6-80

IMPORTANT NOTICE

ompletion of this form is necessary r consideration for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

RETURN APPLICATION TO:

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
Attention: Medical Section
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786

RECEIVED
APR 29 1980
DEPARTMENT OF REGISTRATION AND EDUCATION
CASH SECTION

FOR OFFICIAL USE ONLY
County Code 137016
Graduation Date 2-26-72
License No. 66660
Certificate Issued 6-7-83
Certificate Mailed 6-9-83

APPLICATION FOR LICENSURE UNDER THE MEDICAL PRACTICE ACT

IN THE BLOCK BELOW, CHECK TYPE OF LICENSURE FOR WHICH YOU ARE APPLYING AND THEN THE BASIS UNDER WHICH YOU ARE APPLYING.

Type of Licensure:	[X] Physician-Surgeon	[ ] Osteopath	[ ] Doctor of Chiropractic
Basis of Licensure:	[X] Flex Endorsement [ ] Flex Examination [ ] Reciprocity	[ ] National Board Endorsement [ ] LMCC Endorsement	[ ] Examination [ ] National Board Diplomate [ ] Reciprocity

All candidates for licensure must complete the following. False or misleading information may be cause for disciplinary action on the grounds of a lack of good moral character.

1. PRINT NAME AS IT SHOULD APPEAR ON CERTIFICATE (Limited to 20 characters first name, middle initial and 20 characters last name)
Daniel
~~Dacyong~~ Ur

2. SOCIAL SECURITY NUMBER
[redacted]
Designation of number is not mandatory—used only to ensure identification, accessibility, and accuracy of the application.

3. HOME STREET ADDRESS	4. CITY	5. COUNTY	6. STATE	7. ZIP CODE
[redacted]		[redacted]		

8. INTENDED STREET ADDRESS	9. CITY	10. COUNTY	11. STATE	12. ZIP CODE
[redacted]			[redacted]	

13. TELEPHONE NO. (Area Code)	14. PLACE OF BIRTH	15. DATE OF BIRTH (Month/Day/Year)	16. AGE
[redacted]	[redacted]	[redacted]	39

EDUCATION – Official transcripts must be submitted with this application.

17. COLLEGE EDUCATION *(Do not include medical schooling.)*

NAME OF INSTITUTION	LOCATION (City and State)	DATES OF ATTENDANCE	CREDIT HOURS
Catholic College	505 Banpo-Dong Seoul, Korea	From 3/2/66 To 2/26/68	[X] ____ Semester [ ] ____ Quarter
[redacted]		From To	DATE OF GRADUATION

18. MEDICAL COLLEGE OR UNIVERSITY – *Exact copy of diploma of said institution must be attached.*

NAME OF INSTITUTION	LOCATION (City and State)	DATES OF ATTENDANCE
Catholic Med. Sch	505 Banpo-Dong, Kangnam-Ku Seoul 135, Korea	From 3/2/68 To 2/26/72
		From To

TYPE OF DEGREE GRANTED	NAME OF INSTITUTION GRANTING DEGREE	DATE DEGREE WAS GRANTED
Catholic Med. Sch.	M.D.	Feb. 26, 1972

19. SPECIALTY/RESIDENCY TRAINING – *For applicants desiring licensure as a physician-surgeon.*

NAME OF INSTITUTION	LOCATION (City and State)	TYPE OF PROGRAM	DATES OF ATTENDANCE
St. Joseph's Hosp.	Paterson, N.J.	Surgery	From 7/1/78 To 6/30/80

MAY 3 83
DEPT. OF REG. & ED. FOR DEPOSIT
PAY 1ST NAT'L BK. CHICAGO
STATE OF ILLINOIS

20. PERSONAL HISTORY — *If any of the following questions are answered "YES", a detailed explanation must be furnished on a separate sheet and attached.*		YES	NO
A.	Do you hold a license in any of the other healing arts?		X
B.	Have you ever been denied a certificate, or the privilege of taking any examination, before any State Medical Board? *If yes, the State Medical Board must submit a certified statement of the charge and its disposition.*		X
C.	Are you now, or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or habit-forming drugs?		X
D.	*If the answer is yes to either of the following, attach a statement from the treating psychiatrist and a copy of his board certification or, if he is not board-certified, his curriculum vitae.*		
	1. Have you ever been a patient (voluntarily or otherwise) in any institution for the treatment of mental or emotional illness, drug addiction, or inebriety?		X
	2. Have you ever been treated, but not hospitalized, for mental or emotional illness, drug addiction, or inebriety?		X
E.	Have you ever been convicted of any criminal offense(s) in Illinois or in another state or in federal court (other than minor traffic violations)?		X
F.	Have you ever been denied hospital staff privileges? *If yes, please attach an explanation from the hospital administrator.*		X
G.	Do you have any physical impairment or disability that could interfere with your ability to practice your profession?		X
H.	Have you ever applied for a certificate of registration as a physician-surgeon or chiropractor?		X
I.	Have you ever written a licensure examination to practice medicine and surgery or chiropractic in Illinois or any other state? *If yes, complete the following:*	X	

