RECEIVED
CASH SECTION

DEC 0 8 2015

Div. of Professional Regulation

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	*0 3 6*	*Endorsement*	*$ 700.00*

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.
Nucatola, M.D.	*Deborah*	*L.*	*M.D.*	[redacted]

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

5. BUSINESS ADDRESS STREET	CITY STATE/COUNTRY	ZIP CODE	COUNTY
434 W. 33rd Street	*New York, NY*	*1 0 0 0 1*	

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	9. DATE OF BIRTH Month Day Year	10. AGE	
[redacted]		[redacted]	*43*	☑ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (*3 2 3*) *6 9 7* – *6 4 5 8* (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): Nucatola, M.D., Deborah L.

SS#: [redacted]

Profession: Physician

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
Herricks High School	*New York, NY*	*0 6* / *1 9 9 0* (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	DATES OF ATTENDANCE 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, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM	DATES OF ATTENDANCE TO	Did You Complete 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

NAME (Last, First, MI): Nucatola, M.D., Deborah L.

SS#: [redacted]

Profession: Physician

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. 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 (Passed, Failed, Absent)
USMLE I	***NY***	***06/1996***	[redacted]
USMLE II	***NY***	***03/1998***	
USMLE III	***CA***	***12/1998***	

(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 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.*		✓

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] 8/18/15
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): Nucatola, M.D., Deborah L.
SS#: [redacted]
Profession: Physician

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
PERSONAL HISTORY INFORMATION

SUPPORTING DOCUMENT

PH

NAME LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
Nucatola, M.D.	*Deborah*	*L.*	[redacted]

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

Certification Statement

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

[redacted]

Signature of Applicant

8/18/15

Date

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.

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

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE
Nucatola, M.D. ***Deborah*** ***L.***

3. PROFESSIONAL LICENSE NUMBER (if any)
____ - _____

2. ADDRESS STREET, CITY, STATE, ZIP CODE
[redacted]

4. SOCIAL SECURITY NUMBER
[redacted]

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

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

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

		Yes	No
1)	Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☑
2)	Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration?	☐	☑
3)	Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☑
4)	Are you currently charged with or have you been convicted of a forcible felony? *	☐	☑

*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.

[redacted]
Signature ~~of Applicant~~

Date 8/18/15

PHYSICIAN
LICENSING SERVICE

8831 S. Redwood Road, Suite B
West Jordan, UT 84088

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

I, **DEBORAH L. NUCATOLA, M.D.**, 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.

Signature

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
FEB 09 2016
IDFPR - MEDICAL UNIT

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

NUCATOLA DEBORAH LYNN

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

RECEIVED
BUSINESS SERVICES
FEB 9 2016

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment. Also list any breaks of six (6) months or longer in medical practice since graduation from medical school.

A. NAME OF PRACTICE / WORK LOCATION
EDEN SURGICAL CENTER

JOB TITLE
DIRECTOR, FAMILY PLANNING

ADDRESS STREET, CITY, STATE, ZIP CODE
23951 CRAFTSMAN ROAD
CALABASAS, CA 91302

DATE OF EMPLOYMENT/ATTENDANCE
From 01 / 01 / 2013 (Month / Day / Year)
To present (Month / Day / Year)

HOURS WORKED PER WEEK
8

TYPE OF EMPLOYMENT
☐ Full-time ☒ Part-time

TOTAL TIME WORKED (Year/Month)
3 YEARS

DESCRIPTION OF DUTIES PERFORMED
DEVELOP POLICIES, PROCEDURES AND PROTOCOLS AND PROVIDE CARE TO FAMILY PLANNING PATIENTS.

B. NAME OF PRACTICE / WORK LOCATION
PPFA

JOB TITLE
SENIOR DIRECTOR, MEDICAL SERVICES

ADDRESS STREET, CITY, STATE, ZIP CODE
434 W 33RD ST, NY, NY 10001

DATE OF EMPLOYMENT/ATTENDANCE
From 07 / 22 / 2009 (Month / Day / Year)
To present (Month / Day / Year)

HOURS WORKED PER WEEK
28

TYPE OF EMPLOYMENT
☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
6 YEARS 6 MONTHS

DESCRIPTION OF DUTIES PERFORMED
DEVELOP EVIDENCE-BASED PRACTICES AND PROTOCOLS FOR PPFA. PROVIDE CME ACTIVITIES. SERVE AS KNOWLEDGE RESOURCE.

