

AFPLICATION FOR LICENSURE AND OR Professional Regular 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.

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

FOR OFFICIAL USE ONLY

A Type or print legibly with black ink only.

B. FEESARENOTREFUNDABLE.

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.

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

- Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
- INSTRUCTION SHEET, which gives step by step application instructions for your profession.
- REFERENCE SHEET, which gives detailed coding information for your profession.
- SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
- 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.

PART I: Application Cated	ory Information			# # # # # # # # # # # # # # # # # # #		
A. SEE REFERENCE SHEET,	CHARTI, ORINSTE					
PROFESSION NAME		2. PROFESSION	NCODE 3.	LICENSURE METH	1OD	4. FEE
Physician		<u>0</u> <u>3</u>	6	Endorsement		\$ 700.00
B. CHECKBOXINDICATINGTI This is the first tir profession in Illinoi I have previously n Illinois. However, m now reapplying. Other:	me I have made is. nade application	application for for this profession	this	My application denied in Illinoi additional requ I have previous	 I am reapplying irements. Iy made application 	had previously been since I have fulfilled for this profession in g under new statutory
of Profession		d/or Continenta	I Testing Servic			Regulation - Division s after you file this
1. NAME LAST	FIRST N	MIDDLE	2. TITLE (e.g., I	M.D., D.D.S., etc.)	3. UNITEDSTATES	SOCIAL SECURITY NO.
Nucatola, M.D.	Deborah	L.	м	I.D.		
4. PERMANENT MAILING AD	DRESS STREET	CITYSTA	TE/COUNTRY		P CODE	COUNTY
5. BUSINESS ADDRESS S	TREET	CITYSTA	TE/COUNTRY	Z	PCODE	COUNTY
434 W. 33rd Street		New Yo	ork, NY	1 0	0 0 1	
6. MAIDEN, GIVEN SURNAN DOCUMENTS WILL BE SU					7. MOTHER'SMAID	ENNAME
8. PLACE OF BIRTH C	ITY STATE/COU	NTRY	9. DATE OF	BIRTH		10.AGE
						43 Y Female
			Month	Day	Year	☐ Male
11. TELEPHONE NUMBER W	HERE YOU MAY B					ERREDe-MAIL
Work: (<u>3 2 3</u>) <u>6 9</u> (Area Code)	7-645	<u>8</u> Home	(Area Code)		ADDR	RESS(ES) [Ifavailable]
Fax: ()		Fax:	()(Area_Code)			

IL486-1019 01/14 (LT)

APPLICATION FOR LICENSURE AND/OR EXAMINATION - Page 1 of 4

PART III: Education Information		Political		
1. PRELIMINARY EDUCATION (Elementary a				
1 2 3 4 5 6 7 8 9 10 11 (High School? Tes INO		.D.? Yes	s 🗆 No
NAME OF LAST PRELIMINARY SCHOOL ATTENDED	LAST PRELIMINARY SCHOOL LOCATI (City and State)		ATE OF GRADUA	9 9 0
Herricks High School	New York, NY		Month	Year
5. COLLEGE OR UNIVERSITY (Circle number 1 2 3 4 5 6 7 8)	er of years completed) Graduated? Yes	□No		
COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF AT	TENDANCE TO	TYPE OF DEGREE EARNED
University of Wisconsin	Madison, WI USA	Month/Year 08/90	Month/Year 05/94	B.S. Kineisiology
State University of New York Downstate Medical Center	Brooklyn, NY USA	07/94	05/98	M.D.
		-		
7. SPECIALIZED TRAINING (Residency, Prof	fessional Training, Vocational Training, Practica	ıl or Clinical Traini	ng)	
	LOCATION		ATTENDANCE	Did You Complete
INSTITUTION NAME	(City and State or Country)	FROM	то	Training?
LAC/USC Healthcare Network	Los Angeles, CA USA	Month/Year 06/98	Month/Year 06/02	☑ Yes □ No
Keck School of Medicine	Los Angeles, CA USA	07/02	06/04	✓ Yes □ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ 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				
California	Physician	A70101	10/22/99	Active
State of Current Licensure where you most recently have been practicing. California				
Other States of Licensure				
New York	Physician	256206	02/12/10	Active
	· .			

(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. EACHEXAMINATION 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	MONTHYEAR	EXAM RESULTS
USMLE I	NY	06/1996	(Passed Failed Absent)
USMLE II	NY	03/1998	
USMLE III	CA	12/1998	
		A	
(If additional space is need	ded, attach a separate	sheet.)	