List state(s) in which you took examination	Type of Examination Taken	Date of Examination
Massachusetts	FLEX (Medicine)	6/13,14,15/80

J.	Have you ever been licensed as a physician-surgeon or chiropractor in Illinois or in another state? *If yes, complete the following and attach a certification of original licensure, with state seal affixed.*	X	

List state(s) in which you have ever been licensed.	License Number	Dates of Licensure From	Dates of Licensure To	Is license current?	Has license ever been revoked or otherwise disciplined?
Mass.	46478	8/15/80	1/15/84	(X) YES ( ) NO	( ) YES (X) NO
Ohio	48782	4/14/83	12/31/84	(X) YES ( ) NO	( ) YES (X) NO
				( ) YES ( ) NO	( ) YES ( ) NO

[redacted]

STATE OF Ohio)
COUNTY OF Parma)

MARGARET O'NEIL BARON, Notary Public
State of Ohio - Cuyahoga County
My Commission Expires March 14, 1988

I hereby certify that I personally completed this application and that the answers appearing hereon are true and correct to the best of my knowledge and belief.

3-14-88

X [redacted]
Signature (In full-Use no initials)

Subscribed and sworn before me this 20 day of April, 1983. NOTARY SEAL

[redacted]
Signature of Notary Public

St Joseph's Hospital and Medical Center

703 Main Street • Paterson • New Jersey 07503 • (201) 977-2000

DEPARTMENT OF SURGERY

Continuing Commitment to Care

DAVID BREGMAN, M.D.
Chairman, Department of Surgery

(201) 977-2124
(201) 977-2125

To: Sister Jane
President

From: David Bregman, M.D.
Chairman, Department of Surgery

Date: January 19,1983

Please be advised, that the information on the sheet is correct. Daeyong Ur, M.D., was an intern/resident in the Department of Surgery from 1978 through 1980.

Please sign and seal, as requested by the Board, the enclosed three documents.

Thank you for your attention in this matter.

STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

CERTIFICATE OF HOSPITAL REQUIREMENTS

INTERNSHIP OR PGY 1 _____ RESIDENCY X

(CHECK TYPE OF SERVICE BEING CERTIFIED)

Board will not accept Certificate unless it has been completed by the Chief Executive Officer, from the records of the hospital.

Hospital Address 703 Main St., Paterson, NJ

Date 1/18/83

We hereby certify that Dr. Daeyong Ur, Department of Surgery St. Joseph's Hospital & M.C. ~~graduate~~ has rendered satisfactory service in each of the various departments as an intern/resident in the St. Joseph's Hospital in an approved AMA Internship/Residency Training Program and the requirements of the New Jersey statute, governing the year of hospital Internship/Residency, has been complied with on the part of the hospital.

We further certify that the following statements are true:

Length of regular internship/residency 5 yrs.

Date applicant commenced internship/residency 1978/80 transferred to ~~Anesthesia residency~~ in

Date internship/residency was (will be) completed 1980

If time spent at hospital does not represent full period of internship/residency, state why Dr. Ur. transferred into an Anesthesia residency program in 1980.

Type of Internship _____

Type of Residency ~~General surgery~~

We further certify that the applicant is, in our opinion, a person of good moral character and worthy of licensure to practice Medicine and Surgery in the State of New Jersey.

[redacted], M.D.
President, Medical Staff

X [redacted] M.D.
Chairman, Department of Surgery

[redacted]
Chief Executive Officer

(Seal of Hospital)

Commonwealth of Pennsylvania
Department of State
Bureau of Professional and Occupational Affairs

GRADUATE TRAINING CERTIFICATE

State Board of Medical Education and Licensure
Box 2649, Harrisburg, Pa. 17105

Date 1/18/83

This is to certify that Jaeyong Un, M. D., a graduate of the Catholic Medical School has rendered satisfactory service as a trainee at St. Joseph's Hospital at Paterson, New Jersey in an approved clinical program from July 1st, 78 to June 30, 1980.

