Guiahi, Maryam

01000004401

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
PHYSICIAN	1 2 5	ENDORSEMENT	$ 100.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [X] 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.

RECEIVED
CASH SECTION
MAR 06 2008
IDFPR
Div. of Professional Regulation

RECEIVED
MAR 11 2008
IDFPR
NURSE SECTION

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

125-49258

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

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
2160 S. FIRST AVE MAYWOOD IL USA 60150 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] 10. AGE

Female
Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (708) 216-3961 (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): Gulahi, Maryam

SS#: [redacted]

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
WALT WHITMAN	SO. HUNTINGTON NY	0 6 / 9 9 (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 (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
DREW UNIVERSITY	MADISON NJ	8/1992	– 6/1998	–
CORNELL UNIVERSITY	ITHACA NY	8/1998	6/2001	BS
STRITCH SCHOOL OF MEDICINE - LOYOLA	MAYWOOD IL	7/2001	6/2005	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 (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
LOYOLA UNIVERSITY	MAYWOOD IL	7/2001	6/2005	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Gulabi, Maryam

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	PHYSICIAN			
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 I	ILLINOIS	6/2003	[redacted]
USMLE STEP II	ILLINOIS	10/2004	
USMLE STEP II CS	ILLINOIS	1/2005	
USMLE STEP III	ILLINOIS	5/2007	

(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] 11/2/2007

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): Guishi, Maryam

SS#: [redacted]

Profession: 125

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

March 14, 2008

MARYAM GUIAHI MD
DEPT OF GME

Your application for temporary licensure in Illinois has been approved, and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 07/01/2008. Assuming you remain in the training program listed below, this license will be valid until 06/30/2009.

PROGRAM: Obstetrics & Gynecology
TRAINING FACILITY: LOYOLA UNIV MEDICAL CENTER

Utilization of this license is limited to the training program listed above. It may not be used for any clinical medical practice which occurs outside of the residency program; i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferred from one program/institution to another.

Applications for temporary licensure transfers must be filed with the Department at least 60 days prior to commencement of the new program. You are not eligible to begin a new training program until your current temporary license has been returned to the Department and a license has been issued for the new program.

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

If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department's Springfield address indicated below.

Sandra Dunn, Manager
Medical Unit

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: GHAFFI; FIRST: MARYAM; MIDDLE: —

2. DATE OF BIRTH — Month Day 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.

Profession Name: PHYSICIAN

Profession Code: 125

6. MAIDEN OR GIVEN SURNAME:

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

A. HOSPITAL/INSTITUTION NAME: Loyola University Medical Center

B. BEGINNING DATE: 07 / 01 / 2008 (Month / Day / Year)

C. ENDING DATE: 06 / 30 / 2009 (Month / Day / Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: 2160 S. 1st Avenue, Maywood, IL 60153

E. SPECIALTY / RESIDENCY NAME: OB/Gyne

F. BUSINESS TELEPHONE NUMBER: Area Code (708) 216-9000

G. YEAR OF POSTGRADUATE TRAINING: PGY 4

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.

[redacted]

Signature of Program Director

Ronald K. Pothul, M.D.

Print Name of Program Director

Program Director, OB/Gyn

Title

2/28/08

Date

SEAL

IL486-0272 08/04 (MD)

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

May 3, 2005

Maryam Guiahi MD
[redacted]

Dear Dr. Guiahi:

Your application for temporary licensure in Illinois has been approved, and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 06/27/2005. Assuming you remain in the training program listed below, this license will be valid until 06/26/2008.

PROGRAM: Obstetrics & Gynecology
TRAINING FACILITY: F G McGaw Hospital Loyola

Utilization of this license is limited to the training program listed above. It may not be used for any clinical medical practice which occurs outside the residency program; i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferable from one program/institution to another.

Applications for temporary licensure transfers must be filed with the Department at least 60 days prior to commencement of the new program. You are not eligible to begin a new training program until your current temporary license has been returned to the Department and a license has been issued for the new program.

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

If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department of Financial and Professional Regulation, Division of Professional Regulation, 320 West Washington Street, Springfield, Illinois 62786.

