3 0 0 0 0 0 5 4 1 J

PAGE ONE

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

0 0 9 5 7 0 0 0 2 2

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.

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

A. Type or print legibly with black ink only.

B. The licensure and application fee are NOT refundable.

C. Disclosure of Social Security number is not mandatory. It is used only to ensure identification, accuracy and to expedite processing of your application.

D. 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 Category Information

A. SEE REFERENCE SHEET, CHART I, PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician	0 3 6	Endorsement	$ 300.00

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

PART II: Applicant Identifying Information

You must notify the Department of Professional Regulation and/or Continental Testing Services of any address or name change after you file this application or any changes to the above information.

1. NAME LAST / FIRST / MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. SOCIAL SECURITY NUMBER
Fernandez Louis M	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

NONE

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE D ABOVE)

NONE

7. PLACE OF BIRTH CITY STATE/COUNTRY	8. DATE OF BIRTH (Month Day Year)	9. AGE
[redacted]	[redacted]	31

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (310) 422-3561 (Area Code) Home [redacted] (Area Code)

IL486-1019 9/93 (LT)

PAGE TWO

PART II: 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? [X] 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
Wheeling H.S.	Wheeling Il.	0 6 / 8 1 (Month / Year)

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 (8)

Graduated? [X] Yes [ ] No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	TO Month/Year	TYPE OF DEGREE EARNED
Northwestern University	Evanston, Il.	09/81	06/85	B.S.
University of Illinois	Chicago, Il.	09/85	06/89	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	TO Month/Year	Did You Complete Training?
Harbor - UCLA Medical Center	Torrance, Ca	07/89	06/94	[X] Yes [ ] No
				[ ] 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 and Surgeon	G 71660	06/25/91	Active
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
National Board I	Il.	06/87	[redacted]
National Board II	Il.	06/88	[redacted]
National Board III	Ca.	03/90	[redacted]

(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 statement for each conviction including date and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.*		✓
2. 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.*		✓
3. 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.*		✓
4. 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.*		✓
5. Are you a U.S. citizen OR a lawfully admitted alien of the United States?	[redacted]	

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. TEST CODES: [ ] [ ] [ ] [ ] [ ] [ ]

b) CHART III - Select the examination site you desire and enter Test Center Code. TEST CENTER CODE: [ ]

c) CHART IV - Find your School of Graduation and enter school code. SCHOOL CODE: [ ]

d) Record the number of times you have taken this exam in Illinois or any other state. EXAM ATTEMPTS: [ ]

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

DEPT OF PROF. REG. FOR DEPOSIT
PAY CONTINENTAL BK-CHICAGO
MAY 5 '94

PART VIII — 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]
Signature of Applicant

4/1/94
Date

My signature above authorizes the Department of 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.

PRINTED BY THE AUTHORITY OF
THE STATE OF ILLINOIS
[illegible]/REQ. X29073
PRINTED ON RECYCLED PAPER

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

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
Fernandez Louis Manuel

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; 036 — Profession Code

6. MAIDEN OR GIVEN SURNAME
-0-

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:
Illinois Department of Professional Regulation, 320 West Washington - HSS1, Springfield, Illinois 62786

NOTE: ***Certification of postgraduate clinical training will not be accepted if certified more than 15 days prior to date of actual completion.***

This is to certify that the above-named applicant has/will have satisfactorily completed 48 months of postgraduate clinical training in Harbor-UCLA Obstetrics & Gynecology
(Name of Accredited Postgraduate Clinical Training Program)

from 6/24/90 to 6/30/94 at the following hospital:

Hospital: Harbor-UCLA Medical Center
Number and Street: 1000 West Carson Street
City, State and Zip Code: TorrANCE, CA 90509

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

- [x] the Accreditation Council for Graduate Medical Education;
- [ ] the Accreditation Council on Canadian Graduate Medical Education; or
- [ ] the American Osteopathic Association.

Name of Postgraduate Clinical Training Program Director: Charles R. Brinkman, III, M.D.

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 6/15/94

SEAL

Telephone No: 310-222-3561

IL486-1535 8/93 (MD)

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WORK HISTORY

8 9 5 7 0 8 0 0 7 2

SUPPORTING DOCUMENT

WH

APPLICANT: Complete Work History, typewritten or in black ink. You may not photocopy... You are authorized to photocopy this form if additional space is required.

