Application - LICENSED PHYSICIAN AND SURGEON

Name	Jamie Phifer
Credential	LICENSED PHYSICIAN AND SURGEON

Fee Details

INITIAL APPLICATION FEE	$ 500 00
	$ 500.00

Licensed Physician Application Instructions

- **Applicants may apply to become a Licensed Physician on the basis of Acceptance of Examination or Endorsement.**
- **The licensure fee is $500 and is non-refundable. Payment may be made by eCheck or credit card. License applications are valid for 3 years from the date of receipt by the Department.**
- **Acceptance of Examination Applicant has passed a National Exam, referred to by Illinois statute AND meets Illinois requirements in effect at the time of application. Applicant is not currently licensed to practice medicine in another state.**
- **Endorsement Applicant is currently licensed to practice medicine in another state. Requirements to receive original physician license in other state were substantially equivalent to Illinois licensure requirements in effect when original physician license was issued.**

Application Method

1. Please select your desired application method.
Endorsement

Authorization for Third-Party Contact

2. I would like to authorize a person/business other than myself or my business to communicate with the IDFPR regarding my application for licensure.
No

Public and Mailing Addresses

7. Please verify or enter your Public Address

Address Line 1 [redacted]
Address Line 2
City [redacted]
State [redacted]
Zip Code [redacted]
County
Country [redacted]
Phone [redacted]
Cell Phone

8. Please verify or enter your Mailing Address

Address Line 1 [redacted]
Address Line 2
City [redacted]
State [redacted]
Zip Code [redacted]
County
Country [redacted]
Phone [redacted]
Cell Phone

Personal Information

11. Birth City
[redacted]

12. Birth State *(if foreign born choose UNKNOWN)*
[redacted]

13. Birth Country
[redacted]

14. Gender
Female

15. Which ethnicity best describes you?
Caucasian

Date of Birth

16. Date of Birth
[redacted]

Name Change

17. Do any of your supporting documents have a different name than your current legal name?
No

18. If you answered *"Yes"* to the question above, please add proof of your name change in the grid below

Previous Name on Document(s)	From	To	Supporting Document Type	Supporting Document Upload	Name Change Reason(s)

FCVS Physician Information Profile

19.

IDFPR accepts Physician Information Profiles compiled by the Federation Credentials Verification Service (FCVS). Will you be using the FCVS to verify your credentials?

If so, please contact FCVS to send your Physician Information Profile to IDFPR. This will include verification of the following

- **Medical School Transcripts and Diploma**
- **ECFMG Certification**
- **Physician Exam**
- **Postgraduate Clinical Training**

Yes

Education Location

20. Were you educated in the U.S. or one of its Territories or were you Foreign Educated?

U.S. or one of its Territories

Education Information

21. Please list information on your primary school education in the grid below

Primary School Type (High School, or GED)	School Name	City	State (If foreign, select Unknown)	Country	Date Graduated
Graduated	Duncan U Fletcher High School	Neptune Beach	Florida	UNITED STATES	06/01/2003

22. Please list information on your undergraduate, graduate and vocational training degree(s) earned in the grid below

College, University, or Training School	City	State (If foreign, select Unknown)	Country	Attendance From	Attendance To	Degree Major	Degree Earned	Graduated?
University of Florida	Gainesville	Florida	UNITED STATES	08/25/2003	05/05/2007	Interdisciplinary Studies/Microbiology	BS	Graduated

Proof of Pre-Medical Education

23. How will you deliver your proof of education to IDFPR?

My school will mail or electronically transmit my official transcripts directly to IDFPR.

24.

Please upload an official transcript verifying completion of at least two academic years of instruction in a college, university, or other institution.

The transcript must bear the official seal and signature of the institution.

Note If you graduated from a 6-year medical program, please proceed to question 24 to upload your official transcript.

Medical School Location

25.

Did you graduate from a medical or osteopathic college located in the United States/Canada or in another foreign country?

United States/Canada

26. If another country, please specify where.

Verification of Professional Capacity

32.

Have you been actively engaged in the practice of medicine or been a student engaged in a formal program during the 2 years immediately preceding today's date?

Yes

33.

