2/21

BUSINESS SERVICES
FEB 21 2012

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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

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

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

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Extension/Reissue	1 2 5	Nonexamination	$ 100.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☐ This is the first time I have made application for this profession in Illinois.
- ☒ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: FEB 24 2012
- ☐ 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.

RECEIVED
FEB 24 2012
DEPT. OF MEDICAL UNIT

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.
Griffin	Leanne	Rita	MD	[redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
250 East Superior St. #52177 Chicago IL 60611 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] Month Day Year

10. AGE 28 ☒ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: (312) 412-4673 (Area Code)
Home: [redacted] (Area Code)
Fax: (___) ___-____ (Area Code)
Fax: (___) ___-____ (Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) [If available]
[redacted]

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

NAME (Last, First, MI): Griffin, Leanne K

SS#

Profession: 125

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
Lynn Classical High School	Lynn, MA	06/2001 (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
University of Massachusetts Dartmouth	N. Dartmouth, MA	Month/Year 08·2001	Month/Year 05·2005	BS
Georgetown University School of Medicine	Washington DC	08·2005	05·2009	MD

RECEIVED
FEB 24 2012
IDFPR - MEDICAL UNIT

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?
McGaw Medical Center	Chicago IL	Month/Year 06/09	Month/Year present	☑ Yes ☐ No currently
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Griffin, Leanne K

SS#: [redacted]

Profession: 125

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure Illinois	125	125055807	06·2009	active
State of Current Licensure where you most recently have been practicing. Illinois	125	125055807	06·2009	active.
Other States of Licensure				
			RECEIVED FEB 24 2012 IDFPR - MEDICAL UNIT	

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

PART V: Record of Examination

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

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

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

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		X
2. Have you been convicted of a felony?		X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		X
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		X
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		X

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

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

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

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

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

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

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

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

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

RECEIVED
FEB 24 2012
IDFPR - MEDICAL UNIT

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

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

PART IX: Certifying Statement

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

[redacted] 2.17.2012

Signature of Applicant — Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

NAME (Last, First, MI): Griffin, Luann K

SS#: [redacted]

Profession: 125

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

NOTE: An applicant shall not commence specialty/residency training before he or the hospital/institution receives written notice of the approval of his application from the Department of Financial and Professional Regulation.

APPLICANT: Complete the applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the remainder of the form.

1. NAME — LAST: Griffin — FIRST: LeAnne — MIDDLE:

3. SOCIAL SECURITY NUMBER: [redacted]

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

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

Temporary Physician (Profession Name) — 125 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

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

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

B. BEGINNING DATE: 06 (Month) 23 (Day) 2012 (Year)

C. ENDING DATE: 06 (Month) 22 (Day) 2013 (Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: 420 E. Superior, Suite 12.174 Chicago, IL 60611

E. SPECIALTY / RESIDENCY NAME: OB/Gyn

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

G. YEAR OF POSTGRADUATE TRAINING: PGY4

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

10

SEAL

[redacted]
Signature of Program Director

Magdy Milad
Print Name of Program Director

Program Director
Title

2/16/2012
Date

IL486-0272 08/04 (MD)

Northwestern University
Feinberg School of Medicine

Division of Graduate Medical Education
Department of Obstetrics and Gynecology
Prentice Women's Hospital
and Maternity Center
250 East Superior Street, Suite 05-2177
Chicago, Illinois 60611

Magdy P. Milad, MD, MS
Division Head
Professor

mmilad@nmh.org
Phone 312-472-4673
Fax 312-472-4687

NORTHWESTERN
UNIVERSITY

February 13, 2012

Illinois Department of Professional Regulations
Medical Unit #1
320 W. Washington
Springfield, IL 62786

To whom it may concern:

Re: Leanne Griffin - 125055807

This letter is to request an Illinois Temporary License extension for Leanne Griffin in order to complete the required residency training in Obstetrics and Gynecology at Northwestern McGaw Medical Center in Chicago, Illinois. Please reissue licensure from June 23, 2012 to June 22, 2013.

Please feel free to contact me should you have any questions or concerns.