Sandy Dunn, Manager
Medical Unit

FC: lv3.125

0100000 03712

38479

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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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.** APR 1 2 2005

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 with a child support ...e to identify persons ...alty or interest shown ...ent or tax penalty or ...stered by the Illinois ...s for verification of

GUIAHI, MARYAM MD
0125 file# 38479 04-18-05
By: NON-EXAM ASG: tandrews
SSN: [redacted]

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.
GUIAHI	MARYAM	—	M.D.	[redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
721 WEST BARRY ST #1B CHICAGO IL USA 60657

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 [redacted] Female Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

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

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
WALT WHITMAN H.S.	HUNTINGTON STATION, NEW YORK	0 6 / 1 9 9 7 (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 (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
DREW UNIVERSITY	MADISON, NJ USA	8/1997	6/1998	–
CORNELL UNIVERSITY	ITHACA, NY USA	8/1998	6/2001	B.S.
Loyola Stritch School of Medicine	Maywood, IL USA	7/2001		M.D.

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

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

SS#:

Profession:

NAME (Last, First, MI):

SS#:

Profession:

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	IL	6/2003	
USMLE - Step 2	IL	10/2004	

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

NAME (Last, First, MI):

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: ☐☐

e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated? Yes ☐ No ☐

SS#:

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 ☑

Profession:

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] 4/5/2005

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.

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	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
Guiahi	Maryam		[redacted]	[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	B. BEGINNING DATE	C. ENDING DATE
Loyola University Medical CEnter	06 / 27 / 2005 (Month / Day / Year)	06 / 26 / 2009 (Month / Day / Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE	E. SPECIALTY / RESIDENCY NAME
2160 S. First Avenue Maysood, Il 60153	Obstetrics and Gynecology

F. BUSINESS TELEPHONE NUMBER	G. YEAR OF POSTGRADUATE TRAINING
Area Code (708) 216 — 5459	First

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

[redacted]
Signature of Program Director

John G. Gianopoulos, M.D.
Print Name of Program Director

Program Director
Title

4/6/05
Date

IL486-0272 08/04 (MD)

Chicago's Jesuit University
LOYOLA UNIVERSITY CHICAGO

Suite 220, Bldg. 120
2160 South First Avenue
Maywood, Illinois 60153
Telephone: (708) 216-3222

STRITCH SCHOOL OF MEDICINE
Registration & Records

April 15, 2005

Sandra Dunn, Manager
Medical Licensing Unit
Division of Professional Regulation
Illinois Department of Financial
and Professional Regulation
320 West Washington, 3rd Floor
Springfield, IL 62786

Dear Ms. Dunn:

This is to verify that the enclosed is a roster of senior medical students who are expected to graduate on June 12, 2005 from Loyola University Chicago Stritch School of Medicine.

I trust that the submission of this roster will help to expedite the temporary licensing procedure for Stritch graduates. If there are any questions regarding this roster, please contact our Director of Registration and Records, Helene Orloff, at 708/216-3222.

Thank you.

Sincerely,

[redacted]

Stephen Slogoff, M.D.
Dean

Enclosure – 2005 Graduate Roster

cc: Ms. Teresa Wronski, Associate Dean, Student Affairs

grad/license.tmp

4/18/05
Roster
is acceptable.
[redacted]

