0073091.00018 (40/40)

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.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

AUG 21 2003

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	036	EXAMINATION	CTS $ 70.10 FSMB $590.00 Total $660.10

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.
- ☐ 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.
- ☒ Other: PERM LICN APPL

AUG 27 2003 75.10

PART II: Applicant Identifying Information - You must notify the Department 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. MD, DDS, etc.)	3. UNITED STATES SOCIAL SECURITY NO.
BRADSHAW	JOI	FERUL	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

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 [redacted]

9. DATE OF BIRTH [redacted] Month Day Year

10. AGE [redacted] ☒ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: (312) 619-4772 (Area Code)
Home: [redacted]

12. PREFERRED e-MAIL ADDRESS(ES) [If available]
[redacted]

Additional application forms can be downloaded from the IDPR Web site at www.dpr.state.il.us

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
Morgan Park Academy	Chicago, Illinois	06/1992 (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
Spelman College	Atlanta, GA	08/1992	05/1996	B.S.

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?
University of Illinois	Chicago, Illinois	08/1996	12/2000	☒ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Additional application forms can be downloaded from the IDPR Web site at www.dpr.state.il.us.

0073091.00018 (40/40)

NAME (Last, First, MI) Bradshaw, Toi F. SSN [redacted] 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	125043140	6/17/01	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
USMLE Step 1	Illinois	06/1998	[redacted]
USMLE Step 1	Illinois	06/1999	
USMLE Step 2	Illinois	01/2000	

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

NAME (Last, First, M.I.): Bradshaw, Jon F.

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.*		X
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.*		X
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.*		X
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.*		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

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

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]
Signature of Applicant

8/13/03
Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. 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

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

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RECEIVED
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IMPORTANT NOTICE. Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled 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

(CTS)

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
CRADSHAW	JOE	FERDL	[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:

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable): 125043144

8. ISSUANCE DATE: 6/17/2001

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Continental Testing Services, Inc., P.O. Box 100, LaGrange, Illinois 60525-0100

This is to certify that the above-named applicant satisfactorily completed 25 months of postgraduate clinical training in Obstetrics and Gynecology
(Name of Accredited Postgraduate Clinical Training Program)

from 6/17/01 to 8/11/03 at the following hospital:

Hospital: University of Illinois Chicago

Number and Street: 820 S. Wood St. M/C 808

City, State and Zip Code: Chicago, IL. 60612

I further certify that at the time of such training 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: [redacted]

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 8-11-03

SEAL

Telephone No: [redacted]

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WORK HISTORY

SUPPORTING DOCUMENT

WH

APPLICANT: Complete Work History. If you have never been employed you may stop at box 8. You are authorized to photocopy this form if additional space is required.

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
BRADSHAW	JOI	FEROL	[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:

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☐

8. DATE FORM COMPLETED: 8/6/03

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:

ADDRESS STREET, CITY, STATE, ZIP CODE:

SUPERVISOR NAME:

JOB TITLE: Independent Study

DESCRIPTION OF DUTIES PERFORMED: Independent study in preparation for starting residency

DATE OF EMPLOYMENT/ATTENDANCE: From 12/10/2000 (Month Day Year) To 06/17/2001 (Month Day Year)

HOURS WORKED PER WEEK: 30

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

TOTAL TIME WORKED (Year/Month):

B. NAME OF BUSINESS / INSTITUTION: University of Illinois @ Chicago

ADDRESS STREET, CITY, STATE, ZIP CODE:

SUPERVISOR NAME: Dr. Gloria Elam

JOB TITLE: Resident

DESCRIPTION OF DUTIES PERFORMED: Obstetrics + Gynecology resident. Clinical duties including calls

DATE OF EMPLOYMENT/ATTENDANCE: From 06/17/2001 (Month Day Year) To __/__/2005 (Month Day Year)

HOURS WORKED PER WEEK: 80

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

TOTAL TIME WORKED (Year/Month):

NAME (Last, First, MI): Bradshaw, Joi F.

SS#: [redacted]

Profession: Physician

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 (Year/Month)

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 (Year/Month)

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 (Year/Month)

Screener

APPLICATION TRANSMITTAL - Physician

(This transmittal must accompany the application.)

1. NAME LAST / FIRST / MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
BRADSHAW / JOI / FEROL	[redacted] Month Day Year	[redacted]
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO BOXES A-1 AND A-2 IN PART I ON YOUR APPLICATION FOR LICENSURE/EXAMINATION	
[redacted]	Physician (Profession Name) 0 3 6 (Profession Code)	

In the area below, indicate whether you have enclosed the 4-page application and the other items listed below or if you have requested an item to be forwarded directly to the Department by another entity (i.e. exam scores).

Enclosed	Requested	Description
X		4-page Application for Licensure and/or Examination
		Application Fee
X		Form WH (required for all applicants)
[redacted]		FCVS Physician Profile
	X	TN-MED Form
	X	ECFMG Certificate (Copy)
	X	Medical School Diploma (Copy)
	X	Proof of Pre-Medical and Medical Education (Official transcript of grades issued by medical college or university with school seal affixed) from: Spelman College - Univ. of Illinois
		AF-MED
		ED-NON
		5th Pathway/Social Service
[redacted]	X	Certification of Licensure (CT) from original and current state of licensure
	X	Exam Scores (Sent directly from USMLE, FLEX, National Board, LMCC or State Board)

The above items are those documents most frequently requested. In the area below, list any other documentation you are submitting with your application that may be required for licensure.

Remarks: ______________________________

IL486-1914 05/02 (MD)

State of Illinois - License Look-up Results

Fernando E. Grillo, Director

Illinois Department of Professional Regulation

Rod R. Blag

Start a New Search

Printer Fri

SEARCH FOR LICENSE BY LICENSE NUMBER

Profession is Medical License, Temporary

You requested license number: 125-043144

Licensee's Name	DBA / AKA	License Number	License Status	City, State	Program Name	Program Start Date	Issuance Date	Current Expira
JOI FEROL BRADSHAW MD		125043144	ACTIVE	CHICAGO, IL	Obstetrics & Gynecology	06/17/2001	06/17/2001	06/16/2004

Express Access License Look-Up has been approved for use as a primary sourc verification by the Joint Commission of Accreditation of Healthcare Organizations and the National Committee for Quality Assurance.

If the "Ever Disciplined" field contains a "Y," there has been disciplinary action against this license. Click on the "Y" to view details of the disciplinary action. If yo view comprehensive reports in Adobe Acrobat format for disciplines that occurre September 1996, click HERE. The Illinois Department of Professional Regulation pu monthly report detailing disciplinary action taken by the Department. Each Disci Report is a listing of all licensees disciplined by the Department within a given mo Information includes the name of the disciplined professional, the city where he/ practicing at the time of action, the discipline imposed and a brief description of th for the discipline. All Monthly Disciplinary Reports are accurate on the date of ins initial date of publication. However, disciplinary actions may be subject to furthe orders that may stay, affirm, reverse, remand or otherwise alter Department disc orders. Please note that discipline that has been stayed or reversed will not appe summary of discipline.

Click here for definitions of the different types of disciplinary actions the Departm impose.

Note: Access to some parts of this site require a minimum version of Internet Explorer 5.0 above, * Netscape Navigator 6 and above and IBM Homepage Reader 3.0 and above.

* (Certain applications may be viewed and all information is accessible using Netscape 4.7 due to the age of the browser and the lack of standards in place at the time of its develop it will not display/handle the pages as effectively as newer browsers.)