P	ART: VI: Personal History Information (This part must be completed by all applicants)	YES	NÖ
Sec. 96	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.		✓
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.		✓
P/	ART VII: Examination Coding Information (This part is for examination applicants only)	r. Territo	Year.
Re	efer to the REFERENCE SHEET enclosed with this application package and complete the following:	yetan maso-ipidi	a our JPS
	CHART II - Select examination(s) you desire and enter Test Codes.		
b)	CHARTIII- 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:		
F	PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to response following questions)	ond to	the
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 Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in with a child support order. Failure to certify shall result in disciplinary action, and making a false statement may subject licensee to contempt of court.	comply	
	Are you more than 30 days delinquent in complying with a child support order? (NOTE: If you are not subject to a child support order, answer "no.")	No 🔽	
2.	In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renew aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commis other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)	the Illino al if the	ois
	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 v	
P/	ART IX: Certifying Statement		
Ur	nder penalties of perjury, I declare that I have examined the application and all supporting documents submitted to innection therewith, and to the best of my knowledge, they are true, correct, and complete.	oy me i	n
_	8118115		_
Re	Signature of Applicant INDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Profequilation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if bmitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than the required fee hereunder.	f the an	noun

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ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION PERSONAL HISTORY INFORMATION

SUPPORTING DOCUMENT

 PH

NAN	E LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER		
<u> </u>	Nucatola, M.D.	Deborah	L.	-		
In c	rder for your application to	oe evaluated, you must r	espond to each of the f	ollowing questions:	YES	NO
1.				pended, or terminated) by any ete and accurate explanation.		>
2.		by any hospital or healt	_	at could lead to any restriction, ttach a separate sheet with		>
3.	membership or privileges in or suspended? You must a withdrawn or failed to proc	nvoluntarily reduced, limi answer yes if any of thes eed with an application fo ccurate explanation ANL	ted, placed on probation se actions are currently or privileges/membersh D request the hospital of	or health care facility or had such n, relinquished, denied, revoked pending or if you have nips. If yes, attach a separate or health care facility to submit a		✓
4.	Has your provider status en including but not limited to sheet with complete and an	Medicare, Medicaid, Tri	•	any insurance carrier, ier? If yes, attach a separate		✓
-5.	jurisdiction? This does no renewal fee. If yes, attach	t include allowing your lic a separate sheet with co ents including initial com	cense to expire solely d complete and accurate e	y state, country, or U.S. federal lue to non-payment of the xplanation AND request all ers, agreements or reprimands		~
6.	Have you ever withdrawn a license in any other state, complete and accurate exp complaint, stipulations, ord	country, or U.S. federal joint and the country, or U.S. federal joint and the country is a second and the country is a second and the country is a second and the country, or U.S. federal joint and the country is a second and the	jurisdiction? If yes, atta Il official disciplinary do	ach a separate sheet with cuments including initial		√
7.	actions include, but are no	ciety or association or co uding but not limited to ar it limited to, any allegation conse to this question. In request all official discipli	ommittee thereof, or by my governmental assista ons currently pending.) f yes, attach a separate inary documents includ	any non-licensing ance agency? (Disciplinary Disclose any stipulation to a sheet with a complete and		✓
	submitted by me in conn	, I declare that I have exa		I supporting documents and/or in dge, they are true, correct, and co 8 118 / 15 Date		n

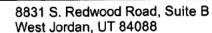
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HEALTH CARE WORKERS CHARGED WITH OR CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