LOYOLA UNIVERSITY CHICAGO STRITCH SCHOOL OF MEDICINE

Expected Graduate Roster

GRADUATION DATE: 06/12/2005

SSN	Student Name	Date of Birth	Graduation Date
[redacted]	Acquaviva, Michael	[redacted]	6/12/2005
	Alsan, Burak		6/12/2005
	Alsan, Marcella		6/11/2005
	Anderson, Amy		6/12/2005
	Anderson, Ingrid		6/12/2005
	Arbuckle, Justin		6/12/2005
	Armbruster, Steven		6/12/2005
	Arndt, Stephen		6/12/2005
	Ayuste, Brian		6/12/2005
	Azih, Chinelo		6/12/2005
	Bartfield, Jessica		6/12/2005
	Bauer, Todd		6/12/2005
	Blakkolb, Christi		6/12/2005
	Boeve, Sally		6/12/2005
	Borges, Elizabeth		6/12/2005
	Boyden, Thomas		6/12/2005
	Brown, Vanessa		6/12/2005
	Burke, James		6/11/2005
	Calasanti, Piper		6/11/2005
	Camarda, Joseph		6/11/2005
	Campbell, Laura		6/12/2005
	Carreon, Sarah		6/12/2005
	Casey, Paul		6/12/2005
	Caswell, Jennifer		6/12/2005
	Caufield, Sean		6/12/2005
	Cocoma, Sarah		6/12/2005
	Costakis, Anna		6/12/2005
	Credo, Marcia		6/12/2005
	Cunningham, Kelly		6/12/2005
	Daniels, David		6/12/2005
	De Angelo, Carolyn		6/12/2005
	DeFrates, Megan		6/12/2005
	DeLucia, Tracey		6/11/2005
	Dick, Ryan		6/12/2005
	Dingman, Jessica		6/12/2005
	Dorgan, Christopher		6/12/2005
	Dorner, Matthew		6/12/2005
	Duncker, Katie		6/12/2005
	Dutta, Sayon		6/12/2005
	Epstein, Andrew		6/12/2005
	Erwin, Daniel		6/12/2005
	Finnan, Ryan		6/12/2005
	Fisher, Jeffrey		6/12/2005
	Flagel, Benjamin		6/11/2005
	Frost, Elizabeth		6/12/2005
	Frost, Nathan		6/12/2005
	Fuhrman, Jeanna		6/12/2005
	Funk, Luke		6/12/2005
	Gagovic, Veronika		6/12/2005

LOYOLA UNIVERSITY CHICAGO STRITCH SCHOOL OF MEDICINE

Expected Graduate Roster

GRADUATION DATE: 06/12/2005

[redacted]	Gassman, Andrew	[redacted]	6/12/2005
	Gierut, Angelica		6/12/2005
	Guiahi, Maryam		6/12/2005
	Hagan Buchanan, Amy		6/12/2005
	Hanson, Kristopher		6/12/2005
	Harris, Angela		6/12/2005
	Heinrich, Scott		6/12/2005
	Hoffman, Tracy		6/12/2005
	Hoyme, Eric		6/12/2005
	Hugen, Cory		6/12/2005
	Humphrey, Isaac		6/12/2005
	Ivey, Jacqueline		6/11/2005
	Jacob, Gabriel		6/12/2005
	Kalhorn, Stephen		6/12/2005
	Kang, Caroline		6/12/2005
	Kavanaugh, Michael		6/12/2005
	Klein, Kimberly		6/12/2005
	Kraseman, Stephen		6/12/2005
	Kucharski, Christopher		6/12/2005
	Lanoue, Christopher		6/12/2005
	Lebda, Paulette		6/12/2005
	Lin, Frank		6/12/2005
	Luebbert, Jeffrey		6/12/2005
	Lupash, Daniel		6/12/2005
	Madsen, Nathaniel		6/12/2005
	Malekiani, Christina		6/12/2005
	Manalo, Danielle		6/12/2005
	Manteuffel, Kristin		6/12/2005
	Marfia, Paula		6/12/2005
	Martino, Julie		6/12/2005
	Marucci, Leonardo		6/12/2005
	McBrine, Michael		6/12/2005
	McLain, Amanda		6/12/2005
	Merwood, Michelle		6/12/2005
	Miller, Charles		6/12/2005
	Miller, Kathryn		6/12/2005
	Motta, Sandra		6/12/2005
	Muller, Eric		6/12/2005
	Mulligan, Molly		6/11/2005
	Nitzschke, Stephanie		6/12/2005
	O'Brien, Bridget		6/12/2005
	Pederson, Aaron		6/13/2005
	Polcari, Anthony		6/12/2005
	Porter, Ryan		6/12/2005
	Prahl, James		6/12/2005
	Pulia, Michael		6/12/2005
	Rosenbaum, Christopher		6/12/2005
	Rudy, Alison		6/12/2005
	Russell, Brett		6/12/2005
	Sandu, Cezar		6/12/2005
	Schroeder, Kathryn		6/13/2005