If you answered No, you must submit evidence to establish your present capacity to practice chiropractic with reasonable judgement, skill, and safety. The following may be considered as evidence of your present capacity specialized training or education, publications of original work in learned chiropractic journals, public clinical research, federal clinical research, or other professional clinical activities related to the practice of chiropractic medicine. Please upload a detailed statement which clearly identifies each activity specified above that you are claiming to meet the professional capacity requirement. The statement must be signed and dated. Also provide official documentation that verifies completion of each activity.

Physician Verification of Employment/Experience

34.

Please record your work history chronologically for the five (5) years preceding the date of application, starting with present employment. For each position held, please provide complete information including the name of each practice/work location along with the address where patient care was provided, your dates of employment, job title, description of duties performed, and time employed.

Name of Practice/Work Location	Employer Address	Employer Address	Employer City	Employer Country	Employer State	Employer Zip	Dates of Employment - Start Date	Dates of Employment - End Date	Currently Employed	Were you a full-time employee or a part-time employee?	Please state your job title at the time of your employment.	Please provide a description of the duties you performed during your employment.	Total Number of Years Employed	Months Employed
Swedish Medical Group	600 University Street #1200		Seattle	UNITED STATES	Washington	98101	08/24/2014	05/22/2019	Yes	Part-Time	Primary Care Float Physician	Per diem family medicine and urgent care physician for largest non-profit healthcare provider in the Seattle area. Serving on	4	9

												float physician leadership team. Helped the organization open three new clinics since 2015.		
Overlake Medical Clinics	1035 116th Ave NE		Bellevue	UNITED STATES	Washington	98001	04/01/2019	05/22/2019	Yes	Part-Time	Primary and Urgent Care Float Physician	Covering eight dual primary and urgent care sites for rapidly growing medical group. Working directly with senior management to target areas of greatest need and expand scope of practice.	0	2
All Women's Care	9730 3rd Ave NE	#200	Seattle	UNITED STATES	Washington	98115	01/16/2015	03/23/2019	No	Part-Time	Associate Medical Director	Family Planning Contract physician; staff oversight	4	2
Qliance Medical Group	19401 40th Ave W #100		Lynnwood	UNITED STATES	Washington	98036	08/19/2014	04/30/2017	No	Part-Time	Family Physician	nnovative direct primary care model for working class patients. Company closed in 2017 due to lowering reimbursement rates in the region and instability in the insurance market.	2	8
Trust Women Wichita	5107 Kellogg Drive		Wichita	UNITED STATES	Kansas	67218	09/25/2017	12/07/2017	No	Part-Time	Family Planning Contract Physician	Family Planning services	0	3
A Woman's Choice of Jacksonville	4131 University Blvd S		Jacksonville	UNITED STATES	Florida	32216	01/18/2016	08/05/2017	No	Part-Time	Family Planning Contract Physician	Family Planning services	1	8
All Women's Health of Jacksonville	1545 Huffingham Rd		Jacksonville	UNITED STATES	Florida	32216	03/03/2016	10/07/2016	No	Part-Time	Contract Physician	Family Planning services	0	7
Country Doctor After Hours Clinic	550 16th Ave		Seattle	UNITED STATES	Washington	98122	06/07/2014	12/07/2014	No	Part-Time	Urgent Care Physician	Urgent medical care for majority underserved patients. Helped guide this facility in its first year open such that it could serve as referral source for new patients to its parent FQHC	0	6

Fingerprint Background Check

This profession requires a fingerprint criminal background check.

1. Further instructions on how to complete this requirement can be found **here**.
2. Fingerprints must be taken within 60 days from the date that the application is submitted.
3. A list of licensed Illinois Fingerprint Vendors can be found **here**.

40. Were your fingerprints taken by a licensed *Illinois Fingerprint Vendor* or were they taken by an *Out-of-State Entity*?

Fingerprints not yet completed

Record of Licensure

44. Please list all other related or non-related professional licenses held in Illinois or another state(s).

Please be sure to list all temporary, trainee or apprenticeship licenses or permits.

