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	Acceptance of Examination	$ 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 applying 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
DEC 25 2007
IDFPR

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.
Smid, Marcela	MD	[redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: 5841 S. Maryland Ave., MC 1052, Chicago, IL 60637-1470

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME

8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH Month Day Year	10. AGE	
[redacted]	[redacted]	[redacted]	Female / Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (773-) 702-6760 (Area Code)

Home: ([redacted]) (Area Code)

Fax: (773) 702-0861 (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): Marcela Smid

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
Eleanor Roosevelt High School	Greenbelt, MD	05 / 1999 (Month / Year)

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

1 2 3 4 5 6 7 (8)

Graduated? ☑ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
Case Western Reserve	Cleveland OH	8/1999	5/2003	BA/MA
Univ of California Berkeley	Berkeley CA	6/2003	4/2006	MS
Univ of California SF	San Francisco CA	6/2003	5/2009	MD

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
Univ of Chicago	Chicago IL	6/2009	11/2012	☐ Yes ☑ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Marcela Smid

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 Illinois	Physician Temporary	125 056220	6/24/2009	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
Step 1	CA	3/2012	(Pas[redacted]sent)
Step 2 CS	CA	2/2009	
Step 2 CK	CA	6/2007	
Step 3		4/2006	

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

NAME (Last, First, MI): Smid, Marcela

SS#: [redacted]

Profession: Physician

PART VI: Personal History Information *(This part must be completed by all applicants)*

	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*	☐	☑
2. Have you been convicted of a felony?	☐	☑
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*	☐	☑
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*	☐	☑
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*	☐	☑
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*	☐	☑

PART VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes. ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐

b) CHART III - Select the examination site you desire and enter Test Center Code: ☐☐☐☐

c) CHART IV - Find your School of Graduation and enter school code: ☐☐☐☐☐☐

d) Record the number of times you have taken this exam in Illinois or any other state: ☐☐

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? *(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] 11/12/12

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.

3-4

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	3. PROFESSIONAL LICENSE NUMBER (if any)
SAID MARCELA	___ - _____
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.**

- ☐ Advanced Practice Nurses
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Occupational Therapists
- ☐ Optometrists
- ☐ Pharmacists
- ☐ Podiatrists
- ☐ Physical Therapists
- ☐ Physician Assistants
- ☒ Physicians (036)
- ☐ Registered Nurses
- ☐ Speech Pathologists

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? *	☐	☒

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] 2/25/13

Signature of Applicant Date

PLEASE RETURN THIS NOTICE WITH YOUR PERMANENT LICENSE APPLICATION

Illinois Department of Financial and Professional Regulation
Attn: Division of Professional Regulation
320 West Washington, Med-1
Springfield, Illinois 62786

Re: Permission to Check Status of License Application

To Whom It May Concern:

I give my permission for the Office of Graduate Medical Education, University of Chicago Medical Center to inquire as to the status of my Illinois Permanent Licensure Application.

Resident Name: Marcela Smid
Please Print

Soc. Sec. #: [redacted]

Signature: [redacted]

11/12/12
Date

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VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

Smid, Marcela

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

5. SOCIAL SECURITY NUMBER

[redacted]

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☑ Permanent Physician License	036
☐ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION

Univ of Chicago Medical Center

JOB TITLE

Resident Physician

ADDRESS STREET, CITY, STATE, ZIP CODE

5841 S Maryland Ave MC 2050 Chicago IL 60637

DESCRIPTION OF DUTIES PERFORMED

Inpatient and outpatient OB/GYN care

DATE OF EMPLOYMENT/ATTENDANCE

From 06 / 24 / 2009
Month Day Year

To 12 / 12 / 2012
Month Day Year

HOURS WORKED PER WEEK

80

TYPE OF EMPLOYMENT

☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

3/5

B. NAME OF BUSINESS / INSTITUTION

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)

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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: Smid, Marcela
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): 125056220
8. ISSUANCE DATE: 6/24/2009

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 41 months of postgraduate clinical training in Obstetrics and Gynecology (Name of Specialty Program)

from 06/24/2009 (MM/DD/YYYY) to 12/17/2012 (MM/DD/YYYY) at the following hospital:

Hospital: University of Chicago

Number and Street: 5841 S. Maryland Ave., MC 2050

City, State and Zip Code: Chicago, IL 60637

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: Anita Blanchard

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 12/17/2012

Telephone No: 773-834-0598

University/Hospital SEAL

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

Direct Inquiries to the IDFPR Call Center

Telephone No.: 1-800-560-6420

Attn:

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 4/18/2013

Initials: AR

License No: 036.132507

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:

MARCELA SMID MD
UNIV OF CHICAGO MEDICAL CENTER
DEPT OF GME ROOM J 141
5841 S MARYLAND AVE MC 1052
CHICAGO, IL 60637-1470

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

The Department acknowledges receipt of a faxed copy of your Health Care Workers Charged With or Convicted of Criminal Acts (CCA) form. You must also submit the original with original signature.

ORIGINAL WAS MAILED 2/28/2013.

THANK YOU,
SHERRI

RECEIVED
APR 23 2013
IDFPR - MEDICAL UNIT

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.

Direct Inquiries to the
IDFPR Call Center

Telephone No.: 1-800-560-6420

Attn:

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
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TO:

MARCELA SMID MD
UNIV OF CHICAGO MEDICAL CENTER
DEPT OF GME ROOM J 141
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CHICAGO, IL 60637-1470

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