

Application Summary

2/2/19 9:58 AM

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License Type: **Physician's and Surgeon's**
Application: **Physician's and Surgeon's - Initial Application**
Application Number: **14619760**
Application Date: **02/02/2019 (mm/dd/yyyy)**

Application Questions

Are you applying with an Individual Taxpayer Identification Number (ITIN)?

Have you served or are you currently serving in the military?

Are you requesting expediting of this application for spouses or domestic partners of an active duty member of the U.S. Armed Forces?

Are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces?

Are you requesting expediting of this application to practice in a medically underserved area or population?

Are you currently enrolled in an ACGME/RCPSC-accredited postgraduate training program in the United States or Canada?

Yes

Personal Detail

First Name: **Taylor**
Middle Name: **Alise**
Last Name: **Stanton**
Birthdate: ******/****/******
Gender: **Female**
SSN/ITIN: *********

Addresses

License Related Addresses

Address of Record (Required)

Warning:

In order to protect your privacy and identity, address will not be displayed.

License Attributes Selected

Transaction

Reduced Initial Licensing Fee

Previous Application or License

9. Have you served or are you currently serving in the U.S. Military?

[Redacted]

10. Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the U.S. Armed Forces?

[Redacted]

11. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?

12. Have you previously held a Physician's and Surgeon's License in California?

No

Examinations

13. Are you certified by the Educational Commission for Foreign Medical Graduates?

No

Examinations 1

Examination:

United States Medical Licensing Examination (USMLE) Step 1

Date Passed:

[Redacted]

✓

Examinations 2

Examination:

United States Medical Licensing Examination (USMLE) Step 2CK

Date Passed:

[Redacted]

✓

Examinations 3

Examination:

United States Medical Licensing Examination (USMLE) Step 2CS

Date Passed:

[Redacted]

✓

Examinations 4

Examination:

United States Medical Licensing Examination (USMLE) Step 3

Date Passed:

[Redacted]

✓

Education History

Medical School Name

University of Illinois College of Medicine at Rockford

Mailing Address of the Medical School

1601 Parkview Ave
Rockford, IL 61107

ILDU

Attendance Start Date

09/01/2011 (mm/dd/yyyy)

Attendance End Date

05/10/2015 (mm/dd/yyyy)

Were You Awarded a Degree?

Yes

Title of Degree Awarded

MD - Doctor of Medicine

Issue Date of Degree

05/10/2015 (mm/dd/yyyy)

ACGME or RCPSC Accredited Postgraduate Training Programs

16. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada?

Yes

17. Have you ever received partial or no credit for a postgraduate training program?

18. Have you ever taken a leave of absence or break from your training?

19. Have you ever been terminated, dismissed or expelled from a program?

20. Have you ever been placed on probation for any reason?

21. Have you ever been disciplined or placed under investigation?

22. Have you ever had any limitations or special requirements placed upon you for clinical performance professionalism, medical knowledge, discipline, or for any other reason?

23. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?



✓

✓

ACGME or RCPSC Accredited Postgraduate Training Programs

Program Facility Name

University of Chicago

City:

Chicago

State/Province:

Illinois

Specialty:

Obstetrics & Gynecology

LOE3AB

Training Start Date:

06/24/2015 (mm/dd/yyyy)

Training End Date:

06/30/2019 (mm/dd/yyyy)

Medical License(s)

24. Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province?

Yes

✓

Medical License(s)

U.S. State, U.S. Territory or Canadian Province:

Illinois

License Number:

036-145215

LO LV

Practice Start Date:

02/28/2018 (mm/dd/yyyy)

ABMS Certification

25. Are you currently certified by a Member Board of the American board of Medical Specialties? **No**

Malpractice History

26. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgement, or arbitration?

Disciplinary History

27. Have you ever had your DEA privileges denied, suspended, restricted, or terminated?

28. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?

29. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?

30. Have you ever been denied a license to practice medicine?

31. Is any denial pending against you?

32. Have you ever had any license to practice medicine subjected to any disciplinary action?

33. Is any disciplinary action pending against any of your licenses to practice medicine?

34. Have you ever surrendered a license to practice medicine?

35. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?

36. Have you ever had any license to practice medicine subjected to any action including, but not limited to, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?

37. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?

38. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?

39. Is any disciplinary action pending against your hospital or staff privileges?

40. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?

41. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?

Criminal Record History

42. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in the United States, its territories, or a foreign country?

43. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357 (b), (c), (d), (e), or section 11360 (b) which are two years or older, have you had a conviction that was set aside or later expunged from the record of the court?

44. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?

45. Are you a registered Sex Offender?

Practice Impairment or Limitations

46. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?

47. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?

48. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?

49. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?

50. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?

51. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?



Family Physician Training Program Voluntary Fee

Would you like to contribute? **No**

Attachments

Fees

Application Fee	\$442.00
Department of Justice (DOJ) Fee	\$32.00
Federal Bureau of Investigation (FBI) Fee	\$17.00
50% Initial License Fee	\$391.50
Stephen M. Thompson LRP	\$25.00
Total Amount Due:	\$907.50

Applications are not considered submitted for processing until payment is received.