License Type	License Status	License Number	City	State (If foreign country, select UNKNOWN)	Country
WA State Physician & Surgeon License	Active	MD60359609	Olympia	Washington	UNITED STATES
NJ State Medical Doctor License	Active	25MA10601400	Trenton	New Jersey	UNITED STATES
KS Medical License	Inactive	0440305	Topeka	Kansas	UNITED STATES
FL Medical License	Inactive	ME125540	Tallahassee	Florida	UNITED STATES

Proof of Out-of-State Licensure

45. If you are applying for licensure via *Endorsement* you must submit license certifications from your state of *original licensure* and *current licensure*.

You may do this by uploading either

1. **A License Certification (CT) Form Completed in the State of Licensure OR**
   - **A CT Form can be access Here**
2. **A State Agency or State Board's Official Certification**

State (If foreign, select Unknown)	State of Original Licensure?	My state of licensure	Upload a copy of your license certification
Washington	Yes	Only provides license certifications online	
New Jersey	No	Only provides license certifications online	

CCA

Applicants are not obligated to disclose sealed or expunged records of a conviction or arrest.

46. Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act as a part of a criminal sentence?
No

47. 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?
No

48. Are you currently charged with or have you been convicted of a forcible felony?
No

49. If you answered yes to any of the above statements, please attach a certified copy of the court records regarding your conviction, description of the nature of the offense, date of discharge, if applicable, and a statement from the probation or parole office.

Personal History - Medical Specific pt.1

50. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity?
No

51. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated.

52. Have you ever resigned in lieu of discipline or while under investigation that could lead to any restriction, suspension, or termination by any hospital or health care entity?
No

53. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated.

54. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended? You must answer yes if any of these actions are currently pending or if you have withdrawn or failed to proceed with an application for privileges/memberships.
No

55. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated AND request the hospital or health care facility to submit a report directly to the Department regarding the action.

56. Has your provider status ever been restricted, suspended or terminated by any insurance carrier, including but not limited to Medicare, Medicaid, Tricare or any private carrier?
No

57. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated.

Personal History - Medical Specific pt.2

58. Have you ever voluntarily surrendered a license to practice medicine in any state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee.
No

59. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department

60. Have you ever withdrawn an application for a license to practice medicine or any temporary/resident license in any other state, country, or U.S. federal jurisdiction?
No

61. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.

62. Have you ever been admonished, reprimanded, censured and/or disciplined in any way by any professional or medical society or association or committee thereof, or by any non-licensing governmental agency including but not limited to any governmental assistance agency? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Disclose any stipulation to informal disposition in response to this question.
No

63. If you answered yes to the question above, upload a signed/dated complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.

Personal History pt. 1

Applicants are not obligated to disclose sealed or expunged records of a conviction or arrest.

64. 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.
No

65. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*

66. Have you been convicted of a felony? (In general, a felony conviction by itself does not usually result in denial of licensure.)
No

67. *If yes, attach a detailed explanation or a copy of the Certificate of Relief from Disabilities by the Prisoner Review Board.*

68. Have you ever been discharged other than honorably from the armed services or from a city, county, state, or federal position?
No

69. *If yes, attach a detailed explanation.*

Personal History pt. 2

70. Have you had or do you have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition (2) alcohol or other substance abuse (3) physical disease or condition, that presently interferes with your ability to practice your profession?
■

71. *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*

72. 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?
No

73. *If yes, attach a detailed explanation.*

Child Support, Student Loan and Tax History

74. In accordance with 5 ILCS 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.

Are you more than 30 days delinquent in complying with a child support order?
No

75. *If yes, upload a detailed explanation.*

76. In accordance with 20 ILCS 2105-15(a)(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."

Have you ever been or are you currently in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State?
No

77. *If yes, upload a detailed explanation and proof of a satisfactory repayment record (if applicable).*

78. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

Are you delinquent in the filing of state taxes?
No

79. *If yes, upload a detailed explanation.*

Certifying Statements

80. I attest that I will respond to the Division's requests for supplemental information.
Yes

81. I understand that the fees for this application are not refundable.
Yes

82. By entering my full legal name and today's date in the fields below I certify and attest under penalty of perjury that the information provided to the Department in this application is true and accurate to the best of my knowledge.
Jamie M Phifer

83. Today's Date
05/22/2019

Review