Sincerely,

[redacted]

Magdy Milad, MD, MS
Program Director

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

Griffin Leanne Rita

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

[redacted]

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

A. NAME OF BUSINESS / INSTITUTION

McGaw Medical Center

ADDRESS STREET, CITY, STATE, ZIP CODE

DATE OF EMPLOYMENT/ATTENDANCE

From 06 / 28 / 2009 (Month / Day / Year)

To 06 / __ / 2013 (Month / Day / Year)

HOURS WORKED PER WEEK

80

TYPE OF EMPLOYMENT

☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

3yr. 10months – current

JOB TITLE

Resident Physician

DESCRIPTION OF DUTIES PERFORMED

OB/GYN resident physician

B. NAME OF BUSINESS / INSTITUTION

ADDRESS STREET, CITY, STATE, ZIP CODE

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)

JOB TITLE

DESCRIPTION OF DUTIES PERFORMED

RECEIVED

FEB 24 2012

IDFPR - MEDICAL UNIT

IL486-1965 08/06 (MD)

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

May 1, 2009

LEANNE RITA GRIFFIN MD
MCGAW MEDICAL CENTER NORTHWESTERN
DEPT OF GME
645 N MICHIGAN AVE STE 1058A
CHICAGO, IL 60611

The Illinois Temporary Medical License or Permit for the resident listed above has been approved and will be forwarded to your facility as soon as office routine permits. Information regarding all licensees is available instantly on our Web site at www.idfpr.com. Simply click on the Express Access License Look-up icon to verify a license.

LICENSE DETAILS

LICENSE NUMBER:	125.055807
PROGRAM START DATE:	06/23/2009
EXPIRATION DATE:	06/22/2012
PROGRAM:	Obstetrics & Gynecology
TRAINING FACILITY:	MCGAW MED CTR NORTHWESTERN

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

Temporary licenses and permits may not be used for any clinical medical practice which occurs outside of the residency program (i.e. moonlighting).

Temporary licenses and permits are **not** automatically transferred from one program/institution to another. Should the resident transfer to a different residency program within your facility or to a program in another institution, the license or permit must be updated. The resident may not begin a new program until the current temporary license or permit has been returned to the Division and a license or permit has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of temporary licenses and permits. Any violation of the Act may result in disciplinary action by this Department.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

INSTRUCTION: Completion of this form is necessary for consideration for licensure ...f this information is VOLUNTARY. ...eing processed.

Lic#:
GRIFFIN, LEANNE RITA
125 Cred #2896723 04/02/2009
By:NON-EXAM
SSN:026-64-4708

...plication for

...RE AND/OR

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

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

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

PART I: Application Category Information

A. SEE **REFERENCE SHEET, CHART I, OR INSTRUCTIONS** PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Temporary Physician Licensure	1 2 5	Nonexamination	$ 100.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☒ This is the first time I have made application for this profession in Illinois.
- ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: _____
- ☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- ☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
Griffin,	Leanne	Rita	MD	[redacted]

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

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

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

7. MOTHER'S MAIDEN NAME: [redacted]

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

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

10. AGE: 25 ☒ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (___) ___-____ (Area Code) Home: [redacted] (Area Code)

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

12. PREFERRED e-MAIL ADDRESS(ES) [If available]: [redacted]

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

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
Classical High School	Lynn, MA	0 6 / 2 0 0 1 (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	DATES OF ATTENDANCE TO	TYPE OF DEGREE EARNED
University of Massachusetts, Dartmouth	Dartmouth, MA	Month/Year 09/2001	Month/Year 05/2005	BS
Georgetown University School of Medicine	Washington DC	08/2005	05/2009	MD

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

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

NAME (Last, First, MI): Griffin, Leanne K

SS#: [redacted]

Profession:

NAME (Last, First, MI): Griffin, Leanne K

SS#: [redacted]

Profession: 125

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
USMLE Step 1 Examination	VA	06/2007	[redacted]
USMLE Step 2 CS Examination	PA	11/2008	
USMLE Step 2 CK Examination	VA	02/2009	

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

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		✓
2. Have you been convicted of a felony?		✓
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		✓
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		✓
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		✓
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		✓

PART 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] / Signature of Applicant

March 23, 2009
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): Griffin, Leanne K

SS#: [redacted]

Profession:

125

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

NOTE: An applicant shall not commence specialty/residency training before he or the hospital/institution Receives written notice of the approval of his application from the Department of Professional Regulation.