Attestation

I attest I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorized all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present and future), and all government agencies (local, stated, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto is a sufficient basis for denying or revoking a license.

Signature:

Date:

2012993
WES KT 2/2

PHOTOGRAPH

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

MBO
Use Only

Rev LTA-P
Staff Initials
& Date

Photograph

Applicant
Name & DOB

DECLARATION

The applicant, Taylor Alise Stanton
PRINT LEGAL NAME (First, Middle, Last, Suffix) DATE OF BIRTH (mm/dd/yyyy)

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

SIGN LEGAL NAME: [Signature] DATE: 1/28/2019

Applicant
Signature & Date

Applicant
Signature

NOTARY SECTION

SIGNATURE OF APPLICANT: [Signature]
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Illinois
County of Cook

Subscribed and sworn to (or affirmed) before me on this 28th day of January, 2019,
by, Taylor Stanton proved to me on the basis of satisfactory evidence
(PRINT APPLICANT'S LEGAL NAME)

to be the person who appeared before me.
[Signature]
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL
OFFICIAL SEAL
BEVERLY L GARDNER
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES 05/16/20

Applicant
Name &
Notary Date

Notary
Signature & Seal

L1F



MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

Licensing Program
 2005 Evergreen Street, Suite 1200
 Sacramento, CA 95815-5401
 Phone: (916) 263-2382
 Fax: (916) 263-2487
 www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

CERTIFICATE OF MEDICAL EDUCATION

Check one: U.S. or Canadian Medical School Graduate International Medical School Graduate

Type or Print Legibly		APPLICANT INFORMATION				MBC Use Only
LEGAL NAME:		Last Stanton	First Taylor	Middle Alise	Suffix	Applicant Information
Date of Birth: (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation				
		University of Illinois at Rockford				Medical School Information
MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE						School Code
NOTE: If the applicant had an accelerated or extended curriculum, withdrew from this institution, or was accepted with advanced standing, a letter of explanation from a school official is required. The letter must be on medical school letterhead, signed by a school official, and be mailed directly to the Board from the medical school.						L2011
1. Name of Medical School	University of Illinois College of Medicine Rockford					
2. State/Province/Country	Rockford, Illinois, United States					
3. The undersigned further certifies that the records of this institution show that the applicant attended in this institution <u>4</u> years of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089, 2089.5, 2089.7, 2090, 2091.1; 2091.2).						Rev. L2 Staff Initials & Date 3/1/19
Alcoholism and Chemical Dependency Anatomy Anesthesia Biochemistry Child Abuse Detection and Treatment Dermatology Embryology Family Medicine*		Geriatric Medicine Histology Human Sexuality Medicine Neuroanatomy Neurology Obstetrics and Gynecology Ophthalmology		Otolaryngology Pain Management and End-of-Life-Care** Pathology, Bacteriology, and Immunology Pediatrics Pharmacology Physical Medicine Physiology Preventative Medicine, including Nutrition		
*ONLY applicable to medical students who enrolled in medical school on or after May 1, 1988		**ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000				
***ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994						
4. Did the applicant withdraw or transfer from this medical school?					<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
5. What is the standard duration of the curriculum at this institution?					4 years	
6. Date the applicant was enrolled in medical school?					(mm/dd/yyyy) 08/16/2011	
7. Date the applicant was issued the diploma of Bachelor/Doctor of Medicine					(mm/dd/yyyy) 05/10/2015	
UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL						
Any "Yes" response below requires a signed and dated letter of explanation by school official.						
8. Did this applicant ever take a leave of absence from his/her medical education?						
9. Was this applicant ever placed on probation?						
10. Was this applicant ever disciplined or placed under investigation?						
11. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?						
MEDICAL SCHOOL OFFICIAL CERTIFICATION						
AFFIX MEDICAL SCHOOL SEAL	I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.					
	Jodi Pirrello PRINTED NAME OF SCHOOL OFFICIAL		Rockford Registrar TITLE OF SCHOOL OFFICIAL			
	 SIGNATURE OF SCHOOL OFFICIAL		2.19.19 DATE			
Attention Medical School: THE PERSON WHO SIGNS THIS FORM <u>MAY NOT</u> BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.						

NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.