not being processed.	OI OI	MINAL ACTO			
1. NAME LAST FIRST	T MIDDLE	3. PROFESSIONAL LICENSE NUMB	BER (if any)		
Nucatola, M.D. Debor	ah L.				
2. ADDRESS STREET, CITY, STATE	E, ZIP CODE	4. SOCIAL SECURITY NUMBER			
Pursuant to 20ILCS 2105-165(a),			lose information re	garding	convic-
tions pertaining to certain offense	s. Please check applicat	ole profession.			
Acupuncturists	☐ Naprapaths		nysician Assistants	;	
 ☐ Advanced Practice Nurses ☐ Athletic Trainers 	☐ Nursing Home Add☐ Occupational The	ministrators	odiatrists ofessional Counsel	lors	
Audiologists	Occupational The	аріою —	osthetists		
☐ Clinical Psychologists	☐ Optometrists	☐ Re	egistered Nurses		
Clinical Social Workers	☐ Orthotists		egistered Surgical		
Dental Hygienists	Pedorthists	_	egistered Surgical T espiratory Care Pra		-
☐ Dentists ☐ Genetic Counselors	☐ Perfusionists ☐ Pharmacists		eech Pathologists	Cuuone	15
Licensed Clinical Professional					
Counselors	Physical Therapy				
Licensed Practical Nurses	Physicians, includ	ing Medical Doctors			
Licensed Social Workers		Osteopathic Medicine			
	ts (D.O.), and Chirop	oractic Physicians (D.C.)			
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 mu	st respond to each of the follo	owing questions:		200 E
Are you currently charged with of the Sex Offender Registration A		d of a criminal act that requires re	egistration under	Yes	No —
		d of a seissiant batton, anniant on		<u> </u>	Z)
Are you currently charged with a course of patient care or treatment.					Ø
3) Are you required, as part of a cri	minal sentence, to registe	r under the Sex Offender Regist	ration Act? *		Ø
4) Are you currently charged with o	or have you been convicted	of a forcible felony? *			Ø
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		<u>& </u>	8/15		





Illinois Department of Professional Regulation 320 West Washington Street, 3rd Floor Springfield, IL 62786

I, <u>DEBORAH L. NUCATOLA, M.D.</u>, hereby authorize the Illinois Department of Professional Regulation to release all information regarding medical licensure for the purpose of evaluating my professional, ethical and physical qualifications for medical licensure in the state of Illinois to **LYNDSI TAYLOR** of Physician Licensing Service.

I, the undersigned, waive any privileges of confidentiality of information required by the aforementioned entity for the purposes indicated herein. This form shall authorize and request state medical boards to send all letters of deficiency and status correspondence to Physician Licensing Service.

I hereby release the aforementioned entities from all liability for the release of this information. The original or a copy hereof shall operate as full proof of authority and release.



Please fax correspondence to:

PLS 801-512-2001

Please mail correspondence to:

Physician Licensing Service 8831 s. Redwood Road, Suite B

West Jordan, UT 84088

Please e-mail correspondence to:

LT@physicianlicensing.com

RECEIVED BUSINESS SERVICES

DEC ' 8 2015

IDFPFI
Div. of Professional Regulation

Phone: 801-816-1149 | Fax: 801-512-2001

physicianlicensing.com



FEB 0 9 2016

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

ISPER - MEDICAL UNIT

being processed.			
1. NAME LAST · FIR	ST MIDDLE	PLEASE CHECK THE TYPE OF L APPLYING:	ICENSE FOR WHICH YOU ARE
NUCATOLA DEBO			Profession Code
o. Abbridge Street, Girl, Girl	TE, Zii GGBE	Permanent Physician Lic	ense 036
4. DATE OF BIRTH		☐ Temporary Physician Tra	ining License 125
Month Day Year		☐ Chiropractic Physician Lie	BUSINENS STREIDES:
5. SOCIAL SECURITY NUMBER		6. MAIDEN OR GIVEN SURNAME	FEB 9 2016
	I		The second secon
Record work history chronolog employment. Also list any breaks			
A. NAME OF PRACTICE/WORK LOCA	TION	JOB TITLE	
EDENSURGICALCE		DIRECTOR, FAI	11LY PLANNING
ADDRESS STREET, CITY, STATE A 3951 CRAFTSMAN PCALARASAS, CA 912 DATE OF EMPLOYMENT/ATTENDANCE From 01 / 01 / 2013 Month Day Year TO PRESENT TO PRESENTATION TO BY YEAR TOTAL TIME WORKED (Year/Month)	10AD 302	- CARETO FAMIL	ES, PROCEDURES
B. NAME OF PRACTICE / WORK LOCA	ATION	JOB TITLE	
PPFA		SENIOR-DIFECTOR,	H EDICAL SERVICES
ADDRESS STREET, CITY, STATES H34 W 33 PD ST, NY, N		DEVELOP EVIDENCE	E-BASED PRACTICES
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		FOR PPFA. PROVIDE
From 07, 22, 2009	78	CHE ACTIVITIES	SERVE AS
Month Day Year To Pration	TYPE OF EMPLOYMENT	PAICHLESSE PESO	OURCE.
Month Day Year	□ Full-time □ Part-time		
TOTAL TIME WORKED (Year/Month)	<u> </u>		
6YEARS 6 MC) NTHS		
			A STATE OF THE STATE OF



