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JUN 01 2005
GRADUATE MEDICAL EDUCATION

9207/

FOR OFFICIAL USE ONLY

APPLICATION FOR LICENSURE AND/OR ~~EXAMINATION~~

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

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

RECEIVED
CASH SECTION
JUN 09 2005
IDFPR
Div. of Professional Regulation

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
PHYSICIAN	0 ~~5~~ 36	ACCEPTANCE OF ~~NON~~ EXAMINATION	$ 300.00 ~~100.00~~

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.
- ☒ Other: ~~EXTENSION~~ PERMANENT
- ☐ 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.
LOONEY	KIMBERLY	ROCHELLE	MD	[redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
GRADUATE MEDICAL EDUCATION (MC 675) 820 S. WOOD, CHICAGO IL 60612
60612-7313 COOK

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

7. MOTHER'S MAIDEN NAME [redacted]

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

9. DATE OF BIRTH [redacted] Month Day Year

10. AGE 31 ☒ Female ☐ Male

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

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.

NAME (Last, First, MI): LOONEY, KIMBERLY R.

SS#: [redacted]

Profession: PHYSICIAN

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 (12)

Graduated High School? ☒ Yes ☐ No

Received OR G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
M. L. KING MAGNET	NASHVILLE, TN	0 6 / 1 9 9 2 (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	DATES OF ATTENDANCE TO	TYPE OF DEGREE EARNED
FISK UNIVERSITY	NASHVILLE, TN	Month/Year 8/92	Month/Year 5/96	BA, Chemistry
UNIV OF TN - MEMPHIS MEDICAL CENTER	MEMPHIS, TN	8/97	6/02	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	DATES OF ATTENDANCE TO	Did You Complete Training?
UNIV OF IL - CHICAGO	CHICAGO, IL	Month/Year 6/02	Month/Year CURRENT	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☑ No
				☐ Yes ☐ No

NAME (Last, First, MI): LOONEY, KIMBERLY R

SS#: [redacted]

Profession: PHYSICIAN

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure IL	~~KIMBERLY R. LOONEY~~ MD	125-044793	6/17/02	ACTIVE
State of Current Licensure where you most recently have been practicing. IL	MD	125-044793	6/17/02	ACTIVE
Other States of Licensure				

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

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
USMLE STEP I	TN	06/2000	[redacted]
USMLE STEP I	TN	10/2000	
USMLE STEP II	TN	02/2002	
USMLE STEP III	IL	01/2005	

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

NAME (Last, First, MI): LOONEY, KIMBERLY R.

SS#: [redacted]

Profession: PHYSICIAN

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

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

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

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

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

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

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

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

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] 05/20/05

Signature of Applicant Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

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.

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: LOONEY — FIRST: KIMBERLY — MIDDLE: ROCHELLE

2. DATE OF BIRTH — Month Day Year: [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) — 1 2 5 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: [redacted]

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

8. DATE FORM COMPLETED: 5/20/05

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: UNIV OF IL-CHICAGO HOSPITAL

JOB TITLE: RESIDENT PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE:
1740 W. TAYLOR STREET
CHICAGO, IL 60612

SUPERVISOR NAME: DR. GARY LOY

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 17 / 2002 (Month / Day / Year)
To 06 / 18 / 2006 (Month / Day / Year)

HOURS WORKED PER WEEK: 80

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

TOTAL TIME WORKED (Year/Month): 2 YEARS / 11 MONTHS

DESCRIPTION OF DUTIES PERFORMED:
- PROVIDE MEDICAL CARE (INCLUDING OPERATIVE PROCEDURES) FOR FEMALE PATIENTS.
- O.R. RESPONSIBILITIES: Operative deliveries, cesarean sections, hysterectomies, other gyne-related surgeries.
- SUPERVISE/TEACH MEDICAL STUDENTS AND JUNIOR RESIDENTS
- OTHER DUTIES: Chief resident administrative duties.