We also certify that Jaeyong Un, M.D. is a person of good moral character, and that ✓ he has proven to be worthy of the medical profession.

The Trainee participated in the following type of program:

FLEXIBLE _____ CATEGORICAL* _____ CATEGORICAL _____ OTHER _____

DEPARTMENT	SPECIALTY	MONTHS	SIGNATURE OF CHIEF
Allergy-Immunology			
Anesthesiology			
Dermatology			
Family Practice			
Internal Medicine			
Neurology			
Nuclear Medicine			
Obstetrics-Gynecology			
Ophthalmology			
Otolaryngology			
Pathology			
Pediatrics			
Physical Medicine			
Preventive Medicine			
Psychiatry			
Public Health			
Radiology			
Surgery	Surgery	48 24	[redacted]
Urology			
Other			

Remarks: _____

(Notarized affidavit required if [illegible] has no seal)

[redacted]
(SIGNATURE OF SUPERINTENDENT) (COVERED BY SEAL)
PRESIDENT

FORM 2

CERTIFICATE OF POST-GRADUATE TRAINING

MUST BE COMPLETED FOR APPLICANTS WHO ARE GRADUATES OF FOREIGN MEDICAL SCHOOLS*

This certifies that Daeyong Ur, M.D. has rendered satisfactory
Name of Applicant

and continuous service as a Resident/Surgery
Position/Department

at St. Joseph's Hospital and Medical Center, 703 Main St. Paterson, NJ 07503
Hospital Address of Hospital

from July 78 to June 80
Beginning mo/day/yr of Service Ending mo/day/yr of Service

This training was/was not AMA approved.

[redacted]
Signature

(PLACE HOSPITAL SEAL HERE)

DAVID BREEMAN
Name

CHAIRMAN, Dept. of Surgery
Position

1-20-83
Date

This form is to be sent to the hospitals at which the above named physician trained. It must be completed by either the director of the training program, the director of the department, the hospital administrator or an individual authorized to verify the requested information. THE HOSPITAL SEAL MUST BE PLACED IN THE APPROPRIATE PLACE.

This information will be used for licensure purposes.

*Unless the applicant is American-born and holds a full right to practice in a foreign country.

UPON COMPLETION RETURN TO:

STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET
ROOM 510
COLUMBUS, OHIO 43215

CURRICULUM VITAE

Daniel (Daeyong) Ur, M.D.

[redacted]

PERSONAL DATA

Birth Date: [redacted]
Sex: [redacted]
Marital Status: [redacted]
Visa Status: [redacted]

EDUCATION

Catholic College, Seoul, Korea
BA - 1968
Catholic College Medical School
M.D. - 1972
Korean Acupuncture Institute
75 - 76

PROFESSIONAL TRAINING IN KOREA

General Surgeon, Korean Army Hospital
Seoul, Korea, 1972 - 1975

PROFESSIONAL TRAINING IN U.S.A.

Medical Staff, Rutland Heights Hospital
Rutland, Massachusetts, 3/76 - 5/78

Surgical Residency, St. Joseph Hospital
Paterson, New Jersey, 7/78 - 6/80

Anesthesiology Residency, Mt. Sinai Hospital & Medical Center
New York, New York, 7/80 - 6/82

Cardio-Thoracic Anesthesiology Residency
Cleveland Clinic Foundation
Cleveland, Ohio, 7/82 - 12/31/82

LICENSURE

ECFMG
FLEX (Massachusetts)

BOARD ELIGIBILITY

Board eligible

REFERENCES

Available upon request

REFERENCES

Daniel (Daeyong) Ur, M.D.

1. David Stark, M.D.
   Professor and Chairman
   Department of Anesthesiology
   Mt. Sinai Hospital and Medical Center
   New York, New York

2. Henry Tausk, M.D.
   Associate Professor
   Department of Anesthesiology
   Mt. Sinai Hospital and Medical Center
   New York, New York

3. F.G. Estafanous, M.D.
   Chairman
   Department of Cardio-Thoracic Anesthesiology
   The Cleveland Clinic Foundation
   Cleveland, Ohio

4. Norman J. Starr, M.D.
   Director of Resident Education
   Department of Cardio-Thoracic Anesthesiology
   Cleveland, Ohio 44106

UNITED STATES DISTRICT COURT

RICHARD H. WEARE
CLERK

OFFICE OF THE CLERK
EASTERN DISTRICT OF NEW YORK
225 CADMAN PLAZA EAST
BROOKLYN, NEW YORK 11201

JUNE 14, 1982

To Whom It May Concern:

Our records show that DANIEL UR
born on [redacted] was naturalized in this Court
on OCTOBER 6, 1981 and issued Certificate of
Naturalization No. [redacted].
Petition No. [redacted]. Alien Registration No. [redacted].