C. NAME OF PRACTICE / WORK LOCATION	JOB TITLE		
KAISER PANOPAMA CITY	PER DIEM PHYSICIAN		
ADDRESS STREET, CITY, STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED		
13631 WILLARDST, PANOPAHA CITY, CA 91401	PROVIDE OBJEYN CAPE		
DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK	, , , , ,		
To Present	and a Man har below.		
Month Day Year Full-time Part-time			
TOTAL TIME WORKED (Year/Month)	the contract of the agree .		
D. NAME OF PRACTICE / WORK LOCATION	JOB TITLE .		
PLANNEP PAPENTHOOD LOS ANGELES	PHYSICIAN		
ADDRESS STREET, CITY, STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED		
400 N 30THST, LA, CA 900 33	PROVIDE OBJEYN CAPE		
DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK	, , , , , ,		
From 07 101 12004 8	,		
Month Day Year TYPE OF EMPLOYMENT			
To Present Near □Full-time ☑Part-time			
TOTAL TIME WORKED (Year/Month)			
	1		
E. NAME OF PRACTICE / WORK LOCATION	JOB TITLE		
E. NAME OF PRACTICE / WORK LOCATION -ADDRESS STREET, CITY, STATE, ZIP CODE	JOB TITLE DESCRIPTION OF DUTIES PERFORMED		
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DATE OF EMPLOYMENT/ATTENDANCE From / /	JOB TITLE DESCRIPTION OF DUTIES PERFORMED		
DATE OF EMPLOYMENT/ATTENDANCE From / / Month Day Year TYPE OF EMPLOYMENT TO / / Full-time Part-time TOTAL TIME WORKED (Year/Month) F. NAME OF PRACTICE / WORK LOCATION ADDRESS STREET CITY STATE ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / /	JOB TITLE DESCRIPTION OF DUTIES PERFORMED		
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SUPPORTING DOCUMENT

VE-PC

being processed.			
1. NAME LAST FIRST	MIDDLE	PLEASE CHECK THE TYPE OF L APPLYING:	ICENSE FOR WHICH YOU ARE
Nucatola, M.D. Deborah	L.		Profession Code
3. ADDRESS STREET, CITY, STATE,	, ZIP CODE	Permanent Physician Lice	ense 036
4. DATE OF BIRTH		☐ Temporary Physician Tra	ining License 125
Month Day Year		☐ Chiropractic Physician Lie	cense 038
5. SOCIAL SECURITY NUMBER		6. MAIDEN OR GIVEN SURNAME	
-			
Record work history chronological employment. Also list any breaks o			
A. NAME OF PRACTICE/WORK LOCATION	ON	JOB TITLE	
Eden Surgical C	enter	Director of	Family Planning
ADDRESS STREET, CITY, STATE,		DESCRIPTION OF DUTIES PERI	
22054 Crafteman Boad, Cala	-h CA 01202		
23951 Craftsman Road, Cala DATE OF EMPLOYMENT/ATTENDANCE H	HOURS WORKED PER WEEK	\dashv	
From / / <u>2 0 1 3</u> Month Day Year		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
To/ _/ Pres	TYPE OF EMPLOYMENT		
Month Day Year	□Full-time □Part-tim	ie	
TOTAL TIME WORKED (Year/Month)		-	
B. NAME OF PRACTICE / WORK LOCATI	ON	JOB TITLE	·
Kaiser Permanente Panorama	City Medical Center		
ADDRESS STREET, CITY, STATE,		DESCRIPTION OF DUTIES PER	RFORMED
13651 Willard Street, Panoral	ma Citv. CA 91402		
	HOURS WORKED PER WEEK	=	
From <u>0 8 / / 2 0 1 1</u>			
M D	TYPE OF EMPLOYMENT	\dashv	
To //Pres			
Month Day Year	☐Full-time ☐Part-tim	пе	
TOTAL TIME WORKED (Year/Month)	Andrew Constitute of the Const		
	The second secon	AND THE PROPERTY OF THE PROPER	