B. NAME OF BUSINESS / INSTITUTION:

JOB TITLE:

ADDRESS STREET, CITY, STATE, ZIP CODE:

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):

DESCRIPTION OF DUTIES PERFORMED:

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)		

NAME (Last, First, MI): LOADER, KIMBERLY P

SS#: [redacted]

Profession: PHYSICIAN

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GRADUATE MEDICAL EDUCATION

testing

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

APPLICANT: ***Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
LOONEY, KIMBERLY R.	[redacted]	
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.	
6. MAIDEN OR GIVEN SURNAME	PHYSICIAN (Profession Name)	036 (Profession Code)
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)	8. ISSUANCE DATE	

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IDPR

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
320 West Washington - MED-1
Springfield, Illinois 62786

This is to certify that the above-named applicant satisfactorily completed 36 months of postgraduate clinical training in OBSTETRICS & GYNECOLOGY
(Name of Accredited Postgraduate Clinical Training Program)

from JUNE 17, 2002 to JUNE 10, 2005 at the following hospital:

Hospital: UNIVERSITY OF ILLINOIS-CHICAGO

Number and Street: 820 S. WOOD ST.

City, State and Zip Code: CHICAGO, IL 60612

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

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

SEAL

Name of Postgraduate Clinical Training Program Director: Gary Loy MD, MPH

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 6/10/05

Telephone No: 312 996 0532

IL486-1535 08/04 (MD)

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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
LOONEY	KIMBERLY	ROCHELLE	[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.

6. MAIDEN OR GIVEN SURNAME: [redacted]

PHYSICIAN (Profession Name) — 0 3 6 (Profession Code)

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable): 125-044793

8. ISSUANCE DATE: 6/17/02

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 22 months of postgraduate clinical training in OBSTETRICS & GYNECOLOGY
(Name of Accredited Postgraduate Clinical Training Program)

from 6/17/02 to 4/27/04 at the following hospital:

Hospital: University of Illinois at Chicago

Number and Street: 820 S. Wood Street (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

SEAL

Name of Postgraduate Clinical Training Program Director: Gary Loy, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 4/27/04

Telephone No: 312-996-0532

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

PAID
MAY 24 2004
BY: 823081

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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.
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A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician	0 3 6	Examination	$ CTS 82.30 FSMB 610.00 Total 692.30

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.
- ☐ 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.
LOONEY	KIMBERLY	ROCHELLE	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

DEPT OF OBSTETRICS & GYNECOLOGY
820 S. WOOD ST (MC 808) CHICAGO IL/USA 60612-7313

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]	[redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH Month Day Year	10. AGE	
[redacted]	[redacted]	30	☒ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED	12. PREFERRED e-MAIL ADDRESS(ES) [If available]
Work (312) 996-0532 (Area Code) Home: [redacted] (Area Code)	[redacted]

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

NAME (Last, First, MI): LOONEY, KIMBERLY, R.

SS#: [redacted]

Profession: PHYSICIAN

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 (12) Graduated High School? ☒ Yes ☐ No Received OR G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
ML KING MAGNET HS FOR HEALTH SCIENCE & ENGN.	NASHVILLE, TN	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
FISK UNIVERSITY	NASHVILLE, TN	08/92	06/96	B.A.
UNIVERSITY OF TENNESSEE-MEMPHIS HEALTH SCI CENTER	MEMPHIS, TN	08/97	06/02	M.D.

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
UNIVERSITY OF ILLINOIS-CHICAGO	CHICAGO, IL	06/02	CURRENT	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): LOONEY, KIMBERLY, R.

SS#: [redacted]

Profession: PHYSICIAN

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure ILLINOIS	M.D.	125-044793	06/17/02	ACTIVE
State of Current Licensure where you most recently have been practicing. ILLINOIS	M.D.	125-044793	06/17/02	ACTIVE
Other States of Licensure				

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

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
USMLE STEP I	TN	06/2000	[redacted]
USMLE STEP I	TN	10/2000	
USMLE STEP II	TN	02/2002	

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

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a 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: [0][0]

e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated? Yes [X] 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 [X]
   (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 [X]

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

03/30/2004 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.

NAME (Last, First, MI): LOONEY, KIMBERLY, R.

SS#: [redacted]

Profession: PHYSICIAN

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.