APPLICANT: Complete the applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the form.

1. NAME LAST FIRST MIDDLE
Griffin, LeAnne Rita

2. DATE OF BIRTH [redacted]
Month Day Year

3. SOCIAL SECURITY NUMBER [redacted]

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

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

Temporary Physician (Profession Name) 1 2 5 (Profession Code)

6. MAIDEN OR GIVEN SURNAME

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

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

B. BEGINNING DATE
06 / 23 / 2009
Month Day Year

C. ENDING DATE
06 / 22 / 2012
Month Day Year

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE
645 N. Michigan Avenue, Suite #1058-A, Chicago, IL 60611

E. SPECIALTY / RESIDENCY NAME
Obstetrics and Gynecology

F. BUSINESS TELEPHONE NUMBER
(312) 503-7975

G. YEAR OF POSTGRADUATE TRAINING
PGY 1

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

[redacted]
Signature of Program Director

Magdy Milad
Print Name of Program Director

Program Director
Title

3/19/09
Date

IL 486-0272 12/93 (MD)

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 ILCS 60/1 et.seq. Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF EDUCATION

(Current Year Graduates of LCME and COCA-Accredited Programs Only)

SUPPORTING DOCUMENT

ED - MED

APPLICANT: *Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.*

1. NAME — LAST: Griffin — FIRST: Leanne — MIDDLE: Rita

2. DATE OF BIRTH — Month Day Year: [redacted] — 3. SOCIAL SECURITY NUMBER

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

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

Temporary physician licensure — Profession Name: 125 — Profession Code

6. MAIDEN OR GIVEN SURNAME

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

April 17, 2009 — Date

[redacted] — Signature

SCHOOL OFFICIAL: Complete the bottom portion of this page and RETURN THIS FORM TO THE APPLICANT.
DO NOT complete this form more than 30 days prior to the graduation date.

A. MEDICAL SCHOOL INFORMATION

Name: —
Address: —
City, State, Zip:
Phone: —
Fax: —

GEORGETOWN UNIVERSITY, SoM
OFFICE OF ACADEMIC RECORDS
3900 RESERVOIR ROAD, NW
WASHINGTON DC 20057
202.687.1856 (O) 202.687.7660 (F)

B. DATES OF ATTENDANCE

Start: 08 / 09 / 2005 (Month / Day / Year)
End: 05 / 01 / 2009 (Month / Day / Year)
Degree: ✓ MD ____ DO

C. CHECK THE APPROPRIATE STATEMENT

{ } Applicant has graduated on ___ / ___ / _____ (Month / Day / Year)

{ ✓ } Applicant will complete all requirements for the medical degree as of 05 / 01 / 2009 (Month / Day / Year) and will graduate on 05 / 17 / 2009 (Month / Day / Year).

When this form is certified prior to the actual graduation of the applicant, the school official is responsible for notifying the Department of Financial and Professional Regulation of any failure on the part of the applicant to complete the requirements for graduation.

I certify that the information recorded herein is true and correct according to the official records of this institution.

[redacted]
Signature of School Official

SCHOOL SEAL

JEANNE WALTHER
Print Name of School Official

SR. ASSOC. DEAN & REGISTRAR
Title

4/17/09
Date

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

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE
Griffin, Leanne Rita

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.

A. NAME OF BUSINESS / INSTITUTION
Georgetown University School of Medicine

ADDRESS STREET, CITY, STATE, ZIP CODE
3900 Reservoir Rd, Washington DC 20007

DATE OF EMPLOYMENT/ATTENDANCE
From 08/14/2006 (Month/Day/Year)
To 05/11/2007 (Month/Day/Year)

HOURS WORKED PER WEEK
3

TYPE OF EMPLOYMENT
☐ Full-time ☒ Part-time

TOTAL TIME WORKED (Year/Month)
9 months

JOB TITLE
Medical Note Service Copier

DESCRIPTION OF DUTIES PERFORMED
Copied the lecture summaries for the pre-clinical years and distributed the packets to medical students.