Very truly yours,
RICHARD H. WEARE, CLERK

[redacted]
Deputy Clerk

NAME WAS CHANGED BY ORDER OF COURT FROM DAEYONG UR TO DANIEL UR, ON OCTOBER 6, 1981.

[redacted]
DEPUTY CLERK

This is a true photocopy of the original document

[redacted]

State of New York
County of Queens

Subscribed to, before me this [redacted] day of [redacted] 19[redacted]

[redacted]

EMANUEL DUBIN
Notary Public, State of New York
No. 41-1029775 - Queens County
Commission Expires March 30, 19[redacted]

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

Date: April 14, 1983

To: Dr. Daniel Ur

This is to notify you that you are now licensed to practice medicine and surgery in the State of Ohio and that your license number is the following: 48782.
The Board approved your request and your number was issued on 4/14/83.

The actual certificate of licensure must be hand printed and will not be sent to you for several months. BE SURE TO NOTIFY THE BOARD OFFICE IN WRITING OF ANY CHANGE OF ADDRESS. NOTE THAT THE ADDRESS YOU SUPPLY THE DRUG ENFORCEMENT ADMINISTRATION MUST BE YOUR ADDRESS OF PRIMARY PRACTICE.

This letter constitutes your authority to begin practice upon its arrival. Your Ohio license will be effective until December 31, 1984 at which time you will be required to have completed mandatory continuing medical education for renewal of your license.

Continuing medical education materials will be mailed as soon as they become available.

This notice also authorizes you to make application for your narcotics permit. To make such application, contact:

Drug Enforcement Administration
Chicago Regional Office
ATTENTION: Janet Petcoff, Registration Branch
1800 Dirksen Federal Building
219 South Dearborn Street
Chicago, Illinois 60604

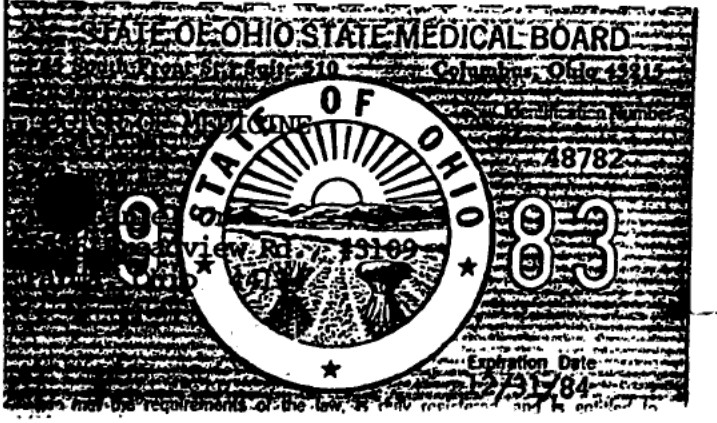
TEL. NO. (312) 353-1236

If you should have any questions pertaining to this, please do not hesitate to contact us.

Very truly yours,

[redacted]

Angela Albert
Chief of Licensure



CATHOLIC MEDICAL COLLEGE

505 BANPO-DONG, KANGNAM-KU
SEOUL 135, KOREA
TEL: 593-5141~9,6121~9,7131~9,8161~9

January 14, 1983

Certificate of Graduation

To whom it may concern :

Name in Full :	Dae Yong Ur
Date of Birth :	[redacted]
Permanent Address :	[redacted]
Date of Admission :	March 2, 1968
Date of Graduation :	February 26, 1972
Degree Received :	Doctor of Medicine (Euhaksa)

This is to certify that the above person graduated from the medical course of the Catholic Medical College.

[redacted]

Bong-Sop Shim, M.D.,Dr.Med.Sci.
Dean

CATHOLIC MEDICAL COLLEGE
505 BANPO-DONG, KANGNAM-KU
SEOUL 135, KOREA
TEL: 593-5141~9,6121~9,7131~9,8161~9

January 14, 1983

Certificate of Course Completed

To whom it may concern :

Name in Full : Dae Yong Ur

Date of Birth : [redacted]

Permanent Address : [redacted]

Date of Admission : March 1, 1966

Date of Completion : February 24, 1968

This is to certify that the above person completed the premedical course of the Catholic Medical College.

