APPLICATION FOR LICENSURE AND/OR EXAMINATION

RECEIVED
CASH SECTION
FEB 21 2017
IDFPR
Div. of Professional Regulation

FOR OFFICIAL USE ONLY

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

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.
B. **FEES ARE NOT REFUNDABLE.**
C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

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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.
HINZ ERICA KAITLIN	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: University of Illinois College of Medicine 820 S. Wood Street MC 808 Chicago, IL 60612 — 60612-____ — COOK

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

7. MOTHER'S MAIDEN NAME: [redacted]

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

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

10. AGE: 33 ☑ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: (312) 996-7206 (Area Code)
Home: [redacted] (Area Code)
Fax: (312) 996-4238 (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.

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) Error EH

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
DANBURY HIGH SCHOOL	DANBURY, CT 06811	06 / 2001 (Month / Year)

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

1 2 3 (4) 5 6 7 (8) Error EH

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
UNIVERSITY OF MICHIGAN	ANN ARBOR, MI	09/2001	05/2005	B.S. Engineering
UNIVERSITY OF CONNECTICUT SCHOOL OF MEDICINE	FARMINGTON, CT	08/2007	05/2011	M.D.

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
THOMAS JEFFERSON UNIVERSITY HOSPITAL	PHILADELPHIA, PA	06/2011	06/2015	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): HINZ, ERICA K

SS#: [redacted]

Profession: PHYSICIAN

03/30/2017 21:02:30 5 80562508

NAME (Last, First, MI): HINZ, ERICA K

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 Pennsylvania	Graduate Medical Trainee Obstetrics & Gynecology	MT199690	6/20/2011	Lapsed
State of Current Licensure where you most recently have been practicing. New York	Medicine & surgery	279302	4/16/2015	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
Basic Written Examination in Obstetrics & Gynecology	New York	09/2015	

(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] 1/23/17

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): [redacted], ERICA K

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
HINZ	ERICA	KAITLIN	[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] 1/24/17

Signature of Applicant Date

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

SUPPORTING DOCUMENT

CCA

1. NAME LAST	FIRST	MIDDLE	3. PROFESSIONAL LICENSE NUMBER (if any)
HINZ	ERICA	KAITLIN	____ - _____

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 1/23/17

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: ERICA K. HINZ	Phone: [redacted]
Address [redacted]	SSN: [redacted]
Profession: PHYSICIAN / OB GYN	Email: [redacted]

I, ERICA HINZ, 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: University of Illinois College of Medicine
820 South Wood Street, MC 808 Chicago, IL 60612

Phone: 312.996.7006

Email: mlholt@uic.edu

[redacted]
Applicant Signature

1/24/17
Date

Completed forms may be sent to the Division at:

fpr.medicalunit@illinois.gov

UIC Department of Obstetrics
UNIVERSITY OF ILLINOIS AT CHICAGO and Gynecology
COLLEGE OF MEDICINE

1/24/17

Illinois Department of Financial & Professional Regulation
Division of Professional Regulation

RE: Release of Information on the IL MD application/licensing process of Dr. Erica Hinz to Monica Holt

To Whom It May Concern:

Attached is my application for an Illinois Physician license and as part of that application I am including this authorization for Release of Information to our Credentialing Coordinator, Monica Holt, from the University of Illinois College of Medicine Department of Obstetrics & Gynecology. You may release to her any and all information you would release to me as relates the processing of the enclosed application.

Should you have any questions or concerns about anything related to this application or the authorization to release information to Monica Holt, do not hesitate to contact me directly either via e-mail [redacted] or phone [redacted]

Sincerely,

[redacted]

Erica Hinz, MD

Obstetrics & Gynecology | 820 South Wood Street, MC 808 | Chicago, IL 60612 | tel: 312.996.7006 | fax: 312.413.1857
www.obgyn.uic.edu

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: HINZ — FIRST: ERICA — MIDDLE: KAITLIN

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: NEW YORK UNIVERSITY / BELLEVUE HOSPITAL

ADDRESS STREET, CITY, STATE, ZIP CODE: 462 1st Avenue New York, NY 10016

DATE OF EMPLOYMENT/ATTENDANCE
From 07 / 01 / 2015 (Month / Day / Year)
To 01 / 23 / 2017 (Month / Day / Year)