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: LOONEY KIMBERLY ROCHELLE

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) 0 3 6 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: [redacted]

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

8. DATE FORM COMPLETED: 03/30/2004

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: UNIV OF ILLINOIS HOSPITAL

JOB TITLE: RESIDENT PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE:
DEPT OF OBSTETRICS & GYNECOLOGY
820 S WOOD ST (MC 808) CHICAGO IL 60647-7313

SUPERVISOR NAME: DR. GARY LOY

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 10 / 2002 (Month / Day / Year)
To 06 / 01 / 2006 (Month / Day / Year)

HOURS WORKED PER WEEK: 80+

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

TOTAL TIME WORKED (Year/Month): 1 year / 10 months

DESCRIPTION OF DUTIES PERFORMED

- PROVIDE MEDICAL CARE (INCLUDING OPERATIVE PROCEDURES) FOR FEMALE PATIENTS.
- OR RESPONSIBILITIES: Operative deliveries, cesarean sections, hysterectomies, other gynecologically related surgeries.
- SUPERVISE / TEACH MEDICAL STUDENTS AND JUNIOR RESIDENTS.
- OTHER DUTIES: Maintain patient records (dictations)

B. 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):

NAME (Last, First, MI):

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)

SS#:

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)

Profession:

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

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. 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.

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	1 2 5	NON-EXAMINATION	$ 100.00

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.
- ☐ 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.
LOONEY KIMBERLY ROCHELLE	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)
[redacted]

7. PLACE OF BIRTH CITY STATE/COUNTRY	8. DATE OF BIRTH Month Day Year	9. AGE
[redacted]	[redacted]	28 ☑ Female ☐ Male

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work (9 0 1) 4 2 8 – 8 0 4 9 (Area Code)
Home: ([redacted] (Area Code)

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

NAME (Last, First, MI): LOONEY, KIMBERLY R.

SS#: [redacted]

Profession: M.D.

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
ML KING MAGNET HS	NASHVILLE, TN	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
FISK UNIVERSITY	NASHVILLE, TN	08/92	05/96	B.A., CHEMISTRY
UNIV OF TN - MEMPHIS HEALTH SCIENCE CENTER	MEMPHIS, TN	08/97	06/02	M.D.

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	DATES OF ATTENDANCE TO Month/Year	Did You Complete Training?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION

May 29, 2002

Kimberly Rochelle Looney MD
[redacted]

Dear Dr. Looney:

Your application for temporary licensure in Illinois has been approved, and the license has been forwarded to the clinical training facility where you have been accepted for residency training. This license was issued with a beginning date of 06/17/2002. Assuming you remain in the training program listed below, this license will be valid until 06/16/2005.

PROGRAM: Obstetrics & Gynecology
TRAINING FACILITY: Univ of Illinois Chicago

Utilization of this license is limited to the training program listed above. It may not be used for any clinical medical practice which occurs outside the residency program; i.e., "moonlighting." Further, should you transfer to a different residency program within this training facility or to a program in another institution, you must reapply to the Department for a temporary license specific to the new program. This temporary license is not automatically transferable from one program/institution to another.

Applications for temporary licensure transfers must be filed with the Department at least 60 days prior to commencement of the new program. You are not eligible to begin a new training program until your current temporary license has been returned to the Department and a license has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of the temporary license. Any violation of that Act may result in disciplinary action by this Department.

If you have any questions concerning the limitations of this license or the procedures to transfer your temporary license, please contact me in writing at the Department of Professional Regulation, 320 West Washington Street, Springfield, Illinois 62786.

Alicia Purchase, Manager
Medical Unit

FC: lv3.125

NAME (Last, First, MI): LOONEY, KIMBERLY R.

SS#: [redacted]

Profession: M.D.

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				
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	TN	06/99	[redacted]
USMLE STEP I	TN	10/99	
USMLE STEP II	TN	02/02	

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

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a 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)***

Every licensee is required by law to respond to the following question regardless of whether or not he or she is subject to a child support order:

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.")

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.**

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] 04/16/02
Signature of Applicant 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.

NAME (Last, First, MI): LOONEY, KIMBERLY R

SS#: [redacted]

Profession: M.D.

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

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statues). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

CA-MED

NOTE: An applicant shall not commence specialty/residency training before he or the hospital/institution receives written notice of the approval of his application from the Department of Professional Regulation.

APPLICANT: Complete the applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the remainder of the form.

1. NAME LAST FIRST MIDDLE: LOONEY, KIMBERLY

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

3. SOCIAL SECURITY NUMBER: [redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE:

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

PHYSICIAN (Profession Name) 1 2 5 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

ADMINISTRATOR: Complete the remainder of this form and return it to the applicant.

