RECEIVED
CASH SECTION
DEC 08 2016
IDFPR
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

- [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.

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.
Ralph	Jessika	Ann	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: 9200 W. Wisconsin Ave, Milwaukee, WI USA 53226 Milwaukee

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE): Jessika Ann Hopson

7. MOTHER'S MAIDEN NAME: [redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY: [redacted]

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

10. AGE: 29 [X] Female [ ] Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: (414) 805-3000 (Area Code)
Home: [redacted] (Area Code)
Fax: (___) ___-____ (Area Code)
Fax: (___) ___-____ (Area Code)

12. **REQUIRED** E-MAIL ADDRESS: [redacted]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI): Ralph, Jessika A

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? [X] Yes [ ] No Received OR G.E.D.? [ ] Yes [X] No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
Tempe Preparatory Academy	Tempe, AZ	05/2005 (Month/Year)

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

1 2 3 (4 JR) 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)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
University of Chicago	Chicago, IL	09/2005	06/2009	B.A.
Northwestern University The Feinberg School of Medicine	Chicago, IL	08/2009	05/2013	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?
Medical College of Wisconsin Affiliated Hospitals	Milwaukee, WI	07/2013	present	[ ] Yes [X] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No

NAME (Last, First, MI): Ralph, Jessika A

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 Wisconsin	Medicine and Surgery	63093 - 20	10/09/2014	Active
State of Current Licensure where you most recently have been practicing. Wisconsin	Medicine and Surgery	63093 - 20	10/09/2014	Active
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	06/2011	(Passed, Failed, Absent) [redacted]
USMLE Step 2 CK	IL	12/2012	
USMLE Step 2 CS	IL	11/2012	
USMLE Step 3	WI	08/2014	

(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 personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*		X
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		X
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.*		X
4. Do you 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.*		X
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.*		X
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.*		X

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? *(NOTE: If you are not subject to a child support order, answer "no.")* Yes ☐ 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] 11/28/16

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): Ralph, Jessika A

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
Ralph	Jessika	A	[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.		X
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.*		X
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.*		X
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.		X
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.*		X
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.*		X
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.*		X

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] 11/28/16

Signature of Applicant — Date

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

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE
Ralph Jessika Ann

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

11/28/16
Date

IMPORTANT NOTICE Completion of this form is necessary for consideration for licensure under 225 ILCS 65/1 et seq of (Illinois Compiled Statutes) Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed

CERTIFYING STATEMENT OF FINGERPRINT SUBMISSION

SUPPORTING DOCUMENT

FP-MED

APPLICANT: *This form must be completed by out-of-state residents unable to utilize the livescan process for fingerprinting in the State of Illinois. Attach this certifying statement with the four-page Application for Licensure and/or Examination as proof of having submitted the required fingerprint cards to the proper authorities.*

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
Ralph	Jessika	Ann	[redacted]	[redacted]

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

6. MAIDEN OR GIVEN SURNAME
Hopson

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

- ☒ Physician 036
- ☐ Chiropractic Physician 038

CERTIFYING STATEMENT

Under penalties of perjury, I declare that I, Jessika Ralph, have submitted the required fingerprints pursuant to Section 60-9.7 of the Medical Practice Act of 1988 (225 ILCS 60) and the Rules for the Administration of the Act (68 Ill. Adm. Code 1285) to the designated agent of the Illinois State Police for processing.

Date: [redacted] Signature: 1/24/17

IMPORTANT NOTICE: Completion of this form is necessary for licensure/employment under provision set forth within the Illinois Compiled Statutes or other related Federal laws. Disclosure of this information is VOLUNTARY. However, failure to comply may result in the denial of your application.

IDENTITY VERIFICATION CERTIFYING STATEMENT

OOS-FP

Pursuant to Title 68 Part 1240.535 of the Private Detective, Private Alarm, Private Security, Fingerprint Vendor, and Locksmith Act of 2004 Rules, fingerprint vendors are required to confirm identity of the individual seeking to be fingerprinted. This identity verification form must be completed for out-of-state residents applying for licensure/employment in the State of Illinois. This form will be utilized to confirm the personal identifying information being placed on the Illinois State Police (ISP) Fee Applicant fingerprint card, form number ISP-404. The out-of-state agency chosen to take your fingerprints, must complete this form, as written confirmation that a valid government issued drivers license or State ID was presented and that the identification provided, belongs to the individual being fingerprinted.

Instructions: This form must be submitted, along with a manual Fee Applicant fingerprint card to which your fingerprints have been applied, to a licensed live scan fingerprint vendor in the State of Illinois possessing "Scan Card" capability to ensure electronic transmission of the Fee Applicant fingerprint card. The electronic transmission of fingerprints to the ISP is mandated pursuant to Title 20 Part 1265 "Electronic Transmission of Fingerprints". **The manual submission of fingerprints to ISP is no longer acceptable.** Once your fingerprints have been taken, a signed original of this form must be attached to your Fee Applicant fingerprint card and submitted to an Illinois licensed live scan fingerprint vendor. As well, an additional copy may be required to be submitted to the requesting State Agency along with any additional application or required documentation specified by the State Agency.