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MEDICAL BOARD OF CALIFORNIA

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Licensing Program
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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

CERTIFICATE OF COMPLETION OF ACGME/RCPCSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

Check one: U.S. or Canadian Medical School Graduate International Medical School Graduate

Type or Print Legibly				APPLICANT INFORMATION				MBC Use Only			
Last		First		Middle		Suffix					
LEGAL NAME:		Stanton		Taylor		A.					
Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN		Medical School of Graduation						Applicant Information		
			University of Illinois						<input checked="" type="checkbox"/>		
PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPCSC TRAINING INFORMATION											
Facility Name		University of Chicago								Verified Program Information	
Facility Address		5841 S. Maryland Ave., MC2050 Chicago, IL 60637								<input checked="" type="checkbox"/>	
Specialty		OBGYN		ACGME 10-digit Program #		2201611092				<input type="checkbox"/>	
Dates of Training (mm/dd/yyyy)		Start Date:		06/25/2015		End Date (or anticipated completion date):				<input type="checkbox"/>	
						06/30/2019				<input checked="" type="checkbox"/>	
UNUSUAL CIRCUMSTANCES											
<p>Program Director: Please provide a signed and dated letter of explanation, including dates, for any "yes" response to questions # 1-7. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.</p>											
1. Did the applicant receive partial or no credit during his/her postgraduate training?										<input checked="" type="checkbox"/>	
2. Did the applicant ever take a leave of absence or break from his/her training?										<input checked="" type="checkbox"/>	
3. Was the applicant ever terminated, dismissed or expelled?										<input checked="" type="checkbox"/>	
4. Was the applicant ever placed on probation?										<input checked="" type="checkbox"/>	
5. Was the applicant ever disciplined or placed under investigation?										<input checked="" type="checkbox"/>	
6. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?										<input checked="" type="checkbox"/>	
7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?										<input checked="" type="checkbox"/>	
GENERAL MEDICINE TRAINING REQUIREMENT											
8. Did the applicant complete a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPCSC?										<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<p>To qualify for licensure in California, applicants who are graduates of an international medical school must complete at least four (4) months of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four (4) months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.</p>											
L3A											

APPLICANT INFORMATION

LEGAL NAME: Last Stanton First Taylor Middle A. Suffix

ATTENTION: PROGRAM DIRECTOR

Do not sign and date this form prior to the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the applicant has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.

Adrianne Dade, M.D.

PRINTED NAME OF PROGRAM DIRECTOR

[Signature]

SIGNATURE OF PROGRAM DIRECTOR

(Signature Stamp Is Not Acceptable)

3/4/2019 DATE

NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR:

(SIGN FULL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____

County of _____

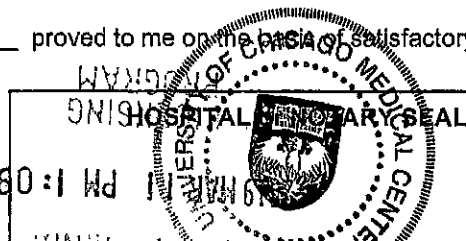
Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____

by, _____ proved to me on the basis of satisfactory evidence

(PRINT PROGRAM DIRECTOR'S NAME)

to be the person who appeared before me.

SIGNATURE OF NOTARY PUBLIC



MBC Use Only:

Applicant's Name

[Checked]

Verified PD Staff Initials & Date

[Signature]

Program Director's Signature & Date

[Checked]

Program Director's Signature

[Checked]

Notary Signature & Seal

[Checked]

Hospital Seal

[Checked]

L3B

NOTE: The completed forms must be mailed directly from the program to the Board to be acceptable.

RECEIVED BOARD OF MEDICAL PROFESSIONS 3/11/2019



MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

Licensing Program
2005 Evergreen Street, Suite 1200
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CURRENT POSTGRADUATE TRAINING ENROLLMENT

Check one: U.S. or Canadian Medical School Graduate International Medical School Graduate

APPLICANT INFORMATION

Type or Print Legibly
LEGAL NAME: Last: Stanton First: Taylor Middle: A. Suffix:

Date of Birth: [Redacted] Last 4 Digits of U.S. SSN or TIN: [Redacted] Medical School of Graduation: University of Illinois

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name: University of Chicago

Facility Address: 5841 S. Maryland Ave., MC 2050

Specialty: OBGYN ACGME 10-digit Program #: 2201611092
https://apps.acgme.org/ads/Public

Dates of Training: Start Date: 06/24/2015 Anticipated Completion Date: 06/30/2019

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the Program Director may sign this form if that signature authority is being delegated to another person; evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

I hereby declare under penalty of perjury under the laws of the State of California that the information contained on this form is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training to the above named applicant and that the applicant is actively participating in a slotted position in an accredited ACGME or RCPSC postgraduate training program.

Adrienne Dade, M.D.

PRINTED NAME OF PROGRAM DIRECTOR

[Signature]

SIGNATURE OF PROGRAM DIRECTOR
(Signature Stamp is Not Acceptable)

2/4/2019

DATE

NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR:

(SIGN FULL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20____

by _____ proved to me on the basis of satisfactory evidence:

(PRINT PROGRAM DIRECTOR'S NAME)

to be the person who appeared before me.

SIGNATURE OF NOTARY PUBLIC



MBC Use Only

Applicant Information

Verified Program Information

Verified Program Start Date & Date

Program Director's Signature & Date

Program Director's Signature

Notary Signature & Seal

Hospital Seal

L4

NOTE: The completed form must be mailed directly from the program to the Board to be acceptable.