A. HOSPITAL/INSTITUTION NAME: UNIVERSITY OF ILLINOIS AT CHICAGO

B. BEGINNING DATE: 06 / 17 / 2002 (Month Day Year)

C. ENDING DATE: 06 / 16 / 2005 (Month Day Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE:
820 S. WOOD ST., (MC 675)
CHICAGO, IL 60612

E. SPECIALTY / RESIDENCY NAME: OBSTETRICS & GYNECOLOGY

F. BUSINESS TELEPHONE NUMBER: Area Code (3 1 2) 9 9 6 — 2 9 3 3

G. YEAR OF POSTGRADUATE TRAINING: 1

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Professional Regulation, the applicant is found to be eligible for licensure.

SEAL

[redacted]
Signature of Program Director

GLORIA ELAM, M.D.
Print Name of Program Director

PROGRAM DIRECTOR
Title

5/7/02
Date

IL486-0272 12/00 (MD)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statues). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF EDUCATION

SUPPORTING DOCUMENT

ED - MED

APPLICANT: ***Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.***

1. NAME — LAST: LOONEY — FIRST: KIMBERLY — MIDDLE: ROCHELLE

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.

TEMPORARY PHYSICIAN LICENSURE — Profession Name: 125 — Profession Code

6. MAIDEN OR GIVEN SURNAME: [redacted]

7. NAME OF INSTITUTION ATTENDED: UNIV OF TN - MEMPHIS

8. DATE OF GRADUATION / COMPLETION: 06 / 07 / 2002 (Month / Day / Year)

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Professional Regulation or its designated testing service the information requested below.

04/16/02 (Date) — [redacted] (Signature)

SCHOOL OFFICIAL: ***Complete the bottom portion of this page and the reverse side, then return to the applicant.***

A. NAME OF INSTITUTION: The University of Tennessee, H.S.C

B. ADDRESS OF INSTITUTION — STREET, CITY, STATE, ZIP CODE: 800 Madison Ave Memphis, . 38163

C. INDICATE YEAR BY YEAR THE DATES OF ATTENDANCE IN COLLEGE (Both pre-medical and medical education must be included)

From 08 / 15 / 1997 (Month / Day / Year)	To 05 / 29 / 1998
From 08 / 17 / 1998	To 06 / 06 / 1999
From 08 / 16 / 1999	To 06 / 14 / 2000
From 07 / 05 / 2000	To 06 / 22 / 2001
From 07 / 05 / 2001	To 06 / 31 / 2002
From ___ / ___ / ____	To ___ / ___ / ____

D. Total academic years attended: 5 Years / - Months / - Days

OR

Total calendar years attended: ___ Years / ___ Months / ___ Days

E. TYPE OF DEGREE OR CERTIFICATE AWARDED: M.D. (TO BE AWARDED)

F. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET: 05 / 31 / 2002 (Month / Day / Year) (TO BE MET)

G. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED: 06 / 07 / 2002 (Month / Day / Year) (TO BE CONFERRED)

H. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

[ ] Applicant has graduated on ___ / ___ / ____ (Month / Day / Year)

[ ] Applicant has completed program on ___ / ___ / ____ (Month / Day / Year)

[X] Applicant will graduate on 06 / 07 / 2002 (Month / Day / Year)

[X] Applicant will complete program on 05 / 31 / 2002 (Month / Day / Year)

I. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:

J. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

NAME (Last, First, MI): LOONEY, KIMBERLY R.

SS#: [redacted]

Profession: M.D.

WHEN THIS FORM IS CERTIFIED PRIOR TO THE ACTUAL GRADUATION OF THE APPLICANT, THE SCHOOL OFFICIAL IS RESPONSIBLE FOR NOTIFYING THE DEPARTMENT OF PROFESSIONAL REGULATION OF ANY FAILURE ON THE PART OF THE APPLICANT TO COMPLETE THE REQUIREMENTS FOR GRADUATION.

I certify that the information recorded herein is true and correct according to the official records of this institution.

[redacted]
Signature of School Official

Lashlee Dorman
Print Name of School Official

Assistant Director/Registrar
Title

4/22/02
Date

SCHOOL SEAL

RETURN THIS FORM TO APPLICANT

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statues. 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: LOONEY — FIRST: KIMBERLY — MIDDLE: ROCHELLE

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.
TEMPORARY PHYSICIAN LICENSURE (Profession Name) — 125 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: [redacted]

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

8. DATE FORM COMPLETED: 04/16/02

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

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

MOVING, VACATION

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 01 / 2002 (Month / Day / Year)
To 06 / 16 / 2002 (Month / Day / Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

B. 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)

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

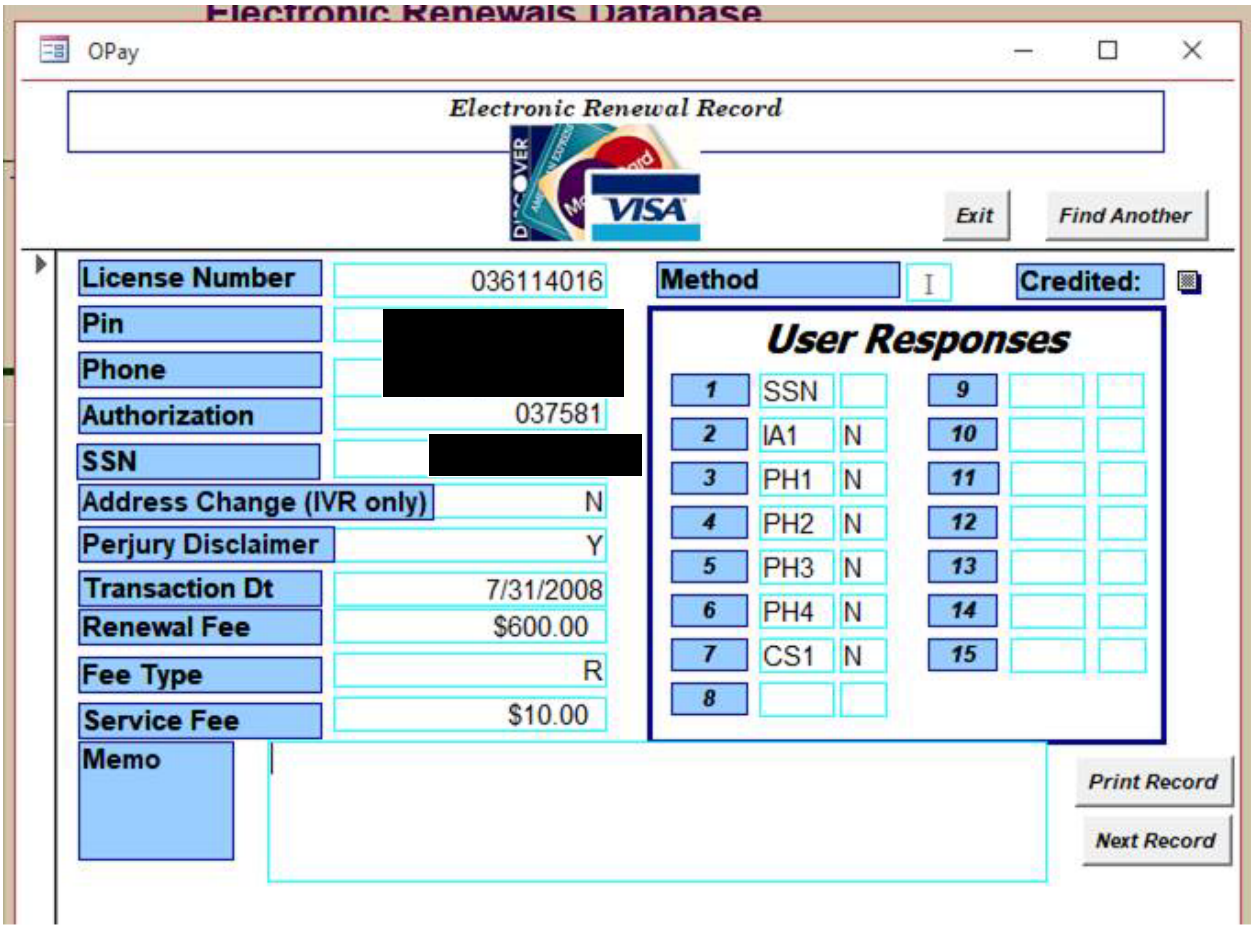
☐ Full-time ☐ Part-time

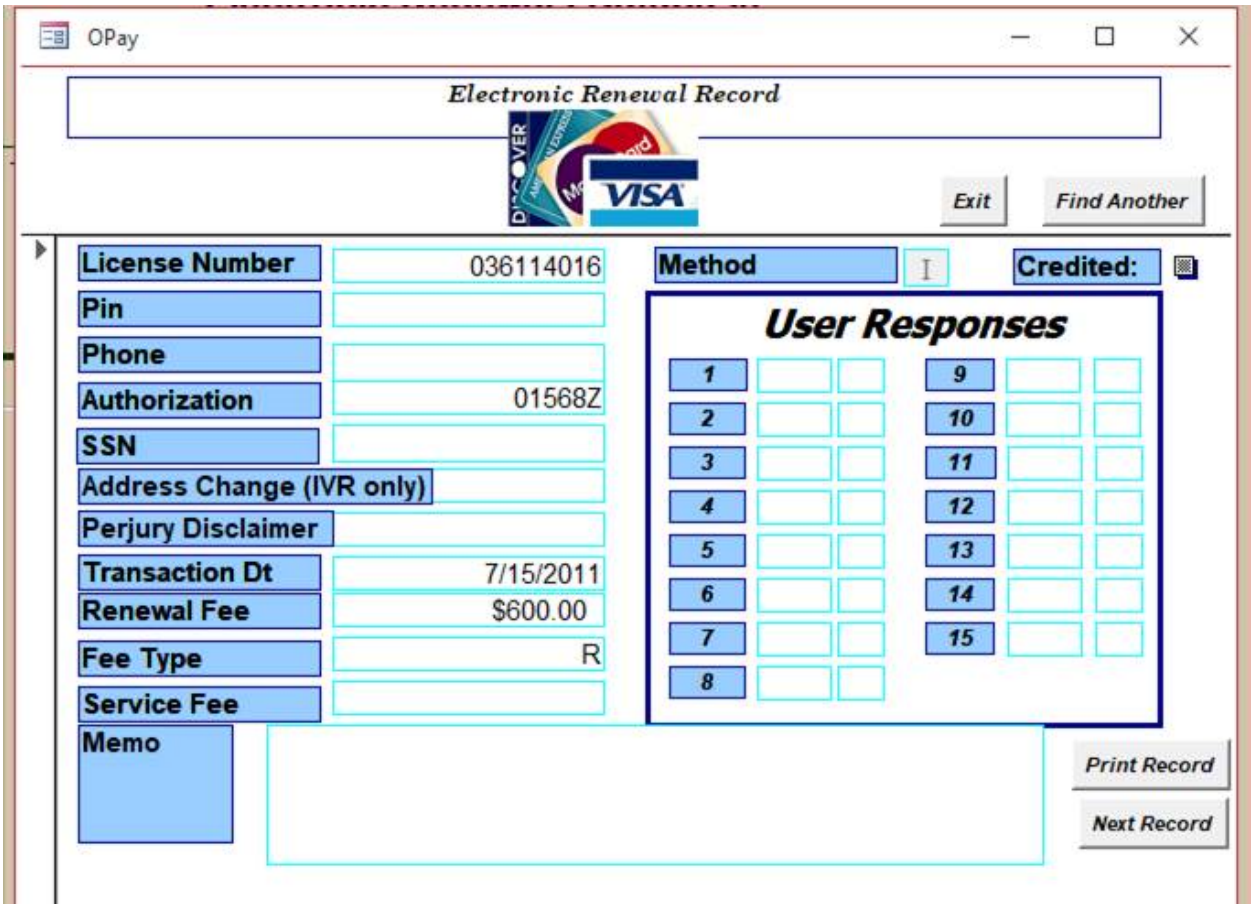
TOTAL TIME WORKED (Year/Month)

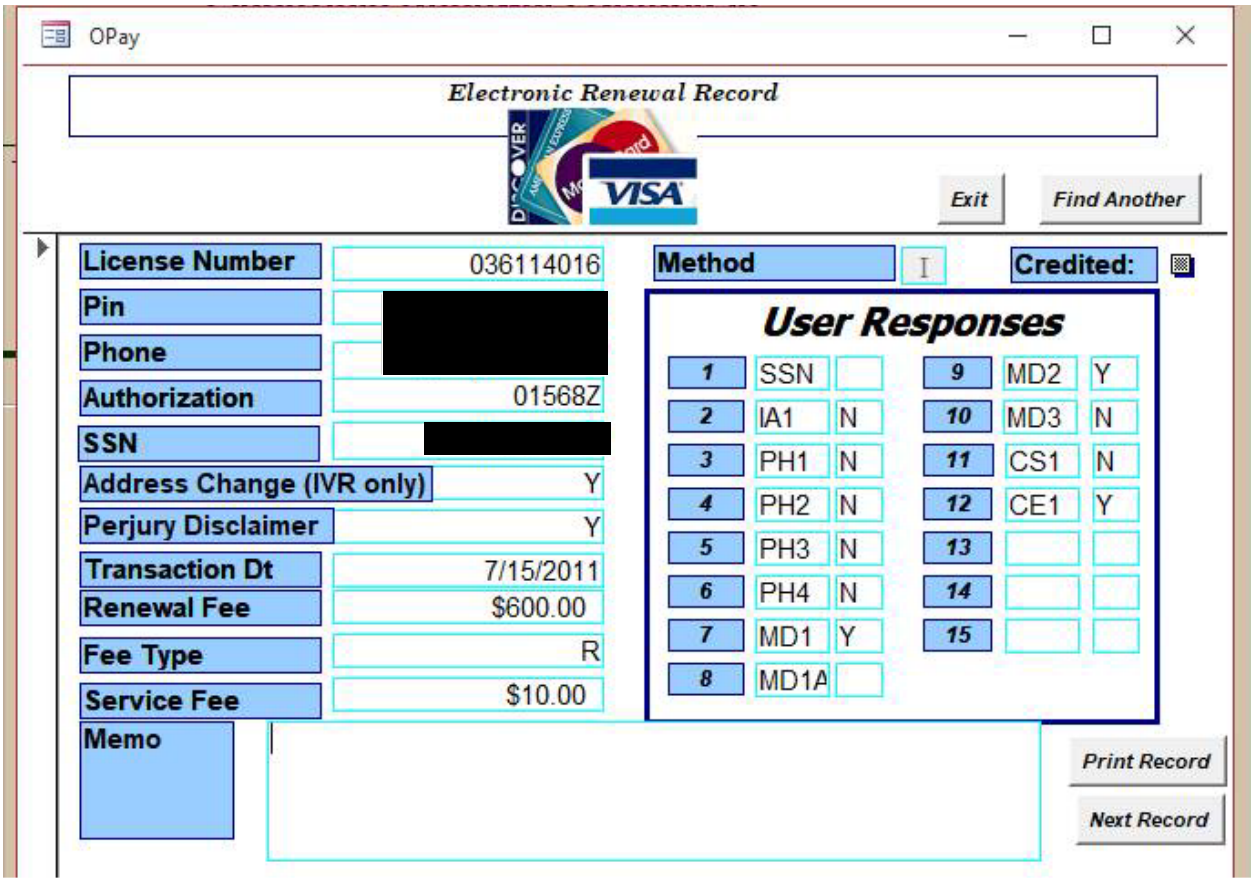
NAME (Last, First, MI): LOONEY, KIMBERLY R.

SS#: [redacted]

Profession: M.D.


Electronic Renewals Database
OPay
Electronic Renewal Record
Exit
Find Another
License Number
036114016
Pin
Phone
Authorization
037581
SSN
Address Change (IVR only)
N
Perjury Disclaimer
Y
Transaction Dt
7/31/2008
Renewal Fee
$600.00
Fee Type
R
Service Fee
$10.00
Memo
Method
Credited:
User Responses
1 SSN
2 IA1 N
3 PH1 N
4 PH2 N
5 PH3 N
6 PH4 N
7 CS1 N
8
9
10
11
12
13
14
15
Print Record
Next Record


OPay
Electronic Renewal Record
Exit
Find Another
License Number
036114016
Pin
Phone
Authorization
01568Z
SSN
Address Change (IVR only)
Perjury Disclaimer
Transaction Dt
7/15/2011
Renewal Fee
$600.00
Fee Type
R
Service Fee
Memo
Method
Credited:
User Responses
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
Print Record
Next Record


OPay
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Authorization
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SSN
Address Change (IVR only)
Y
Perjury Disclaimer
Y
Transaction Dt
7/15/2011
Renewal Fee
$600.00
Fee Type
R
Service Fee
$10.00
Memo
Method
Credited:
User Responses
1 SSN
2 IA1 N
3 PH1 N
4 PH2 N
5 PH3 N
6 PH4 N
7 MD1 Y
8 MD1A
9 MD2 Y
10 MD3 N
11 CS1 N
12 CE1 Y
13
14
15
Print Record
Next Record