Section 1 Applicant Information (All fields mandatory)

LAST NAME:	FIRST:	MIDDLE:	PHONE NUMBER:
Ralph	Jessika	Ann	[redacted]

MAIDEN NAME/GIVEN SURNAME:	POSITION / REASON FINGERPRINTED: (NURSE/DOCTOR/SECURITY GUARD, ETC)
Hopson	Doctor

ADDRESS: (STREET/CITY/STATE/ZIP)	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
[redacted]	[redacted]	[redacted]

Section 2 Certifying Agency Taking Fingerprints (Include TCN from Fee Applicant card)

AGENCY NAME:	TCN: FRM
MC30	[redacted]
DATE FINGERPRINT TAKEN: 01 / 24 / 17	CONTACT PHONE NUMBER: (414) 226-7098

PRINTING AGENT'S NAME: LAST Brumfield FIRST Daniel

☑ I have compared the government issued identification presented by the applicant and attest that to the best determination, I have fingerprinted the same individual. (Must be checked to certify)

PRINTING AGENT'S SIGNATURE: [redacted] 12

Illinois Live Scan Fingerprint Vendor Information

Section 3 Fingerprint Vendor Agency Name

LIVE SCAN FP AGENCY NAME:

REQUESTING STATE AGENCY:	REQUESTING STATE AGENCY ORI:
RECEIVED	
DATE FINGERPRINTS SUBMITTED TO ISP: FEB 03 2017	COST CENTER USED:

IDFPR - MEDICAL UNIT

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

AUTHORIZATION FOR THIRD PARTY CONTACT

Instructions to Applicant: Use this form to authorize individuals or companies (such as employers or credential services) to contact the Department on your behalf regarding your application.

Name: Jessika Ralph	Phone: [redacted]
Address: [redacted]	SSN: [redacted]
Profession: Physician	Email: [redacted]

I, [redacted], hereby authorize the following person/business to communicate with the Division regarding my application for initial licensure. I understand that information received from the person or business listed below shall be binding and that I will be responsible for the accuracy of all information and documents received as part of my application for initial licensure. This authorization shall expire upon issuance of the license, referral to enforcement or expiration of the application.

Name of authorized representative:	Caroline Haldin
Address:	240 E. Huron St. Suite 1-203, Chicago, IL 60611
Phone:	312-503-4748
Email:	c-haldin@northwestern.edu

[redacted]
Applicant Signature

1/24/2017
Date

Completed forms may be sent to the Division at:

fpr.medicalunit@illinois.gov

IL486-2272 5/16

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

Ralph Jessika Ann

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

Hopson

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

Medical College of Wisconsin Affiliated Hospitals

ADDRESS STREET, CITY, STATE, ZIP CODE

9200 W. Wisconsin Ave., Milwaukee, WI 53202

DATE OF EMPLOYMENT/ATTENDANCE

From 07 / 01 / 2013 (Month / Day / Year)

To 06 / 30 / 2017 (Month / Day / Year)

HOURS WORKED PER WEEK

80

TYPE OF EMPLOYMENT

☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

04 / 00

JOB TITLE

Resident Physician

DESCRIPTION OF DUTIES PERFORMED

~~por~~ provision of health care related to women's reproductive health; provision of health care before, during, and after pregnancy; examine patients, order diagnostic tests, diagnose; provide medication and treatment, including surgery; deliver babies.

B. NAME OF PRACTICE / WORK LOCATION

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

RECEIVED
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FEB 02 2017

IDFPR
Division of Professional Regulation

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	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
Ralph	Jessika	Ann	[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.
Physician (Profession Name) — 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME
Hopson

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 24 months of postgraduate clinical training in Obstetrics & Gynecology (Name of Specialty/Program)

from 7/1/2013 (MM/DD/YYYY) to 1/25/2017 (MM/DD/YYYY) at the following hospital:

Hospital: Medical College of Wisconsin

Number and Street: 9200 W. Wisconsin Ave.

City, State and Zip Code: Milwaukee, WI 53226

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: Paul Lepsen, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 1/25/2017

University/Hospital SEAL

Telephone No: 414-805-6613

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

RECEIVED
FEB 03 2017

IL486-1535 10/06 (MD)

IDFPR - MEDICAL UNIT

MEDICAL COLLEGE OF WISCONSIN

Department of
Obstetrics and Gynecology

January 25, 2017

To whom it may concern:

No seal exists for our program.

Sincerely,

[redacted]

Kelly Morey
Ob/GYN Residency Assistant
Medical College of Wisconsin
Phone# 414-805-6613

Department of Obstetrics and Gynecology
8701 Watertown Plank Road
Milwaukee, Wisconsin 53226
(414) 805-6600
FAX (414) 805-6622

100%

N
12/15

STATE OF WISCONSIN
Department of Safety and Professional Services
1400 E Washington Ave
Madison WI 53703-8935

Governor Scott Walker Secretary Dave Ross

Mail to:
PO Box 8935
Madison WI 53703-8935

Email: dsps@wisconsin.gov
Web: http://dsps.wi.gov
Phone: 608-266-2112

CERTIFICATION

DATE: 12/20/2016

I, Michael J. Berndt, do hereby certify that I am the Record Custodian in the Department of Safety and Professional Services, a department of the government of the State of Wisconsin; that I am the custodian of the records relating to Medicine and Surgery and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	RALPH, JESSIKA A
CREDENTIAL TYPE:	MEDICINE AND SURGERY, MD
WAS ISSUED LICENSE NO:	63093-20
ISSUE DATE:	10/09/2014
EXPIRATION DATE:	10/31/2017

Credential Holder History

Date	Code	Description
NO DATE	EXAM	USMLE Passed
05/23/2013	GRADUATED FROM	Graduated from NORTHWESTERN UNIVERSITY MEDICAL SCHOOL

According to our records, this credential holder has not been disciplined.

The information above is the only certification information provided by this Department. To expedite the certification process, the above format is the standard format for all professions regulated by this Department.

[redacted]

Michael J. Berndt
Record Custodian
Department of Safety and Professional Services

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