RECEIVED
APR 17 2017

APPLICATION FOR STATEON CONTROLLED SUBSTANCES REGISTRATION

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.

FOR OFFICIAL USE ONLY

[redacted]

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. PROFESSION NAME	2. PROFESSION CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☐346 Optometrist ☐316 Podiatrist ☐390 Veterinarian ☑336 Physician	Registration	$5

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.
FLEISHER,	JONAH	DAVID	M.D.	[redacted]

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

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

UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE
820 S. WOOD ST. M/C 808
CHICAGO, IL 60612

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)

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

Work (215) 573-5830 (Area Code) FAX (718) 579-4699 (Area Code)

Home [redacted] (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 -
☐	Optometrist	046 -
☑	Physician	036 - [redacted] 143320
☐	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 or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*		✓
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		✓
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.		✓
4. Do you 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.		✓
7. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		✓

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.

3/25/2017
Date of Application

[redacted]
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): FLEISHER, JONAH D.
SS#: [redacted]
Profession: PHYSICIAN

RECEIVED
HIGH SECTION

APR 17 2017

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	0 3 6	ENDORSEMENT	$ 700

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.
FLEISHER	JONAH	DAVID	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

UNIV. OF ILLINOIS COLLEGE OF MEDICINE 820 S. WOOD ST MC 808 CHICAGO, IL 60612-4325 COOK

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

7. MOTHER'S MAIDEN NAME [redacted]

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

9. DATE OF BIRTH [redacted]

10. AGE 35 ☐ Female ☑ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (718) 579-5830 (Area Code)

Home: [redacted]

Fax: (708) 406-1578 (Area Code)

Fax: ( ) [redacted] (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): FLEISHER, JONAH D.

SS#: [redacted]

Profession: 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 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
OAK PARK & RIVER FOREST H.S.	OAK PARK, IL	06 / 1999 (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	DATES OF ATTENDANCE TO	TYPE OF DEGREE EARNED
WASHINGTON UNIVERSITY IN ST. LOUIS	SAINT LOUIS, MO	Month/Year 08/1999	Month/Year 05/2004	A.B. (CONFERRED 05/2003)
FEINBERG SCHOOL OF MED. NORTHWESTERN UNIVERSITY	CHICAGO, IL	08/2005	05/2009	M.D.
COLLEGE OF GLOBAL PUBLIC HEALTH, NEW YORK UNIV.	NEW YORK, NY	09/2014	05/2016	M.P.H.

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM	DATES OF ATTENDANCE TO	Did You Complete Training?
THOMAS JEFFERSON UNIV. (RESIDENCY)	PHILADELPHIA, PA	Month/Year 06/2009	Month/Year 06/2013	☑ Yes ☐ No
NEW YORK UNIVERSITY (FELLOWSHIP)	NEW YORK, NY	07/2014	06/2016	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): FLEISHER, JONAH D.

SS#: [redacted]

Profession: 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 PA	PHYSICIAN	MT 194974 (TRAINEE)	06/20/2009	LAPSED 06/19/2013
State of Current Licensure where you most recently have been practicing. NY	PHYSICIAN	274112	03/10/2014	ACTIVE
Other States of Licensure				
PA	PHYSICIAN	MD 449108 (UNRESTRICTED)	06/17/2013	LAPSED 12/31/2014

(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	IL	06/2007	(Pas[redacted]sent)
USMLE STEP 2 C.K. & C.S.	IL	12/2008	
USMLE STEP 3	PA	06/2010	

(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.*		✓
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		✓
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		✓
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		✓
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		✓

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

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

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

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

c) CHART IV - Find your School of Graduation and enter school code: [ ]

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

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

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

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

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

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

PART IX: Certifying Statement

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

[redacted] 3/25/17

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): FLEISHER, JONAH D.

SS#: [redacted]

Profession: 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.