1. NAME LAST FIRST MIDDLE: Fernandez Louis Manuel
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.
   Profession Name: Physician Profession Code: 036
6. MAIDEN OR GIVEN SURNAME:
7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐
8. DATE FORM COMPLETED: 4/1/94

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: Harbor-UCLA Medical Center

JOB TITLE: Residency in OB-Gyn

ADDRESS STREET, CITY, STATE, ZIP CODE: 1000 W. Carson St. Torrance Ca 90509

DESCRIPTION OF DUTIES PERFORMED: Training in OB-Gyn 4yr

SUPERVISOR NAME: Charles Brinkman III M.D.

DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/90 (Month Day Year) To 06/30/94 (Month Day Year)

HOURS WORKED PER WEEK: >40

TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Yr./Mo.): 4yrs/0months

B. NAME OF BUSINESS/INSTITUTION: Harbor-UCLA Medical Center

JOB TITLE: Internship Psychiatry

ADDRESS STREET, CITY, STATE, ZIP CODE: 1000 W. Carson St. Torrance Ca 90509

DESCRIPTION OF DUTIES PERFORMED: 1st yr Training

SUPERVISOR NAME: Ira Lesser M.D.

DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/89 (Month Day Year) To 06/30/90 (Month Day Year)

HOURS WORKED PER WEEK: 40

TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Yr./Mo.): 1yr/0months

COMPLETE THE REVERSE SIDE OF THIS FORM

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 (Yr./Mo.)		

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 (Yr./Mo.)		

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 (Yr./Mo.)		MH

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CA 95825-3236

(916) 263-2653

0 0 9 5 7 0 3 0 0 7 2

May 10, 1994

Illinois Medical Examiners
320 W. Washington Street
Springfield, IL 62786

TO WHOM IT MAY CONCERN:

This is to verify that Dr. Louis Manuel Fernandez, born on 1/4/63, was issued California physician and surgeon's certificate #G 71660, on 6/25/91, based on National Board Credentials. The license is current and renewal fees are paid through 1/31/95. There is no current record of accusation and/or disciplinary activity.

Sandy Fugett
Division of Licensing

To expedite the verification process, the above is the standard format used by the Medical Board of California.

SEAL

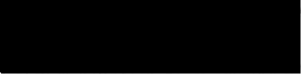
Profession: 036

Date: 6-17-94 Initials: LL

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

Louis M. Fernandez MD

 0 9 6 7 0 3 0 0

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

Mark	Item
	1. Submit the required fee of $________ made payable to the Department of Professional Regulation. This fee is not refundable.
	2. Your application is being returned for completion of Part ________.
	3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: ________ to ________.
	4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).
	5. Submit proof that you are a lawfully admitted alien.
	6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.
	7. When your application is complete, the Medical Licensing Board will review your qualifications.
	8. Your application will be reviewed by the Medical Licensing Board on ________
	9. Submit completed CA-MED form which indicates beginning and ending program dates.
	10. Submit CA-LTD form.
	11. Submit ED-MED form (certification of education).
	12. Submit ED-NON form completed in its entirety.
	13. Affidavits, (ED-AFF forms) must be completed in accordance with DPR policy. Copy of policy attached.
	14. Verification of Pass/Fail Exam History—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.
	15. Submit official premedical/medical transcript with school seal affixed.
XX	16. Submit photocopy of your degree.
	17. Submit proof of Titulo or Acta.
	18. Submit proof of Social Service or Fifth pathway.
	19. Submit proof of E.C.F.M.G. certification.
	20. Submit copy of evaluation form for each of the following core rotations: 1. ________ 2. ________ 3. ________ 4. ________ 5. ________
	21. Complete AF-MED form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s). 1. ________ 2. ________ 3. ________ 4. ________ 5. ________
	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
	25. Submit a list of your work experience from ________ to ________. You must account for entire time period since graduation from medical school (Supporting Document WH).
	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
	28. Have your ________ scores forwarded directly from ________.
	29. Submit evidence of remedial training.
X	30. Submit TN-MED form signed by program director, with seal of hospital.
	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on official stationary must be attached verifying no seal exists.)
	32. Sign form(s) where indicated.
	33. Submit certification of original/current licensure (Supporting Document CT) from ________.
	34. Submit proof that you are Board-certified in a specialty.
	35. Submit restoration questionnaire (Supporting Document RS).
	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
	37. Returning original documents.

Other instructions: