Electronic Renewal Record

Exit | Find Another

Field	Value
License Number	036102311
Pin	[redacted]
Phone	
Authorization	298821
SSN	[redacted]
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	4/29/2005
Renewal Fee	$300.00
Fee Type	R
Service Fee	
Memo	

Method | I | Credited:

User Responses

#	Response	Value	#	Response	Value
1	SSN		9		
2	1	N	10		
3	PH1	N	11		
4	PH2	N	12		
5	PH3	N	13		
6	PH4	N	14		
7	CS1	N	15		
8	CE1	Y			

Print Record | Next Record

Electronic Renewal Record

Exit | Find Another

Field	Value
License Number	036102311
Pin	[redacted]
Phone	[redacted]
Authorization	13209B
SSN	[redacted]
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	5/17/2008
Renewal Fee	$300.00
Fee Type	3
Service Fee	$5.00
Memo	

Method | I | Credited:

User Responses

#	Response	Value	#	Response	Value
1	SSN		9		
2	IA1	N	10		
3	PH1	N	11		
4	PH2	N	12		
5	PH3	N	13		
6	PH4	N	14		
7	CS1	N	15		
8	CE1	Y			

Print Record | Next Record

Electronic Renewal Record

Exit | Find Another

Field	Value
License Number	036102311
Pin	[redacted]
Phone	[redacted]
Authorization	08188A
SSN	[redacted]
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	4/14/2011
Renewal Fee	$300.00
Fee Type	R
Service Fee	$5.00
Memo	

Method: I

Credited:

User Responses

#	Item	Response	#	Item	Response
1	SSN		9	MD2	N
2	IA1	N	10	MD3	Y
3	PH1	N	11	CS1	N
4	PH2	N	12	CE1	Y
5	PH3	N	13		
6	PH4	N	14		
7	MD1	Y	15		
8	MD1A				

Print Record | Next Record

Electronic Renewal Record

Exit | Find Another

Field	Value
License Number	036102311
Pin	[redacted]
Phone	[redacted]
Authorization	177041
SSN	[redacted]
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	4/26/2014
Renewal Fee	$690.00
Fee Type	R
Service Fee	$10.00
Memo	

Method: I

Credited:

User Responses

#	Item	Response	#	Item	Response
1	SSN		9	PH5	N
2	IA1	N	10	PH6	N
3	CE1	Y	11	PH7	N
4	CS1	N	12	PH8	N
5	PH1	N	13		
6	PH2	N	14		
7	PH3	N	15		
8	PH4	N			

Print Record | Next Record

Electronic Renewal Record

Exit | Find Another

License Number	036102311
Pin	
Phone	
Authorization	74090P
SSN	
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	5/19/2017
Renewal Fee	$1,380.00
Fee Type	R
Service Fee	$0.00
Memo	

Method | Credited:

User Responses

#	Code	Response	#	Code	Response
1	SSN		9	PH5	N
2	IA1	N	10		
3	CE1	Y	11		
4	CS1	N	12		
5	PH1	N	13		
6	PH2	N	14		
7	PH3	N	15		
8	PH4	N			

Print Record | Next Record

Electronic Renewal Record

Exit | Find Another

License Number	036102311
Pin	
Phone	
Authorization	20553497
SSN	
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	5/15/2020
Renewal Fee	$543.00
Fee Type	R
Service Fee	$0.00
Memo	

Method | Credited:

User Responses

#	Code	Response	#	Code	Response
1	SSN		9	PH5	N
2	IA1	N	10		
3	CE1	Y	11		
4	CS1	N	12		
5	PH1	N	13		
6	PH2	N	14		
7	PH3	N	15		
8	PH4	N			

Print Record | Next Record

Electronic Renewal Record

Exit | Find Another

Field	Value
License Number	33[redacted]02
Pin	[redacted]
Phone	
Authorization	842382
SSN	[redacted]
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	4/29/2005
Renewal Fee	$15.00
Fee Type	R
Service Fee	
Memo	

Method | Credited:

User Responses

#	Response		#	Response	
1	SSN		9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8					

Print Record | Next Record

Electronic Renewal Record

Exit | Find Another

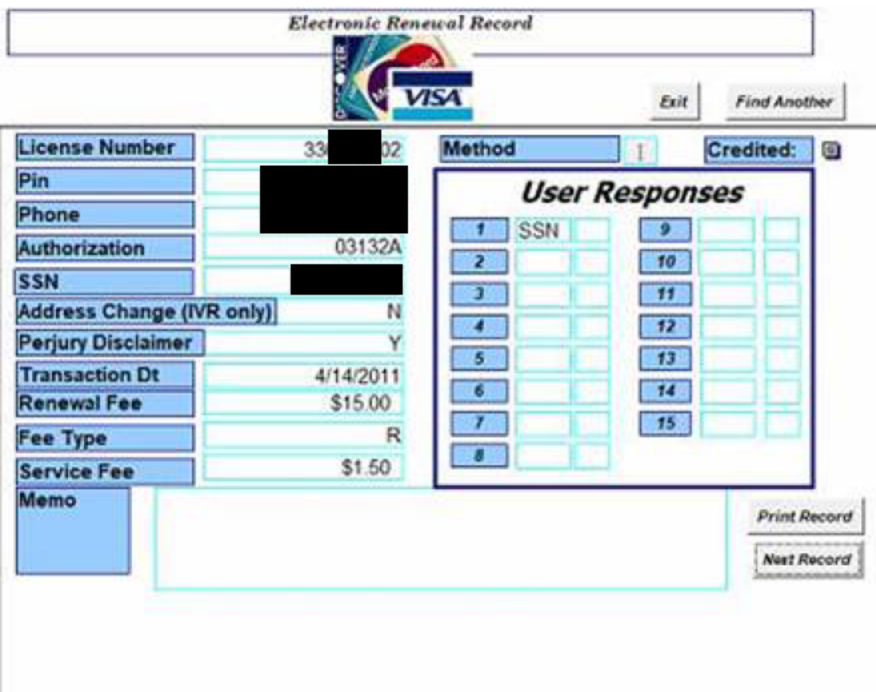
Field	Value
License Number	33[redacted]02
Pin	[redacted]
Phone	[redacted]
Authorization	694236
SSN	[redacted]
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	7/2/2008
Renewal Fee	$15.00
Fee Type	R
Service Fee	$1.50
Memo	

Method | Credited:

User Responses

#	Response		#	Response	
1	SSN		9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8					

Print Record | Next Record


Electronic Renewal Record

Exit | Find Another

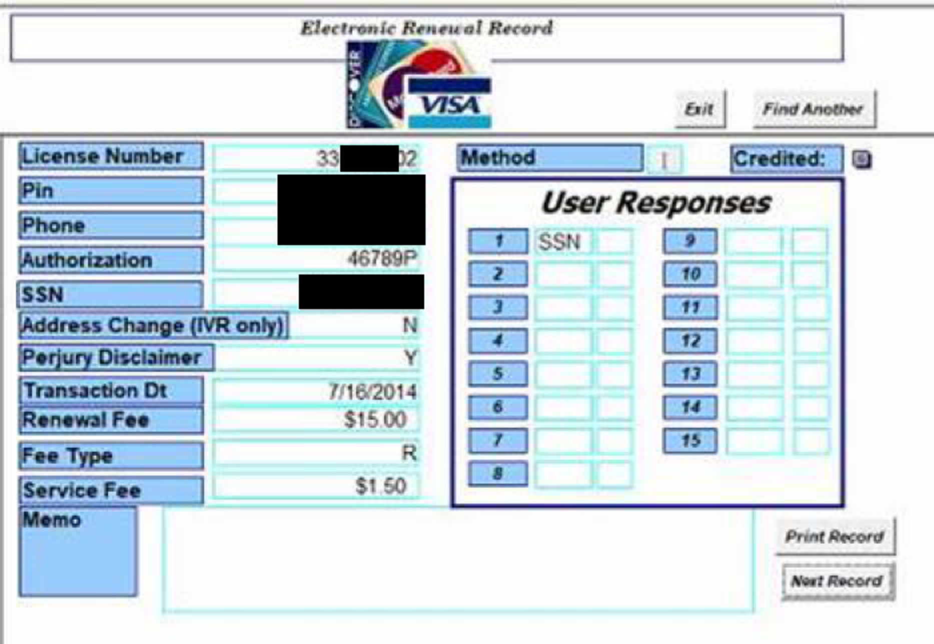
Field	Value
License Number	33[redacted]02
Pin	[redacted]
Phone	[redacted]
Authorization	03132A
SSN	[redacted]
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	4/14/2011
Renewal Fee	$15.00
Fee Type	R
Service Fee	$1.50
Memo	

Method | Credited:

User Responses

#	Response	#	Response
1	SSN	9	
2		10	
3		11	
4		12	
5		13	
6		14	
7		15	
8			

Print Record | Next Record


Electronic Renewal Record

Exit | Find Another

Field	Value
License Number	33[redacted]02
Pin	[redacted]
Phone	[redacted]
Authorization	46789P
SSN	[redacted]
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	7/16/2014
Renewal Fee	$15.00
Fee Type	R
Service Fee	$1.50
Memo	

Method | Credited:

User Responses

#	Response	#	Response
1	SSN	9	
2		10	
3		11	
4		12	
5		13	
6		14	
7		15	
8			

Print Record | Next Record

Electronic Renewal Record

Exit | Find Another

License Number	33[redacted]02
Pin	[redacted]
Phone	[redacted]
Authorization	51370P
SSN	[redacted]
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	5/19/2017
Renewal Fee	$15.00
Fee Type	R
Service Fee	$0.00
Memo	

Method: I | Credited:

User Responses

#	Response		#	Response	
1	SSN		9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8					

Print Record | Next Record

Electronic Renewal Record

Exit | Find Another

License Number	33[redacted]02
Pin	[redacted]
Phone	[redacted]
Authorization	20566774
SSN	[redacted]
Address Change (IVR only)	N
Perjury Disclaimer	Y
Transaction Dt	5/19/2020
Renewal Fee	$15.00
Fee Type	R
Service Fee	$0.00
Memo	

Method: I | Credited:

User Responses

#	Response		#	Response	
1	SSN		9		
2	CE1	Y	10		
3			11		
4			12		
5			13		
6			14		
7			15		
8					

Print Record | Next Record

DO NOT WRITE ON FILE FOLDER
IL486-1327 3/94 (LMU)

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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

RECEIVED MAR 9 2000 IDPR MEDICAL UNIT

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 your U.S. social security number, if you have one, is mandatory. This disclosure is mandated by Illinois Compiled Statutes 100/10-65. The social security number will be provided to the Department of Public Aid to assist in the identification of persons who are more than 30 days delinquent in complying with a child support order.
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.

RECEIVED STATE OF ILLINOIS MAR - 6 2000

PART I: Application Category Information

034040-96

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 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 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.
Reid III	Virgil	Cayton	MD	[redacted]

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

5. BUSINESS ADDRESS STREET / CITY STATE/COUNTRY / ZIP CODE / COUNTY: UNC Hospitals CB#7570 Chapel Hill, NC, USA 27599 Orange

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

7. PLACE OF BIRTH CITY STATE/COUNTRY: [redacted] 8. DATE OF BIRTH: [redacted] 9. AGE: [redacted]

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (919) 216-4712 (Area Code) Home: [redacted] (Area Code)

IL486-1019 7/98 (LT)

0011168.00

PAGE THREE

PART IV: Record of Licensure Information

1/20/2000

Signature of Applicant — 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.

IL486-1019 7/98 (LT)

PAGE TWO

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 — OR Received G.E.D.? [ ] Yes [ ] No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION (Month / Year)
Pinecrest High School	Southern Pines, NC, USA	06 / 88

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
University of North Carolina	Chapel Hill, NC	8/88	5/92	BA
Univ. of North Carolina School of Medicine	Chapel Hill, NC	8/92	5/96	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	TO Month/Year	Did You Complete Training?
University of North Carolina Hospitals	Chapel Hill, NC	7/96	Present: will finish 6/2000	[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No

IL486-1019 7/98 (LT)

PAY TO THE ORDER OF BANK ONE, IL
MAR 0 8 00
FOR DEPOSIT ONLY
IL STATE TREASURER
2370240728
071100269

(Area Code) Home:

IL486-1019 7/98 (LT)

0011168.00187

PAGE THREE

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 North Carolina	Physician	73309	July, 1996	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 I	NC	6/94	
USMLE Step II	NC	3/96	
USMLE Step III	NC	12/96	

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

IL486-1019 7/98 (LT)

0011168.0

3/8/00 ✓ 73309

IANT NOTICE Completion of this form is necessary for

SUPPORTING DOCUMENT

320 West Washington, L & T-1
Springfield, Illinois 62786

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 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.*		✓

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 Information *(This part must be completed by all applicants)*

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.**

You **MUST** check one of the following:

☐ I am not more than 30 days delinquent in complying with a child support order.

☐ I am more than 30 days delinquent in complying with a child support order.

☑ I am not currently under any child support order.

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] 1 | 20 | 2000

Signature of Applicant — 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.

IL486-1019 7/98 (LT)

PAY TO THE ORDER OF

PAGE TWO

PART III: Education Information

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

IL486-1019 7/98 (LT)

3/8/00

73309

[...]ANT NOTICE: Completion of this form is necessary for [con]sideration for licensure under 225 of the Illinois Compiled Statutes [C]hapter 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 BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: *Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.*

1. NAME LAST FIRST MIDDLE: Reid III Virgil Cayton
2. DATE OF BIRTH: [redacted]
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:
7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code [redacted]

8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED (If applicable): Physician

8b. LICENSE NUMBER (If applicable): 73309

8c. ISSUANCE DATE OF LICENSE (If applicable): 1/23/1999

I hereby authorize North Carolina Medical Board (Name of Licensing Agency or Board) to furnish to the Illinois Department of Professional Regulation or its designated testing service, the information requested below.

Signature [redacted] Date 1/20/00

DO NOT RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS

A. The applicant ☑ has written ☐ is scheduled to write the following examination: US MLE (Name of Examination) 12/3/96 (Date of Examination)

B. The applicant has or will have written the above-named examination 1 number of times.

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE: Physician

B. LICENSE NUMBER: Resident Training License to UNC Hospitals

C. ISSUANCE DATE OF LICENSE: 7/17/1996

D. EXPIRATION DATE OF LICENSE: 1/23/2001

E. LICENSURE METHOD
- ☑ Examination (Administered in Your State)
  - ☐ National (Name)
  - ☐ State Constructed
  - ☑ Other (Name) USMLE
- ☐ Endorsement of License (State)
- Acceptance of Examination Results (Administered in Another State)
- ☐ Reciprocity with (State)
- ☐ Waiver/Grandfather
- ☐ Credentials
- ☐ Other (Describe)

F. CURRENT LICENSURE STATUS
- ☑ Active
- ☐ Inactive
- ☐ Lapsed
- ☐ Other (Explain)

G. IF LICENSED BY EXAMINATION, RECORD SCORES
- Type of Examination / Score
- Written ✓ [redacted]
- Practical
- Other (Describe)
- Received no Grade Below
- Examination Period ____ days ____ hours

RECEIVED FEB 18 2000 DPR-MEDICAL UNIT

00 FEB 11 9:04

IL486-0850 10/96 (LT-Front)

COMPLETE THE REVERSE SIDE OF THIS FORM

THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

0011168.00187

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination
(Record all available information)

Date of Examination ____________

Scaled Score		Raw Score	
Standard Deviation		Corrected Score	
National Mean	N/A	Percent Score	

A2

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

A. Is there now or has there ever been any formal action commenced against the applicant? ☐ Yes ☑ No

B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? (**If yes, attach a certified copy of disciplinary action.**) ☐ Yes ☑ No

PART V - RECIPROCAL REGISTRATION

This state ☑ does ☐ does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

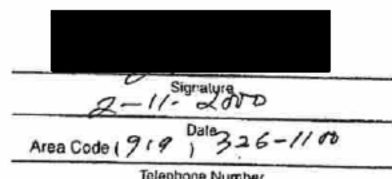
SEAL

Ann Z. Norris
Print Name

Verification Secretary
Title

North Carolina Medical Board
Agency/Board Street Address

Raleigh, NC 27619
City, State, ZIP Code



Signature

2-11-2000
Date

Area Code (919) 326-1100
Telephone Number

0850 10/96 (LT-Back)

RETURN TO: **Department of Professional Regulation**
320 West Washington, L & T-1
Springfield, Illinois 62786

PAGE FOUR

PART VI: Personal History Information (This ...

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IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statues (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

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: Reid III FIRST: Virgil MIDDLE: Cayton
2. DATE OF BIRTH: [redacted]
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: 0 3 6
6. MAIDEN OR GIVEN SURNAME:
7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐
8. DATE FORM COMPLETED: 1/20/2000

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:

JOB TITLE: Intern

ADDRESS — STREET, CITY, STATE, ZIP CODE: UNC Hospitals CB#7570 Chapel Hill, NC 27599

DESCRIPTION OF DUTIES PERFORMED: OB/Gyn intern duties

SUPERVISOR NAME: Jeffrey Kuller, MD

DATE OF EMPLOYMENT/ATTENDANCE — From 07,01,96 (Month Day Year) To 06,30,97 (Month Day Year)

HOURS WORKED PER WEEK: 70

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

TOTAL TIME WORKED (Year/Month): 1 year

B. NAME OF BUSINESS / INSTITUTION:

JOB TITLE: Resident

ADDRESS — STREET, CITY, STATE, ZIP CODE: UNC Hospitals CB#7570 Chapel Hill, NC 27599

DESCRIPTION OF DUTIES PERFORMED: OB/Gyn resident duties

anticipate completion 06/30/2000

SUPERVISOR NAME: Jeffrey Kuller, MD

DATE OF EMPLOYMENT/ATTENDANCE — From 07,01,97 (Month Day Year) To present (Month Day Year)

HOURS WORKED PER WEEK: 70

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

TOTAL TIME WORKED (Year/Month): 3 years at completion

IL486-1071 6/93 (LT-Front)

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 (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)

0011168.00187

3/8/00 ✓ 73309

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statues (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 BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE: Reid III Virgil Clayton
2. DATE OF BIRTH: [redacted]
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:
7. APPLICANT TELEPHONE NUMBER (Daytime): Area Code ([redacted]

8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable): Physician

8b. LICENSE NUMBER (If applicable): 73309

8c. ISSUANCE DATE OF LICENSE (If applicable): 1/23/1999

I hereby authorize North Carolina Medical Board (Name of Licensing Agency or Board) to furnish to the Illinois Department of Professional Regulation or its designated testing service, the information requested below.

Signature [redacted] Date 1/20/00

DO NOT RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS

A. The applicant ☑ has written ☐ is scheduled to write the following examination: US MLE (Name of Examination) 12/3/96 (Date of Examination)

B. The applicant has or will have written the above-named examination 1 number of times.

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE: Physician

B. LICENSE NUMBER:

C. ISSUANCE DATE OF LICENSE:

D. EXPIRATION DATE OF LICENSE:

RECEIVED FEB 18 2000 MEDICAL UNIT

E. LICENSURE METHOD
- ☑ Examination (Administered in Your State)
  - ☐ National (Name)
  - ☐ State Constructed
  - ☑ Other (Name) USMLE
- ☐ Endorsement of License (State)
- Acceptance of Examination Results (Administered in Another State)
- ☐ Reciprocity with (State)
- ☐ Waiver/Grandfather
- ☐ Credentials
- ☐ Other (Describe)

F. CURRENT LICENSURE STATUS
- ☑ Active
- ☐ Inactive
- ☐ Lapsed
- ☐ Other (Explain)

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination — Score
- Written ✓ [redacted]
- Practical
- Other (Describe)

Received no Grade Below
Examination Period ____ days ____ hours

IL486-0850 10/96 (LT-Front)

COMPLETE THE REVERSE SIDE OF THIS FORM

0011168.00187

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

CERTIFICATION OF

SUPPORTING DOCUMENT

TN MED

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination
(Record all available information)

Date of Examination ____________

Scaled Score		Raw Score	
Standard Deviation		Corrected Score	
National Mean	N/A	Percent Score	

A 2.

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

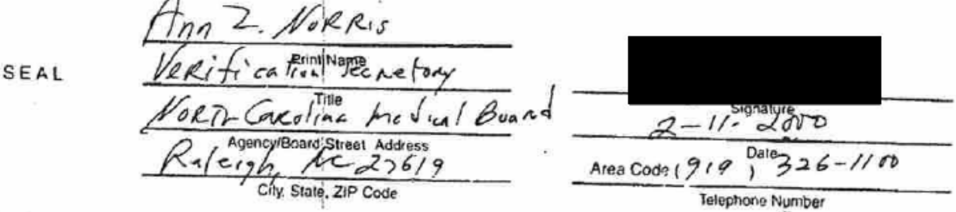
A. Is there now or has there ever been any formal action commenced against the applicant? ☐ Yes ☑ No

B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? **(If yes, attach a certified copy of disciplinary action.)** ☐ Yes ☑ No

PART V - RECIPROCAL REGISTRATION

This state ☑ does ☐ does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.



Ann Z. Norris
Print Name

SEAL

Verification Secretary
Title

North Carolina Medical Board
Agency/Board Street Address

Raleigh, NC 27619
City, State, ZIP Code

Signature

2-11-2000
Date

Area Code (919) 326-1100
Telephone Number

IL486-0850 10/96 (LT-Back)

RETURN TO: **Department of Professional Regulation**
320 West Washington, L & T
Springfield, Illinois 62786

COMPLETE THE REVERSE SIDE OF THIS FORM

0011168.00187

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
Reid III Virgil Cayton

2. DATE OF BIRTH [redacted]

4. [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. [redacted]

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 - MED-1, Springfield, Illinois 62786

This is to certify that the above-named applicant satisfactorily completed 48 months of postgraduate clinical training in Obstetrics and Gynocology
(Name of Accredited Postgraduate Clinical Training Program)

from July 1996 to June 2000 at the following hospital:

Hospital: University of North Carolina Hospitals

Number and Street: 101 Manning Drive

City, State and Zip Code: Chapel Hill, NC 27599

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: Jeffrey Kuller, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 2-12-00

SEAL

Telephone No: 919-966-1601

IL486-1535 4/95 (MD)

0011168.00187

Profession: 36
Date: 3/27/00 Initials: [illegible]

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:
NC Medical Board
Verifications
PO Box 20007
Raleigh NC 27619

Return this form with the requested materials to:
State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

RECEIVED APR 1 2000 IDPR-MEDICAL UNIT

Re: Virgil [illegible] III

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

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 afixed.
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. ________ 4. ________
    2. ________ 5. ________
    3. ________

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

30. Submit TR-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 offical 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:
Complete highlighted areas & return
I apologize for the [illegible]. [illegible] 3-31-2000

IL486-1568 5/94 (LT)

0011168.00187

Profession: 36
Date: 3/27/00 Initials: [illegible]

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

Return this form with the requested materials to:
State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1

IL486-1588 5/94 (LT)

0011168.00187

Profession: 36
Date: 3/27/00 Initials: [illegible]

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

Return this form with the requested materials to:
State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

1. Submit the required fee of $________ made payable to the Department of Professional Regulation. This fee is not refundable.	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. ____
2. Your application is being returned for completion of Part ________.	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: ________ to ________.	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.
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).	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**).
5. Submit proof that you are a lawfully admitted alien.	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
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.	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
7. When your application is complete, the Medical Licensing Board will review your qualifications.	28. Have your ________ scores forwarded directly from ________
8. Your application will be reviewed by the Medical Licensing Board on ________.	29. Submit evidence of remedial training.
9. Submit completed **CA-MED** form which indicates beginning and ending program dates.	30. Submit **TN-MED** form signed by program director, with seal of hospital.
10. Submit **CA-LTD** form.	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on offical stationary must be attached verifying no seal exists.)
11. Submit **ED-MED** form (certification of education).	32. Sign form(s) where indicated.
12. Submit **ED-NON** form completed in its entirety.	X 33. Submit certification of original/current licensure (Supporting Document **CT**) from NC
13. Affidavits, (**ED-AFF** forms) must be completed in accordance with DPR policy. Copy of policy attached.	34. Submit proof that you are Board-certified in a specialty.
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.	35. Submit restoration questionnaire (Supporting Document **RS**).
15. Submit official premedical/medical transcript with school seal affixed.	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
16. Submit photocopy of your degree.	37. Returning original documents
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. ____	

Other Instructions:
RETURNED TO BOARD FOR CORRECTIONS

IL486-1588 5/94 (LT)

0011168.0

Profession 36
Date 3/27/00 Initials: [illegible]

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN ...

0011168.00187

Profession: 76
Date: 3/27/00 Initials: [illegible]

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:
NC Medical Board
Verifications
PO Box 20007
Raleigh NC 27619

Return this form with the requested materials to:
State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

Re: Virgil Reid III

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 afixed.
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. ________ 4. ________
    2. ________ 5. ________
    3. ________
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.
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 offical 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: Complete highlighted areas & return

IL486-1588 5/94 (LT)

(DO NOT USE THIS APPLICATION FOR RENEWAL OF AN EXISTING LICENSE)

IMPORTANT NOTICE: Completion of this form is required by 720 of the Illinois Compiled Statutes (Chap. 56 1/2, of the Ill. Rev. Stat. 1985). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application. This form has been approved by the Forms Management Center.

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

DO NOT SUBMIT APPLICATION UNTIL A PERMANENT PRACTITIONERS LICENSE HAS BEEN ISSUED! CONTROLLED SUBSTANCES LICENSE WILL NOT BE ISSUED TO A TEMPORARY LICENSE HOLDER!

1. Every person who prescribes or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Professional Regulation in accordance with the Illinois Controlled Substances Act.
2. A separate controlled substances registration is required for each place of professional practice or business where controlled substances are stored or located.
3. A State Controlled Substances Registration is prerequisite to a Federal Controlled Substances Registration.

A. Type or print legibly with black ink only.
B. The fee is $5 - Make check payable to the Department of Professional Regulation. THIS FEE IS NOT REFUNDABLE! (Separate application/fee is required for each registration.)
C. Disclosure of your U.S. social security number, if you have one, is mandatory. This disclosure is mandated by 5 Illinois Compiled Statutes 100/10-65. The social security number will be provided to the Department of Public Aid to assist in the identification of persons who are more than 30 days delinquent in complying with a child support order.
D. Submit application and fee to:
Department of Professional Regulation
320 West Washington
Springfield, Illinois 627

APR 1 0 2000

REID, VIRGIL CAYTON III MD
3036 file# 63450 04-17-00
By: NON EXAM ASG UNASSIGN
SSN: [redacted]

CHECK A BOX INDICATING THE APPROPRIATE INFORMATION REGA
(Do not use this form to renew existing Registra

☒ First Time Applicant ☐ Additional Location (separate offi

PART I: Application Category Information

1. PROFESSIONAL NAME	2. PROFESSIONAL CODE - Check applicable box	
Controlled Substances	☐ 319 Dentist ☐ 316 Podiatrist	☒ 336 Physician ☐ 390 Veterinar

33 [redacted] 02

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g. M.D., D.O., etc.)	3. [redacted]
Reid III	Virgil	Cayton	MD	

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

5. NAME OF BUSINESS AND LOCATION (STREET/CITY/ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED
Erie Family Health Center
1701 West Superior
Chicago IL 60622

6. MAIDEN OR GIVEN SURNAME OR ANY NAME

TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Work (312) 216-9712
Home [redacted]

PART III: Professional Activity

Practitioner - CHECK AND COMPLETE ONE OF THE FOLLOWING

	Professional License Number
☐ Dentist	019 -
☒ Physician	036 - [illegible]
☐ Podiatrist	016 -
☐ Veterinarian	090 -

DRUG SCHEDULES (Circle the schedules for which you are applying)
II IIN III IIIN IV V

FOR OFFICIAL USE ONLY Fee $5

BNDD Number:
Type:
Suffix:
Schedule Codes
Additional Function: A
Card Code: K
Issuance Date (Month/Day/Year)

IL486-0600 2/99 (LT)

REVERSE SIDE MUST BE COMPLETED

(DO NOT USE THIS APPLICATION FOR RENEWAL OF AN EXISTING LICENSE)

IMPORTANT NOTICE: Completion of this form is required by 720 of the Illinois Compiled Statutes (Chap. 56 1/2, of the Ill. Rev. Stat. 1985). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application. This form has been approved by the Forms Management Center.

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

DO NOT SUBMIT APPLICATION UNTIL A PERMANENT PRACTITIONERS LICENSE HAS BEEN ISSUED! CONTROLLED SUBSTANCES LICENSE WILL NOT BE ISSUED TO A TEMPORARY LICENSE HOLDER!

1. Every person who prescribes or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Professional Regulation in accordance with the Illinois Controlled Substances Act.
2. A separate controlled substances registration is required for each place of professional practice or business where controlled substances are stored or located.
3. A State Controlled Substances Registration is prerequisite to a Federal Controlled Substances Registration.

A. Type or print legibly with black ink only.
B. The fee is $5 - Make check payable to the Department of Professional Regulation. THIS FEE IS NOT REFUNDABLE! (Separate application/fee is required for each registration.)
C. Disclosure of your U.S. social security number, if you have one, is mandatory. This disclosure is mandated by 5 Illinois Compiled Statutes 100/10-65. The social security number will be provided to the Department of Public Aid to assist in the identification of persons who are more than 30 days delinquent in complying with a child support order.
D. Submit application and fee to:
Department of Professional Regulation
320 West Washington
Springfield, Illinois 6278

APR 1 0 2000

REID, VIRGIL CAYTON III MD
3036 file# 63450 04-17-00
By: NON-EXAM ASG: UNASSIGN
SSN: [redacted]

CHECK A BOX INDICATING THE APPROPRIATE INFORMATION REGA
(Do not use this form to renew existing Registra

☑ First Time Applicant ☐ Additional Location (separate offi

PART I: Application Category Information

1. PROFESSIONAL NAME	2. PROFESSIONAL CODE - Check applicable box	
Controlled Substances	☐319 Dentist	☒336 Physician
	☐316 Podiatrist	☐390 Veterinar

33[redacted]02

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g. M.D., D.D.S., etc.)	3. UNITED STATE SOCIAL SECURITY NO.
Reid III	Virgil	Cayton	MD	[redacted]

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

5. NAME OF BUSINESS AND LOCATION (STREET/CITY /ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED
Erie Family Health Center
1701 West Superior
Chicago IL 60622+____

6. MAIDEN OR GIVEN SURNAME OR ANY NAME

7. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Work (919) 216-4712
Home ([redacted]

PART III: Professional Activity

Practitioner - CHECK AND COMPLETE ONE OF THE FOLLOWING

	Professional License Number
☐Dentist	019 -
☒Physician	036 - [illegible]
☐Podiatrist	016 -
☐Veterinarian	090 -

DRUG SCHEDULES (Circle the schedules for which you are applying)
II IIN III IIIN IV V

FOR OFFICIAL USE ONLY $5

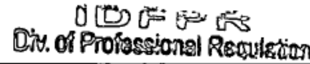
BNDD Number: ___ Type: ___ Suffix: ___
Schedule Codes ___
Additional Function: A Card Code: K
Issuance Date (Month/Day/Year) ___

IL486-0600 2/99 (LT)

REVERSE SIDE MUST BE COMPLETED

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

Lic#: 33 78
REID, VIRGIL CAYTON
336 Cred #3584806 05/13/2016
By:NON-EXAM
SSN
6.28.16



IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

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

1. PROFESSION NAME	2. PROFESSION CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☐346 Optometrist ☐316 Podiatrist ☐390 Veterinarian ☒336 Physician	Registration	$5

PART II: Applicant Identifying Information

1. NAME LAST / FIRST / MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATES SOCIAL SECURITY NO
Reid III / Virgil / Cayton	MD	

4. PERMANENT MAILING ADDRESS / CITY / STATE/COUNTRY / ZIP CODE / COUNTY

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED

Planned Parenthood of Illinois
3051 E. New York St. Aurora, IL 60504

6. If you will *not* be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

☐ I will *not* be storing or dispensing controlled substances, including samples.

7. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

8. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work (312) 592-6800 Area Code FAX (312) 592-6801 Area Code

Home ( ) Area Code FAX ( ) Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:

II III IV V

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 -
☐	Optometrist	046 -
☐	Physician	036 - 102311
☐	Podiatrist	016 -
☐	Veterinarian	090 -

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

Lic#:
REID, VIRGIL CAYTON
336 Cred #3584806 05/13/2016
By:NON-EXAM
SSN: [redacted]

IDFPR
Div. of Professional Regulation

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

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

1. PROFESSION NAME	2. PROFESSION CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☐346 Optometrist ☐316 Podiatrist ☐390 Veterinarian ☒336 Physician	Registration	$5

PART II: Applicant Identifying Information

1. NAME LAST: Reid III FIRST: Virgil MIDDLE: Cayton
2. TITLE (e.g., M.D., O.D., etc.): MD
3. UNITED STATES SOCIAL SECURITY NO.: [redacted]

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

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED

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3051 E. New York St. Aurora, IL 60504

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7. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

8. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work (312) 592-6800 Area Code FAX (312) 592-6801 Area Code

Home [redacted] Area Code FAX ( ) Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:

(II) (III) (IV) (V)

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

	Professional License Number
☐ Dentist	019 -
☐ Optometrist	046 -
☒ Physician	036 - 102311
☐ Podiatrist	016 -
☐ Veterinarian	090 -

RECEIVED
JUN 24 2016
IDFPR - MEDICAL UNIT

PART V: 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.		✓
7.	Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		✓

PART VI: 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 VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

5/10/2016
Date of Application

[redacted]
Signature of Applicant

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.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

NAME (Last, First, MI):

SS#:

Profession:

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 Reid Viryl Cayton	3. PROFESSIONAL LICENSE NUMBER (if any) 036.102311
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:

	Question	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.

RECEIVED
JUN 24 2016

[redacted]
Signature of Applicant

Date 6/20/16

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: 6/16/2016

Initials: JA

License No: 336

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:

VIRGIL CAYTON REID III MD
PLANNED PARENTHOOD OF ILLINOIS
3051 E NEW YORK ST
Aurora, IL 60504-5160

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Circle the drug schedules for which you are applying in Part III

The CCA form is required for all health care workers.

RETURN INFORMATION WITH A COPY OF THIS NOTICE.

RECEIVED
CASH SECTION
MAY 1 ? 2016
Div of Professional Regulation

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

Lic#: S3[redacted]79
REID, VIRGIL CAYTON
336 Cred #3584679 05/13/2016
By:NON-EXAM
SSN[redacted] 6.28.16

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

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

1. PROFESSION NAME	2. PROFESSION CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☐346 Optometrist ☐316 Podiatrist ☐390 Veterinarian ☒336 Physician	Registration	$5

PART II: Applicant Identifying Information

1. NAME LAST / FIRST / MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
Reid III / Virgil / Cayton	MD	[redacted]

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

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED

601 N. Bruns Lane
Springfield, Illinois 62702

6. If you will *not* be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

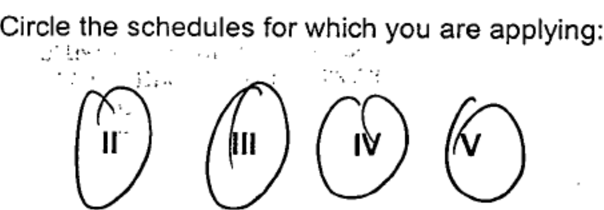
☐ I will *not* be storing or dispensing controlled substances, including samples.

7. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

8. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Work (312) 592 - 6800 FAX (312) 592 - 6801
Area Code / Area Code
Home ([redacted] FAX ( ) ________
Area Code / Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:



PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 -
☐	Optometrist	046 -
☒	Physician	036 - 102311
☐	Podiatrist	016 -
☐	Veterinarian	090 -

PART V: 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.		✓
7. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		✓

NAME (Last, First, MI):

PART VI: 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.")

SS#:

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 ☑

Profession:

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

5/10/2016
Date of Application

[redacted]
Signature of Applicant

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.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

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

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE	3. PROFESSIONAL LICENSE NUMBER (if any)
Reid Virgil Clayton	036-102311
2. ADDRESS STREET CITY STATE ZIP CODE	4. SOCIAL SECURITY NUMBER
[redacted]	[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
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- ☐ 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
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- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

RECEIVED
JUN 24 2016
IDPR-MEDICAL UNIT

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:

	Question	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] 6/20/16

Signature of Applicant Date

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: 6/16/2016

Initials: JA

License No: 336

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:

VIRGIL CAYTON REID III MD

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

The CCA form is required for all health care workers.

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