B. NAME OF BUSINESS / INSTITUTION
Institute of Emergency Medical Education of Massachusetts

ADDRESS STREET, CITY, STATE, ZIP CODE
285 Oldwestport Rd, North Dartmouth, MA 02747

DATE OF EMPLOYMENT/ATTENDANCE
From 03/01/2004 (Month/Day/Year)
To 05/01/2006 (Month/Day/Year)

HOURS WORKED PER WEEK
4

TYPE OF EMPLOYMENT
☐ Full-time ☒ Part-time

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

JOB TITLE
Teaching Assistant

DESCRIPTION OF DUTIES PERFORMED
Assisted students attempting to become licensed EMT's through basic life saving techniques and laboratory exercises.

NAME (Last, First, MI): Griffin, Luanne K

SS#:

Profession: Code 125

C. NAME OF BUSINESS / INSTITUTION: University of Massachusetts, Dartmouth

JOB TITLE: Research Assistant

ADDRESS STREET, CITY, STATE, ZIP CODE: 285 Old Westport Rd, North Dartmouth MA 02747

DESCRIPTION OF DUTIES PERFORMED: Performed chemical and biological experiments.

DATE OF EMPLOYMENT/ATTENDANCE
From 01 / 02 / 2003 (Month / Day / Year)
To 05 / 31 / 2005 (Month / Day / Year)

HOURS WORKED PER WEEK: 10

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

TOTAL TIME WORKED (Year/Month): 2 years and 4 months

D. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

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

HOURS WORKED PER WEEK

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

TOTAL TIME WORKED (Year/Month)

E. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

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

HOURS WORKED PER WEEK

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

TOTAL TIME WORKED (Year/Month)

F. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

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

HOURS WORKED PER WEEK

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

TOTAL TIME WORKED (Year/Month)

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

March 12, 2012

LEANNE RITA GRIFFIN MD
MCGAW MED CTR NORTHWESTERN
DEPT OF GME
420 E SUPERIOR STE 12-174
CHICAGO, IL 60611

The Illinois Temporary Medical License or Permit for the resident listed above has been approved and will be forwarded to your facility as soon as office routine permits. Information regarding all licensees is available instantly on our Web site at www.idfpr.com. Simply click on the Express Access License Look-up icon to verify a license.

LICENSE DETAILS

LICENSE NUMBER:	125.055807
PROGRAM START DATE:	06/23/2012
EXPIRATION DATE:	06/22/2013
PROGRAM:	Obstetrics and Gynecology
TRAINING FACILITY:	MCGAW MED CTR NORTHWESTERN

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

Temporary licenses and permits may not be used for any clinical medical practice which occurs outside of the residency program (i.e. moonlighting).

Temporary licenses and permits are **not** automatically transferred from one program/institution to another. Should the resident transfer to a different residency program within your facility or to a program in another institution, the license or permit must be updated. The resident may not begin a new program until the current temporary license or permit has been returned to the Division and a license or permit has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of temporary licenses and permits. Any violation of the Act may result in disciplinary action by this Department.

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

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

Date: 4/7/2009

Initials: DR

License No: 125 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

LEANNE RITA GRIFFIN MD
MCGAW MEDICAL CENTER NORTHWESTERN
DEPT OF GME
645 N MICHIGAN AVE STE 1058A
CHICAGO, IL 60611

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

ED-MED may be completed and submitted by your medical school with seal affixed not more than 30-days prior to graduation.
OR
Submit official transcript(s) verifying medical education with school seal/signature upon graduation.

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

MCGAW Center for Graduate Medical Education

March 31, 2009

Illinois Department of Professional Regulation
3rd Floor Medical Unit#1
320 W. Washington Street
Springfield, IL 62786

RE: Leanne Griffin, MD

Dear Director:

Dr. Griffin is requesting a Temporary License with the State of Illinois. Enclosed you will find the following documents to process the request.

- Complete 4 Page application
- Check – 100.00
- CA-Med
- VE-PC form

If you have any questions or need additional information, please feel free to call me at 1-312-503-4748.

Sincerely,

[redacted]

Andre'a Robinson
Visa/Licensing Coordinator
Graduate Medical Education

Office of Graduate Medical Education
645 North Michigan Avenue, Suite 1058-A
Chicago, Illinois 60611-2875
Tel: (312)503-7975
Fax: (312)503-5230