[redacted]

Bong-Sop Shim, M.D.,Dr.Med.Sci.
Dean

IMPORTANT NOTICE

Completion of this form is required for applicant to be considered for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
Attention: Medical Section
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786

CERTIFICATION OF LICENSURE

APPLICANT

APPLICANT: Complete the top of this page and forward it to the state in which you hold a license.

NAME (Last, First, Middle): Ur Daeyong

MAIDEN NAME:

ADDRESS (Street, City, State and ZIP Code): [redacted]

ORIGINAL LICENSE NUMBER: 46478

TYPE OF REGISTRATION: [X] Physician-Surgeon [ ] Osteopath [ ] Chiropractor

DATE ISSUED: Aug. 15, 80

I hereby authorize the Mass. State Medical Board to furnish
Name of State Medical Board or State Agency to Which Form is Being Sent
to the Illinois Department of Registration and Education the information requested below.

Date May 24, 1983 Sign [redacted]

LICENSING AGENCY ONLY

This is to certify that the above-named individual was issued license number 46478

to practice: Medicine Date of Issuance: August 15, 1980

Licensed by:
[ ] Oral Examination
[X] Written Examination
[ ] Endorsement
[ ] Exemption
[ ] Reciprocity

Current licensure status:
[X] Active
[ ] Inactive
[ ] Lapsed

Date license expires: Jan. 15, 1984

Is there any disciplinary action now pending concerning this license or has this license ever been revoked, suspended, surrendered, restricted, limited, or placed on probation? [ ] Yes [X] No If yes, explain on reverse side.

Does your state grant the same privilege of reciprocal registration to Illinois registrants? [ ] Yes [ ] No

SEAL

Signature [redacted]

Title Secretary

State Massachusetts

Date May 26, 1983

TO THE BOARD: Return this form directly to the applicant named above. If agency policy prohibits you from following this procedure, it may be forwarded to the Department of Registration and Education at the above address.

IL 486-0280 7/81 (MD)

IL 486–0280 7/81 (MD)

IMPORTANT NOTICE
Completion of this form is required for applicant to be considered for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

DEPARTMENT OF REGISTRATION AND EDUCATION

CERTIFICATION OF CLINICAL TRAINING

NAME OF APPLICANT: Daeyong Ur, M.D.

ILLINOIS TEMPORARY CERTIFICATE NUMBER (If applicable):

This is to certify, that the above-named applicant has satisfactorily completed 24 months in a program of specialty/residency training from July 1, 1978 to June 30, 1980 at the following hospital.

NAME OF HOSPITAL: St. Joseph's Hospital and Med. Center

NUMBER AND STREET: 703 Main Street

CITY, STATE, AND ZIP CODE: Paterson, New Jersey 07503

SEAL OF HOSPITAL

DATE: May 26, 1983.

SIGNATURE OF MEDICAL DIRECTOR: [redacted]

IL 486–0265 7/81 (MD)

IMPORTANT NOTICE

Completion of this form is required for applicant to be considered for licensure under Chapter 111 of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

DEPARTMENT OF

REGISTRATION AND EDUCATION

[redacted]

STATEMENTS OF IDENTITY

TO BE COMPLETED FOR APPLICANTS APPLYING FOR REGISTRATION AS A PHYSICIAN-SURGEON ONLY.

INSTRUCTIONS TO APPLICANT: Please attach a photograph in the space provided on this form. This form must be completed by two licensed physicians who can attest to your identity and submitted with your application.

FIRST STATEMENT

This is to certify that I, Sang Joon Lee, M.D. (Print name), am personally acquainted with Daeyong Ur, M.D., who is applying for licensure as a physician-surgeon in the State of Illinois, and I hereby attest that the attached photograph is a true likeness of him/her.

[redacted] (Signature of Physician) April 19, 1983 (Date)

[redacted] (Number and Street, City, State, ZIP Code)

Ohio (State of Licensure) # 036540. (License Number)

SECOND STATEMENT

This is to certify that I, Young S. Hahn, M.D. (Print name), am personally acquainted with Daeyong Ur, M.D., who is applying for licensure as a physician-surgeon in the State of Illinois, and I hereby attest that the attached photograph is a true likeness of him/her.

[redacted] (Signature of Physician) April 19, 1983 (Date)

[redacted] (Number and Street, City, State, ZIP Code)

Ohio (State of Licensure) 038484 (License Number)