HOURS WORKED PER WEEK: 50

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

TOTAL TIME WORKED (Year/Month): 1 YEAR / 6 MONTHS (EMPLOYED UNTIL 7/1/2017)

JOB TITLE: PHYSICIAN (FELLOW)

DESCRIPTION OF DUTIES PERFORMED: CLINICAL OBSTETRICS & GYNECOLOGY RESEARCH

B. NAME OF PRACTICE / WORK LOCATION: THOMAS JEFFERSON UNIVERSITY HOSPITAL

ADDRESS STREET, CITY, STATE, ZIP CODE: 834 Chestnut St. Philadelphia, PA 19107

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 20 / 2011 (Month / Day / Year)
To 06 / 20 / 2015 (Month / Day / Year)

HOURS WORKED PER WEEK: 70

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

TOTAL TIME WORKED (Year/Month): 4 YEARS

JOB TITLE: PHYSICIAN (RESIDENT)

DESCRIPTION OF DUTIES PERFORMED: CLINICAL OBSTETRICS & GYNECOLOGY

IL486-1965 01/14 (MD)

NAME (Last, First, MI):

SS#:

Profession:

C. 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)

D. 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)

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)

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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
HINZ	ERICA	KAITLIN	[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

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 (Name of Specialty Program)

from 06/30/2011 (MM/DD/YYYY) to 06/30/2015 (MM/DD/YYYY) at the following hospital:

Hospital: Thomas Jefferson University Hospital

Number and Street: 111 So. 11th St.

City, State and Zip Code: Philadelphia PA, 19107

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: Abigail Wolf, M.D.

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 2/9/17

Telephone No: 215-955-1085

University/Hospital SEAL

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

Jefferson.

833 Chestnut Street, Mezzanine
Philadelphia, PA 19107
T 215-955-8461
F 215-955-5536

February 10, 2017

To Whom It May Concern,

This letter is in reference to Dr. Erica Hinz's [redacted] application for an Illinois Medical license. I am happy to notarize any documents that you may need for the application of her license, but at present no University/Hospital seal exists to add to the completed document.

Please feel free to notify my office if I can be of further assistance in this matter.

Sincerely,

[redacted]

Joellen C. Hodorovich, B.S.
GME/Residency Program Coordinator
Department of Obstetrics and Gynecology
Thomas Jefferson University
833 Chestnut Street
Mezzanine #132
Philadelphia PA, 19107
215-955-1085

joellen.hodorovich@jefferson.edu

App/Se(IL)

THE UNIVERSITY OF THE STATE OF [redacted] YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, HINZ ERICA KAITLIN
was issued license/certificate number 279302 for the practice of MEDICINE on 04/16/15.

Our records also indicate the following information:
Date of birth: [redacted]
School attended: UNIVERSITY OF CONNECTICUT
Date of graduation: 05/15/11
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
11/11						[redacted]		[redacted]	
06/10			[redacted]						
06/09									

EXMS TAKEN=03

A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 03/31/17
Address: [redacted]

Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Cathy Hanczaryk, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

[redacted] 01/27/17
Office Assistant Three

RECEIVED
CASH SECTION
DEC 21 2007
DIV. of Professional Regulation

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

FOR OFFICIAL USE ONLY

[redacted]

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. PROFESSION NAME	2. PROFESSION CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
PHYSICIAN Controlled Substances	☐319 Dentist ☐346 Optometrist ☐316 Podiatrist ☐390 Veterinarian ☑336 Physician	ENDORSEMENT 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.
HINZ	ERICA	KAITLIN	M.D.	[redacted]

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

[redacted]

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, OBSTETRICS AND GYNECOLOGY
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)

HINZ

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

Work (312) 996-7001 (Area Code) FAX (312) 996-4238 (Area Code)

Home [redacted] FAX ( ) (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 - 143972
☐	Podiatrist	016 -
☐	Veterinarian	090 -

NAME (Last, First, MI): HINZ, ERIKA K

SS#: [redacted]

Profession: PHYSICIAN

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.

1/24/17
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.