LOYOLA UNIVERSITY CHICAGO STRITCH SCHOOL OF MEDICINE

Expected Graduate Roster

GRADUATION DATE: 06/12/2005

[redacted]	Schwieger, Jennifer	[redacted]	6/12/2005
	Sears, Benjamin		6/12/2005
	Shah, Anuj		6/12/2005
	Sharma, Tushar		6/12/2005
	Siddiqi, Alvia		6/12/2005
	Slimack, Nicholas		6/12/2005
	Sostak, James		6/12/2005
	Spear, Lisa		6/12/2005
	Stahle, Christine		6/11/2005
	Stutman, Ross		6/12/2005
	Sullivan, Joseph		6/12/2005
	Sullivan, Patrick		6/12/2005
	Takagishi, Troy		6/12/2005
	Thawani, Anjali		6/12/2005
	Thompson, David		6/12/2005
	Thomson, Tricia		6/12/2005
	Tobin, Katherine		6/12/2005
	Tompkins, Andrew		6/12/2005
	Triplett, Cherrell		6/12/2005
	Tuite, Adam		6/12/2005
	Tuohy, Elizabeth		6/12/2005
	Wade, Terence		6/12/2005
	Washington, Terri		6/12/2005
	Weedon, James		6/12/2005
	Wenckus, Dalia		6/12/2005
	Wickman, Amy		6/12/2005
	Wu, Cindy		6/12/2005
	Zargaroff, Sherwin		6/12/2005

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.

WORK HISTORY

SUPPORTING DOCUMENT

WH

APPLICANT: Complete Work History. If you have never been employed you may stop at box 8. You are authorized to photocopy this form if additional space is required.

1. NAME LAST: GUIAHI FIRST: MARYAM MIDDLE: —

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

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

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☒

8. DATE FORM COMPLETED: 04/05/2005

9. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

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)

B. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

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)

NAME (Last, First, MI):

SS#:

Profession:

C. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

D. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

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

SUPERVISOR NAME

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)

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

GUIAHI MARYAM

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

LOYOLA UNIVERSITY MEDICAL CENTER

ADDRESS STREET, CITY, STATE, ZIP CODE

2160 S. FIRST AVE IL 60153

DATE OF EMPLOYMENT/ATTENDANCE

From 07 / 01 / 2005 (Month / Day / Year)

To 06 / 30 / 2009 (Month / Day / Year)

HOURS WORKED PER WEEK

60-80

TYPE OF EMPLOYMENT

☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

3+ YRS

JOB TITLE

RESIDENT

DESCRIPTION OF DUTIES PERFORMED

OB/GYN RESIDENT RESPONSIBILITY

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

05

LOYOLA MEDICINE
Loyola University Chicago Stritch School of Medicine

Department of Obstetrics and Gynecology
Office: (708) 327-3314 • Fax: (708) 327-3248

RECEIVED
CASH RECEIPTION
MAR 0 3 2008
IDFPR
Div. of Professional Regulation

February 14, 2008

Ms. Susan Irwin
Illinois Department of Financial and Professional Regulation
Attn: Division of Professional Regulation
P. O. Box 7199
Springfield, IL 62791

RE: Maryam Guiahi, M.D.

Dear Ms. Irwin:

We are requesting an extension of temporary medical licensure for Dr. Guiahi in order for Dr. Guiahi to complete the 4 year Obstetrics and Gynecology training program. Dr. Guiahi is currently a resident in good standing at Loyola University Medical Center. Her anticipated date of graduation from our program is June 30, 2009.

Thank you for your consideration.

Sincerely,

[redacted]

Ronald K. Potkul, M.D.
Professor & Director
Gynecologic Oncology
Resident Director
Obstetrics & Gynecology

RECEIVED
MAR 0 4 2008
IDFPR - MEDICAL UNIT

RKP/cs

LOYOLA MEDICINE
Loyola University Chicago
Stritch School of Medicine

Department of Obstetrics and Gynecology
Office: (708) 327-3314 • Fax: (708) 327-3248

February 14, 2008

Ms. Susan Irwin
Illinois Department of Financial and Professional Regulation
Attn: Division of Professional Regulation
P. O. Box 7199
Springfield, IL 62791

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Thank you for your consideration.

Sincerely,

[redacted]

Ronald K. Potkul, M.D.
Professor & Director
Gynecologic Oncology
Resident Director
Obstetrics & Gynecology

RKP/cs