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APR 20 2015

FOR OFFICIAL USE ONLY

# APPLICATION FOR LICENSURE AND/OR EXAMINATION

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, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME <b>Temporary Physician</b>	2. PROFESSION CODE <b>1 2 5</b>	3. LICENSURE METHOD <b>Non-Examination</b>	4. FEE <b>\$ 230.00</b>
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B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

<input checked="" type="checkbox"/> This is the first time I have made application for this profession in Illinois.	<input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
<input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.	<input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.
<input type="checkbox"/> Other: _____	

### 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 <b>Stanton Taylor Wise</b>	2. TITLE (e.g., M.D., D.D.S., etc.) <b>MD</b>	3. UNITED STATES SOCIAL SECURITY NO. [REDACTED]
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4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY [REDACTED]
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5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY <b>5841 S. Maryland Ave., MC 1052, Chicago, IL 60637</b>
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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]
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8. PLACE OF BIRTH CITY STATE/COUNTRY [REDACTED]	9. DATE OF BIRTH [REDACTED] Month Day Year	10. AGE [REDACTED] <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male
--	--	--

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: ( <b>773</b> ) <b>702</b> - <b>6760</b> Home: [REDACTED] (Area Code) (Area Code) Fax: ( <b>773</b> ) <b>702</b> - <b>0831</b> Fax: ( ) - - (Area Code) (Area Code)	12. PREFERRED e-MAIL ADDRESS(ES) [if available] [REDACTED]
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2 5195602 510712/00  
 NAME (Last, First, MI): Stanton, Taylor A  
 SS#: [REDACTED]  
 Profession: TEMPORARY PHYSICIAN LICENSURE

**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: Fauquier High School  
 3. LAST PRELIMINARY SCHOOL LOCATION (City and State): Warrenton, VA  
 4. DATE OF GRADUATION: 0 6 / 2 0 0 5  
 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		TYPE OF DEGREE EARNED
		FROM	TO	
Earlham College	Richmond, IN	Month/Year 08/2005	Month/Year 05/2009	BA
University of Illinois college of Medicine at Rockford	Rockford, IL	08/2011	05/2015	MD Pending

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		Did You Complete Training?
		FROM	TO	
	NA	Month/Year	Month/Year	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**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	NA			
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
<del>NBME Pathology</del>	IL	04/2013	
<del>NBME Microbiology</del>	IL	04/2013	
<del>NBME Pharmacology</del>	IL	04/2013	
USMLE Step 1	IL	06/2013	
USMLE Step 2 CK	IL	07/2014	
USMLE Step 2 CS	IL	12/2014	

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

NAME (Last, First, MI): Stanton, Taylor A  
 SS#: [REDACTED]  
 Profession: TEMPORARY PHYSICIAN LICENSURE

NAME (Last, First, MI): **Stanton, Taylor A**  
 SS#: **5996075**  
 04/21/2015 2059675  
 Profession: **TEMPORARY PHYSICIAN LICENSURE**

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 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.			<input checked="" type="checkbox"/>
2. Have you been convicted of a felony?			<input checked="" type="checkbox"/>
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.			<input checked="" type="checkbox"/>
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.			<input checked="" type="checkbox"/>
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.			<input checked="" type="checkbox"/>
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.			<input checked="" type="checkbox"/>

**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.

 Signature of Applicant 3/25/15 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.

**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
	Stanton	Taylor	Alise	[REDACTED]

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

**Certification Statement**

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

[REDACTED SIGNATURE]

Signature of Applicant

3/25/14

Date

## \* DEFINITIONS

A **"forcible felony"**, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

- a) First Degree Murder (Section 9-1);
- b) Intentional Homicide of an Unborn Child (Section 9-1.2);
- c) Second Degree Murder (Section 9-2);
- d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
- e) Drug-induced Homicide (Section 9-3.3);
- f) Kidnapping (Section 10-1);
- g) Aggravated Kidnapping (Section 10-2);
- h) Unlawful Restraint (Section 10-3);
- i) Aggravated Unlawful Restraint (Section 10-3.1);
- j) Forcible Detention (Section 10-4);
- k) Involuntary Servitude (Section 10-9(b));
- l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
- m) Trafficking in Persons (Section 10-9(d));
- n) Criminal Sexual Assault (Section 11-1.20);
- o) Aggravated Criminal Sexual Assault (Section 11-1.30);
- p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
- q) Criminal Sexual Abuse (Section 11-1.50);
- r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
- s) Aggravated Battery (Section 12-3.05);
- t) Compelling Organization Membership of Persons (Section 12-6.5);
- u) Compelling Confession or Information by Force or Threat (Section 12-7);
- v) Home Invasion (Section 12-11);
- w) Robbery (Section 18-1);
- x) Armed Robbery (Section 18-2);
- y) Vehicular Hijacking (Section 18-3);
- z) Aggravated Vehicular Hijacking (Section 18-4);
- aa) Aggravated Robbery (Section 18-5);
- bb) Terrorism (Section 29D-14.9);
- cc) Causing a Catastrophe (Section 29D-15.1);
- dd) Possession of a Deadly Substance (Section 29D-15.2);
- ee) Making a Terrorist Threat (Section 29D-20);
- ff) Falsely Making a Terrorist Threat (Section 29D-25);
- gg) Material Support for Terrorism (Section 29D-29.9);
- hh) Hindering Prosecution of Terrorism (Section 29D-35);
- ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
- jj) Armed Violence (Section 33A-2); and
- kk) Attempt (Section 8-4) of any of the above specified offenses.