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
PERSONAL HISTORY INFORMATION

SUPPORTING DOCUMENT

PH

NAME LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
FLEISHER	JONAH	DAVID	[redacted]

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

Certification Statement

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

[redacted] Signature of Applicant

3/25/2017 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: FLEISHER JONAH DAVID

3. PROFESSIONAL LICENSE NUMBER (if any): ---'-------

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

4. SOCIAL SECURITY NUMBER: [redacted]

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

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

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

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

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

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

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

Signature of Applicant: [redacted]

Date: 3/25/2017

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:	Jonah Fleisher	Phone:	[redacted]
Address:	[redacted]	SSN:	
Profession:	Physician (Ob/Gyn)	Email:	

I, JONAH FLEISHER, 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:	Monica Holt
Address:	820 South Wood Street, MC 808, Chicago, IL 60612
Phone:	312-9967006
Email:	mlholt@uic.edu

[redacted]
Applicant Signature

3/25/17
Date

Completed forms may be sent to the Division at:

fpr.medicalunit@illinois.gov

Section IV

Medical Education

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Northwestern University Medical School

Address Line 1:
Northwestern Univ Feinberg Sch of Med

Address Line 2:
303 East Chicago Ave Ward Building 1-003

City: Chicago **State/Province:** IL **Zip Code (Postal Code):** 60611-3008
Country: US

If name of institution was different when this individual attended, please note this name below:

Premedical Education:
Years of education required for admission to your medical school: 3(honors program)or 4
Credential/degree presented by the applicant for admission to your medical school: BA or BS

Enrollment and Participation: Our records indicate that Fleisher, Jonah David
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 154 weeks of medical education on the following dates: From: 08/22/05 (Month Day Year) To: 05/14/09 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 05/14/09 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.

SEAL VERIFIED

Name: Miroslava Rachuy
Signature: [redacted]
Title: Academic Records Assistant
Date of Signature: 04/19/13 Phone: (312) 503-4070
Fax: (312) 503-0715 Email:

277507 277507 1150 1150 215461195

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

FLEISHER, JONAH DAVID

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

5. SOCIAL SECURITY NUMBER

[redacted]

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

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

6. MAIDEN OR GIVEN SURNAME

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

A. NAME OF PRACTICE / WORK LOCATION

LINCOLN MEDICAL & MENTAL HEALTH CENTER

ADDRESS STREET, CITY, STATE, ZIP CODE

234 E. 149th St, BRONX, NY 10451

DATE OF EMPLOYMENT/ATTENDANCE

From 07 / 25 / 2016 (Month / Day / Year)

To 06 / 30 / 2017 (Month / Day / Year)

HOURS WORKED PER WEEK

60

TYPE OF EMPLOYMENT

☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

1 year

JOB TITLE

ATTENDING PHYSICIAN

DESCRIPTION OF DUTIES PERFORMED

Clinical care and supervision of resident physicians across the spectrum of OB/GYN care.

(END DATE OF 06/30/2017 IS ANTICIPATED END DATE.)

B. NAME OF PRACTICE / WORK LOCATION

BELLEVUE HOSPITAL CENTER

ADDRESS STREET, CITY, STATE, ZIP CODE

462 FIRST AVE, NBV-9E2, NEW YORK, NY 10016

DATE OF EMPLOYMENT/ATTENDANCE

From 07 / 01 / 2014 (Month / Day / Year)

To 06 / 30 / 2016 (Month / Day / Year)

HOURS WORKED PER WEEK

50

TYPE OF EMPLOYMENT

☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

2 years

JOB TITLE

FELLOW / CLINICAL ASSISTANT ATTENDING

DESCRIPTION OF DUTIES PERFORMED

Learned the subspecialty of Family Planning as a Fellow; also provided clinical care and resident physician supervision across the spectrum of general OB/GYN care.

NAME (Last, First, MI): FLEISHER, JONAH D

SS#: [redacted]

Profession: PHYSICIAN

C. NAME OF PRACTICE / WORK LOCATION
PENNSYLVANIA HOSPITAL

JOB TITLE
ATTENDING PHYSICIAN / LABORIST

ADDRESS STREET, CITY, STATE, ZIP CODE
801 SPRUCE ST., PHILADELPHIA, PA 19107

DESCRIPTION OF DUTIES PERFORMED
Clinical care and supervision of resident physicians across the spectrum of OB/GYN care, focusing on inpatient obstetrics

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 31 / 2013 (Month / Day / Year)
To 06 / 30 / 2014 (Month / Day / Year)

HOURS WORKED PER WEEK
60

TYPE OF EMPLOYMENT
☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
1 year

D. NAME OF PRACTICE / WORK LOCATION
THOMAS JEFFERSON UNIVERSITY HOSPITAL

JOB TITLE
RESIDENT PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE
111 S. 11th St., PHILADELPHIA, PA 19107

DESCRIPTION OF DUTIES PERFORMED
Clinical care across the spectrum of OB/GYN care.