IAW cont on back

NAME (Last, First, MI):

SS#:

Profession:

C. NAME OF PRACTICE / WORK LOCATION
KAISER PANORAMA CITY

JOB TITLE
PER DIEM PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE
13651 WILLARD ST, PANORAMA CITY, CA 91402

DESCRIPTION OF DUTIES PERFORMED
PROVIDE OB/GYN CARE

DATE OF EMPLOYMENT/ATTENDANCE
From 08 / 01 / 2011
Month Day Year
To PRESENT
Month Day Year

HOURS WORKED PER WEEK
8

TYPE OF EMPLOYMENT
☐ Full-time ☒ Part-time

TOTAL TIME WORKED (Year/Month)

D. NAME OF PRACTICE / WORK LOCATION
PLANNED PARENTHOOD LOS ANGELES

JOB TITLE
PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE
400 W 30TH ST, LA, CA 90033

DESCRIPTION OF DUTIES PERFORMED
PROVIDE OB/GYN CARE

DATE OF EMPLOYMENT/ATTENDANCE
From 07 / 01 / 2004
Month Day Year
To PRESENT
Month Day Year

HOURS WORKED PER WEEK
8

TYPE OF EMPLOYMENT
☐ Full-time ☒ Part-time

TOTAL TIME WORKED (Year/Month)

E. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

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)

F. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

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

Nucatola, M.D. *Deborah* *L.*

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

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

5. SOCIAL SECURITY NUMBER

[redacted]

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment. Also list any breaks of six (6) months or longer in medical practice since graduation from medical school.

A. NAME OF PRACTICE / WORK LOCATION

Eden Surgical Center

ADDRESS STREET, CITY, STATE, ZIP CODE

23951 Craftsman Road, Calabasas, CA 91302

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / 2 0 1 3
Month Day Year

To __ __ / __ __ / P r e s
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

JOB TITLE

Director of Family Planning

DESCRIPTION OF DUTIES PERFORMED

B. NAME OF PRACTICE / WORK LOCATION

Kaiser Permanente Panorama City Medical Center

ADDRESS STREET, CITY, STATE, ZIP CODE

13651 Willard Street, Panorama City, CA 91402

DATE OF EMPLOYMENT/ATTENDANCE

From 0 8 / __ __ / 2 0 1 1
Month Day Year

To __ __ / __ __ / P r e s
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

C. NAME OF PRACTICE / WORK LOCATION	JOB TITLE
Keck School of Medicine of the University of Southern California	***Voluntary Attending Physician / Obstetrics&Gynecology***
ADDRESS STREET, CITY, STATE, ZIP CODE ***1975 Zonal Avenue, Los Angeles, CA 90033***	DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYMENT/ATTENDANCE From ***0 2 / 0 4 / 2 0 0 5*** (Month Day Year) To ***0 7 / 0 1 / 2 0 1 4*** (Month Day Year) HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month) ***9 years 5 months***	

D. NAME OF PRACTICE / WORK LOCATION	JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
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 PRACTICE / WORK LOCATION	JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
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)	

F. NAME OF PRACTICE / WORK LOCATION	JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
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): *Nucatola, M.D., Deborah L.*

SS#: [redacted]

Profession: *Physician*

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.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(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.***

1. NAME	LAST	FIRST	MIDDLE
	Nucatola, M.D.	Deborah	Lynn

2. DATE OF BIRTH [redacted] (Month Day Year)

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.

Physician (Profession Name) — 0 3 6 (Profession Code)

6. MAIDEN OR GIVEN SURNAME

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)

8. ISSUANCE DATE

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed 48 months of postgraduate clinical training in OBGYN
(Name of Specialty Program)

from 06/24/1998 (MM/DD/YYYY) to 06/30/2002 (MM/DD/YYYY) at the following hospital:

Hospital: LAC + USC Medical Center

Number and Street: 1200 N. State Street

City, State and Zip Code: Los Angeles, CA 90033

I further certify that at the time of such training the program was accredited by:

- [x] the ACGME
- [ ] the AOA
- [ ] the CFPC, RCPSC or FMLAC (Canadian Programs)
- [ ] not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: Jenny Jaquis MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: Oct. 13th, 2015

University/Hospital SEAL

Telephone No: (323) 226-3423

(If no seal, attach letter on letterhead stating no seal exists.)

MEDICAL BOARD OF CALIFORNIA
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.

[redacted]

Curtis J. Worden
Chief of Licensing

Direct Inquiries to the
IDFPR Call Center

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:

DEBORAH L NUCATOLA MD
[redacted]

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.

RETURN INFORMATION WITH A COPY OF THIS NOTICE.

Direct Inquiries to the
IDFPR Call Center

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

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:

DEBORAH L NUCATOLA MD
[redacted]

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.

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

RETURN INFORMATION WITH A COPY OF THIS NOTICE.

Direct Inquiries to the
IDFPR Call Center

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

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:

DEBORAH L NUCATOLA MD
[redacted]

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. 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.

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.

RETURN INFORMATION WITH A COPY OF THIS NOTICE.

Direct Inquiries to the
IDFPR Call Center

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

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:

DEBORAH L NUCATOLA MD
[redacted]

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.. 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.

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.

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.

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.

RETURN INFORMATION WITH A COPY OF THIS NOTICE.

Direct Inquiries to the
IDFPR Call Center

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: 12/11/2015

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:

DEBORAH L NUCATOLA MD
[redacted]

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. 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.

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.

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

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.

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.

RETURN INFORMATION WITH A COPY OF THIS NOTICE.