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

SUPPORTING DOCUMENT

# CCA

1. NAME      LAST                  FIRST                  MIDDLE  
Stanton      Taylor      Arlise

3. PROFESSIONAL LICENSE NUMBER (if any)  
 \_\_\_\_\_

2. ADDRESS      STREET, CITY, STATE, ZIP CODE  
 \_\_\_\_\_

4. SOCIAL SECURITY NUMBER  
 \_\_\_\_\_

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.**

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

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? *  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2) Are you currently charged with or have you been convicted of a criminal battery against any patient <i>in the course of patient care or treatment</i> , including any offense based on sexual conduct or sexual penetration? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4) Are you currently charged with or have you been convicted of a forcible felony? *  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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

### Certification Statement

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

\_\_\_\_\_  
 Signature of Applicant

Date 3/25/15

## \* DEFINITIONS

730 ILCS 150 et. seq.—Acts that require Sex Offender Registration:

(B) As used in this Article, "sex offense" means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

- 11-20.1 (child pornography),
- 11-20.3 (aggravated child pornography),
- 11-6 (indecent solicitation of a child),
- 11-9.1 (sexual exploitation of a child),
- 11-9.2 (custodial sexual misconduct),
- 11-9.5 (sexual misconduct with a person with a disability),
- 11-15.1 (soliciting for a juvenile prostitute),
- 11-18.1 (patronizing a juvenile prostitute),
- 11-17.1 (keeping a place of juvenile prostitution),
- 11-19.1 (juvenile pimping),
- 11-19.2 (exploitation of a child),
- 11-25 (grooming),
- 11-26 (traveling to meet a minor),
- 12-13 (criminal sexual assault),
- 12-14 (aggravated criminal sexual assault),
- 12-14.1 (predatory criminal sexual assault of a child),
- 12-15 (criminal sexual abuse),
- 12-16 (aggravated criminal sexual abuse),
- 12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

- 10-1 (kidnapping),
- 10-2 (aggravated kidnapping),
- 10-3 (unlawful restraint),
- 10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

- 10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
- 11-6.5 (indecent solicitation of an adult),
- 11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
- 11-16 (pandering, if the victim is under 18 years of age),
- 11-18 (patronizing a prostitute, if the victim is under 18 years of age),
- 11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

- 11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

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**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 FIRST MIDDLE Stanton, Taylor Alise	2. DATE OF BIRTH ____/____/____ Month Day Year	3. SOCIAL SECURITY NUMBER ____-____-____
4. ADDRESS STREET, CITY, STATE, ZIP CODE _____	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. Temporary Physician 1 2 5 _____ Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME _____		

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

A. HOSPITAL/INSTITUTION NAME University of Chicago Medical Center	B. BEGINNING DATE 06 / 24 / 2015 Month Day Year	C. ENDING DATE 06 / 23 / 2018 Month Day Year
D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE 5841 S. Maryland Ave., MC 1052, Chicago, IL 60637	E. SPECIALTY/RESIDENCY NAME Obstetrics and Gynecology	
F. BUSINESS TELEPHONE NUMBER Area Code ( 773 ) 702 - 6760	G. YEAR OF POSTGRADUATE TRAINING 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 Financial and Professional Regulation, the applicant is found to be eligible for licensure.

SEAL

\_\_\_\_\_  
Signature of Program Director  
Anita Blanchard, MD  
Print Name of Program Director  
Program Director  
Title  
3/23/15  
Date

RECEIVED

4/21

MAY 05 2015

SUPPORTING DOCUMENT

ED - MED

MEDICAL UNIT

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

**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: <u>Stratton</u> FIRST: <u>Taylor</u> MIDDLE: <u>Alise</u>	2. DATE OF BIRTH Month: [redacted] Day: [redacted] Year: [redacted]	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. <u>Temporary Physician Licensee</u>   <u>1 2 5</u> Profession Name   Profession Code	
6. MAIDEN OR GIVEN SURNAME <u>N/A</u>		

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.

03/25/15  
Date

[redacted signature]  
Signature

**SCHOOL OFFICIAL:** Complete the bottom portion of this page and return **ALONG** with a current official medical school transcript. **DO NOT** certify this form more than 30 days prior to the graduation date.

A. MEDICAL SCHOOL INFORMATION Name: <u>The University of Illinois College of Medicine - Rockford</u> Address: <u>1601 Parkview Avenue</u> City, State, Zip: <u>Rockford, IL 61107-1897</u> Phone: <u>815-395-5581</u> Fax: <u>815-395-5979</u> email: <u>allenam@uic.edu</u>	B. DATES OF ATTENDANCE Start: <u>08 / 16 / 2011</u> Month Day Year End: <u>04 / 26 / 2015</u> Month Day Year Degree: <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO
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C.  
Applicant will complete all requirements for the medical degree as of 04 / 26 / 2015 and will graduate on 05 / 10 / 2015  
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]  
Signature of School Official  
Allena J. Fortson  
Print Name of School Official  
Rockford Registrar  
Title  
04/24/2015  
Date

