIN T. DIEDRICH, M.D., M.S.C.I.

**HAS COMPLETED A**

## FELLOWSHIP IN FAMILY PLANNING

**JULY 1, 2013 – JUNE 30, 2015**

[redacted] [redacted] [redacted]

DEAN

Washington
University in St. Louis

Copy for Reference [redacted] DIEDRICH, JUSTIN T.

12/29/2017

• • •

Justin Diedrich MD

[redacted]

Department of Financial and Professional Regulation
P.O. Box 7007
Springfield, IL 62791

**Dear Division of Professional Regulation:**

Please accept this application for licensure in the State of Illinois. If you have any questions or concerns, please feel free to reach me by email a[redacted]r by phone at [redacted] I appreciate the opportunity to work in the great State of Illinois.

Sincerely,

[redacted]

Justin Diedrich MD

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 65/1 et.seq. of (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

# CERTIFYING STATEMENT OF FINGERPRINT SUBMISSION

SUPPORTING DOCUMENT

**FP-MED**

**APPLICANT:** ***This form must be completed by out-of-state residents unable to utilize the livescan process for fingerprinting in the State of Illinois. Attach this certifying statement with the four-page Application for Licensure and/or Examination as proof of having submitted the required fingerprint cards to the proper authorities.***

1. NAME LAST FIRST MIDDLE: DIEDRICH, JUSTIN THOMAS

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.

- ☒ Physician 036
- ☐ Chiropractic Physician 038

6. MAIDEN OR GIVEN SURNAME: DIEDRICH

## CERTIFYING STATEMENT

Under penalties of perjury, I declare that I, JUSTIN THOMAS DIEDRICH, have submitted the required fingerprints pursuant to Section 60-9.7 of the Medical Practice Act of 1988 (225 ILCS 60) and the Rules for the Administration of the Act (68 Ill. Adm. Code 1285) to the designated agent of the Illinois State Police for processing.

Date: [redacted] 1.29.18

Signature: [redacted]

RECEIVED

FEB 06 2018

IDFPR - MEDICAL UNIT

J. DIEDRICH [redacted]

## Regional Office of Education 41

### Public Fingerprinting

**Location:** 157 North Main Street, Suite 438 Edwardsville, IL 62025
**Phone:** 618-296-4530
**Location Note:** You will find us in the Administration Building next to the Madison County Courthouse
**Hours:** Monday – Friday, 8:30 – 4:00pm and break from 1:00 – 2:00 for lunch
**Cost:** $42.00 Cash Only

| First Name | Last Name | Middle Initial |
|---|---|---|
| Justin | Diedrich | T. |

| Maiden Name/ Other Names Used | SSN | DOB | State of Birth |
|---|---|---|---|
| — | [redacted] | | |

| Address | City | State | Zip |
|---|---|---|---|
| [redacted] | | | |

| Gender | Race | Eye Color | Hair Color | Height | Weight |
|---|---|---|---|---|---|
| [redacted] | | | | | |

| Drivers License Number | State Issued | Phone Number |
|---|---|---|
| [redacted] | | |

### Applicant Verification and Authorization

I, the undersigned, hereby authorize the release of any criminal history record information that may exist regarding me from any agency organization, institution, or entity having such information on file. I authorize the Regional Office of Education in Madison County to capture and securely transmit my fingerprints to the Illinois State Police and/or Federal Bureau of Investigations for the purpose of checking my criminal history record information. I further understand that my fingerprints may be retained by the Illinois State Police and/or Federal Bureau of Investigation pursuant to applicable statute.
If your fingerprints are AFIS unacceptable and reprinting is necessary to receive results, the customer is required to pay the reprint fee.

**Signature of Applicant** [redacted] 1.29.18
Signature Date

### Office Use Only

Transaction Control Number (TCN): LS11083L776010061

Technician Signature: [redacted]

Purpose Code: PHY ORI: IL920704Z

Date: 1.29.18 Time: 9 AM