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 20 / 2009 (Month / Day / Year)
To 06 / 19 / 2013 (Month / Day / Year)

HOURS WORKED PER WEEK
80

TYPE OF EMPLOYMENT
☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
4 years

E. 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)

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)

Section V

Graduate Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel (817) 868 5000 Fax (817) 868 5099

Verification of Graduate Medical Education

Institution: Thomas Jefferson University Hospital
Attention: Program Director
Specialty: Obstetrics and Gynecology
Affiliated University: TJUH
Address: Philadelphia, PA

Verification For:

Name: Fleisher, Jonah David
DOB: [redacted]
Individual's Name on Record (If different from above):

Program Participation:

Important:
Report Incomplete Training Levels (years) separate from those that were successfully completed

If the training level (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

Training Level: 4 (e.g., 1, 2, 3, etc.)
☐ Internship
☒ Residency
☐ Chief Residency
☐ Fellowship
☐ Research
Specialty/Subspecialty: OBGYN
From: 6/20/2009 To: 6/19/2013
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ 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

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ 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

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 document notarized

ELECTRONIC SEAL VERIFIED

Rev. 01/21/2014

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: Abigail Wolf, MD
Signature: [redacted]
Title of Signatory: Program Director (e.g., Program Director)
Date of Signature: 01/27/2014
Tel: 215-955-1085 Fax: 215-955-5041 E-Mail: Abigail.Wolf@Jefferson.edu

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name: Jonah David Fleisher

Thomas Jefferson University Hospital

Obstetrics and Gynecology

Unusual Circumstances

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

End of report for: Jonah David Fleisher

PROVIDED BY APPLICANT

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
POST OFFICE BOX 2649
HARRISBURG, PA 17105-2649
www.dos.pa.gov

04/02/2017

VERIFICATION/CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	FLEISHER, JONAH
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE #:	MD449108
LICENSE STATUS:	Inactive
LICENSE ISSUE DATE:	06/17/2013
LICENSE EXPIRATION DATE:	12/31/2014
DISCIPLINARY HISTORY:	No Disciplinary Action Exists

[redacted]

Ian J. Harlow, Commissioner
Bureau of Professional and Occupational Affairs

Section VI

Licensure Examination History

(State Licensing Authorities Only)

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

April 13, 2017

RE: CT Forms (Certification by Licensing Agency)

To Whom It May Concern:

I am applying for an Illinois Physician license (#036) via Endorsement. I was first licensed to practice medicine in Pennsylvania, and I am currently licensed in New York.

Pennsylvania only provides verification of licenses directly to other state boards. I requested this information to be forwarded to the Illinois Department of Professional Regulation on April 2, 2017. Please let me know if you do not receive this information shortly.

New York State's certification is enclosed in a sealed envelope with this application.

Please feel free to contact me with any questions about this.

Sincerely,

[redacted]

Jonah Fleisher, MD

[redacted]

Cell: [redacted]
Email: [redacted]

NU-21

RECEIVED
CASH SECTION
MAY 02 2017
IDFPR
Div. of Professional Regulation

April 27, 2017

To whom it may concern:

Please see my attached receipt for my livescan fingerprinting, performed 4/19/17, in conjunction for my application for an Illinois medical license.

Name: Jonah David Fleisher
DOB: [redacted]
SSN:

For any questions in relation to this matter, please contact me at [redacted]

Thank you,

[redacted]

Jonah Fleisher

A FINGERPRINTING U S PHOTO

210 SOUTH CLARK ST

(Ground Floor Lobby of Adams & Clark Bldg.)

(312) 782-8144 (312)782-8143

* * * * * www.fingerprintingchicago.com * * * * *

-> -> -> E-mail: fingerprintingchicago@gmail.com <- <- <-

FEE APPLICANT LIVESCAN FINGERPRINTING RECEIPT

Date Fingerprinted: 4-19-17

TCN/DCN # LS 106 88 L820 76123 ORI # IL920704Z PROF Code - PUR Code DLE

Last Name: FLEISHER First Name: Jonah Middle Initial: D

Date of Birth: [redacted] Social Security # [redacted] Phone # [redacted]

Address: [redacted] City: [redacted] State: [redacted] Zip Code: [redacted]

Fees are not refundable. Signature of official taking Fingerprints [redacted]

THANK YOU!!

Please fill out this receipt and send with your application and application fees.

RECEIVED

MAY 02 2017

IDFPR - MEDICAL UNIT