C. NAME OF PRACTICE/WORK LOCATION	JOB TITLE Voluntary Attending Physician / Obstetrics&Gynecology
Keck School of Medicine of the University of Southern California	Voluntary Attending Physician / Obstetrics&Gynecology
ADDRESS STREET, CITY, STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
1975 Zonal Avenue, Los Angeles, CA 90033	, the state of the
DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK	irs
From <u>0 2 / 0 4 / 2 0 0 5</u> Month Day Year TYPE OF FMRIONAFAIT	DESCRIPTION OF DUTIES PERFORMED (Last, First, MI):
TO 0 7 / 0 1 / 2 0 1 4	l P
Month Day Year □Full-time □Part-time	[]
TOTAL TIME WORKED (Year/Month)	1
9 years 5 months	
D. NAME OF PRACTICE / WORK LOCATION	JOB TITLE >
	uca
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	DESCRIPTION OF DUTIES PERFORMED DESCRIPTION OF DUTIES PERFORMED Deboran
DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK	112
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Month Day Your	
TYPE OF EMPLOYMENT	
Month Day Year □Full-time □Part-time	
TOTAL TIME WORKED (Year/Month)	[
E. NAME OF PRACTICE/WORK LOCATION	JOB TITLE .
E. NAME OF PRACTICE/WORK LOCATION	JOB TITLE
,	SS
ADDRESS STREET, CITY, STATE, ZIP CODE	SS
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK	SS
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / /	SS
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / / Month Day Year TYPE OF EMPLOYMENT TO / /	DESCRIPTION OF DUTIES PERFORMED ##
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / / Month Day Year TYPE OF EMPLOYMENT	DESCRIPTION OF DUTIES PERFORMED ##
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / / Month Day Year TYPE OF EMPLOYMENT TO / / / TO	DESCRIPTION OF DUTIES PERFORMED ##
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / / Month Day Year TYPE OF EMPLOYMENT To / / Month Day Year Full-time Part-time	DESCRIPTION OF DUTIES PERFORMED ##
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / / Month Day Year TYPE OF EMPLOYMENT To / / Month Day Year Full-time Part-time	DESCRIPTION OF DUTIES PERFORMED ##
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / /	DESCRIPTION OF DUTIES PERFORMED ##
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / /	DESCRIPTION OF DUTIES PERFORMED ##
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / /	DESCRIPTION OF DUTIES PERFORMED Profess JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / /	DESCRIPTION OF DUTIES PERFORMED ##
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE From / / HOURS WORKED PER WEEK From / / TYPE OF EMPLOYMENT TO / / Full-time Part-time TOTAL TIME WORKED (Year/Month) F. NAME OF PRACTICE / WORK LOCATION ADDRESS STREET, CITY, STATE, ZIP CODE	JOB TITLE DESCRIPTION OF DUTIES PERFORMED Profession:
ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE From / / Month Day Year TYPE OF EMPLOYMENT TO / / DFUIL-time Part-time TOTAL TIME WORKED (Year/Month) F. NAME OF PRACTICE / WORK LOCATION ADDRESS STREET, CITY, STATE, ZIP CODE DATE OF EMPLOYMENT/ATTENDANCE HOURS WORKED PER WEEK From / / TYPE OF EMPLOYMENT	JOB TITLE DESCRIPTION OF DUTIES PERFORMED Profession:
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IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled

CERTIFICATION OF

SUPPORTING DOCUMENT

TALAMED

VOLUNTARY. However, failure to comply may		TE CLINICAL TRAINING	I IN-MED		
result in this form not being processed.			(DPR)		
APPLICANT: Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.					
NAME LAST FIRST	MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER		
Nucatola, M.D. Deboral		2. DATE OF BIRTH	3. SOCIAL SECURITY NONDER		
4. ADDRESS STREET, CITY, STATE, ZIF		Month Day Year	FFT. Decord profession name and three		
4. ADDRESS STREET, CITY, STATE, ZIP	CODE		EET. Record profession name and three nyou are making Illinois application.		
6. MAIDEN OR GIVEN SURNAME		Physician	0 3 6		
		Profession Nam	e Profession Code		
7. ILLINOIS TEMPORARY LICENSE NUMB	ER (If applicable)	8. ISSUANCE DATE			
		TRAINING PROGRAM DIREC			
Complete the remainder of this for	m. RETURN THE COI	MPLETED FORM DIRECTLY T	O THE APPLICANT.		
		40			
This is to certify that the above-nar	med applicant satisfact	orily completed <u>I &</u> months	of postgraduate clinical		
training in OBGYN					
	(Name of Sp	ecialty Program)			
from 06/24//998 MM/DD/YYYY	to <u>6/3</u>	o/2002 at the following	ng hospital:		
		Medical Center			
Number and Street: 1250	N.State S	Freet			
Number and Street: しょう	i Angeles,	(A 90073			
I further certify that at the time of s	uch training the progra	m was accredited by:			
the ACGME		the CFPC, RCPSC or FMLAC	(Canadian Programs)		
the AOA		not accredited in the US or Car			
		The desired to the early			
Name of Postgraduate Clir	nical Training Program	Director: Jenny Jac	the MD		
Signature of Postgraduate Clir	nical Training Program	Director:			
	Data of this Con	Historian DC+ 13th	7015		
University/Hospital	Date of this Cer	tification: 04.1312 hone No: (323)226	7 2013		
SEAL	Telepl	none No: (325)226	- 7 4 4 7		
(If no seal, attach letter on lette stating no seal exists.)	rhead				





Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382 FAX (916) 263-2944
www.mbc.ca.gov



January 11, 2016

TO WHOM IT MAY CONCERN:

This is to certify that as of January 7, 2016 the records of the Medical Board of California (Board) indicate the following information:

PHYSICIAN:

DEBORAH LYNN NUCATOLA

LICENSE NUMBER:

A70101

ISSUED:

October 22, 1999

EXAM TYPE:

A Written Examination

EXPIRATION DATE:

May 31, 2017

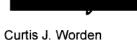
LICENSE STATUS:

CURRENT

BOARD DISCIPLINE:

No

Further public records pertaining to the above licensee may be available from the Board's Web site at www.mbc.ca.gov.



Chief of Licensing

RECEIVED

JAN 1 2 2016

IDFPR - MEDICAL UNIT

RECEIVED ELECTRONICALLY

Telephone No.: 1-800-560-6420

Attn: Medical Services Section

STATE OF ILLINOIS
Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 3/9/2016

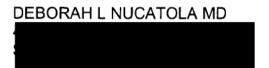
Initials: KW

License No: 036

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES.

NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:



RETURN THIS FORM
AND APPLICATION
WITH REMITTANCE,
IF APPLICABLE

Deficiency Checklist

Results of your State and FBI criminal history background check have not been received. See enclosed notice. You must have your fingerprints taken by a fingerprint vendor licensed by the Department for submission to the State and the FBI. The licensed vendor will provide you a "fingerprint" receipt which must be forwarded to the Department. If you do not have a receipt PLEASE CONTACT THE APPROPRIATE LICENSED VENDOR.

Telephone No.: 1-800-560-6420

Attn: Medical Services Section

STATE OF ILLINOIS
Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 2/22/2016

Initials: KW

License No: 036

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TO:

DEBORAH L NUCATOLA MD

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Submit official transcript(s) verifying medical education with school seal/signature to the attention of the Medical Unit.

Telephone No.: 1-800-560-6420

Attn: Medical Services Section

STATE OF ILLINOIS
Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 2/5/2016

Initials: RA

License No: 036

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BEEN MET.

TO:

DEBORAH L NUCATOLA MD

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Submit official transcript(s) verifying medical education with school seal/signature to the attention of the Medical Unit.

The Department will accept electronic transcripts from secure transcript services (e-Script, Parchment, Student Clearinghouse, etc). The transcripts can be sent to FPR.MedicalUnit@illinois.gov.

Telephone No.: 1-800-560-6420

Attn: Medical Services Section

STATE OF ILLINOIS
Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 1/15/2016

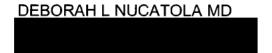
Initials: TM

License No: 036

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Submit official transcript(s) verifying a minimum of 2-years liberal arts education with school seal/signature affixed to the attention of the Medical Unit.

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The Department will accept electronic transcripts from secure transcript services (e-Script, Parchment, Student Clearinghouse, etc). The transcripts can be sent to FPR.MedicalUnit@illinois.gov.

You did not provide description of job duties on any of the employment listed on the VE-PC. Please submit a new VE-PC listing your job duties at each employer.

Telephone No.: 1-800-560-6420

Attn: Medical Services Section

STATE OF ILLINOIS
Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfor.com

Date: 12/11/2015

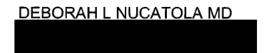
Initials: KW

License No: 036

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Certification of Licensure (CT form) needs to be completed by your original/current jurisdiction of practice from California.

USMLE pass/fail history must be received directly from the Federation of State Medical Boards.