APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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

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

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

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

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

PART I: Application Category Information

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

1. PROFESSION NAME -	2. PROFESSION CODE	3. LICENSURE METHOD -	4. FEE
Temporary Physician Extension	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 Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
Lappen	Justin	Boss	MD	[redacted]

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

[redacted]

5. BUSINESS ADDRESS STREET: Prentice Women's Hospital, 250 E. Superior St, Suite 05-2147 | CITY: Chicago | STATE/COUNTRY: IL | ZIP CODE: 60611 | COUNTY: Cook

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

7. MOTHER'S MAIDEN NAME: [redacted]

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

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

10. AGE: 28 ☐ Female ☒ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (3 1 2) 4 7 2 -- 4 6 7 3 (Area Code)

Home: [redacted] (Area Code)

Fax: ( ) (Area Code)

Fax: ( ) (Area Code)

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

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI): Lappen, Justin, R

SS#: [redacted]

Profession: Temporary Physician Extension

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
Hempfield Area High School	Greensburg, PA	05 / 1 9 9 8 (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
Columbia University	New York City, NY	08/98	05/02	BA – Mathematics
Johns Hopkins University School of Medicine	Baltimore, MD	08/02	05/06	MD

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
Northwestern University	Chicago IL	06/06	current	☐ Yes ☒ No will complete in 06/2010
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Lappen, Justin R

SS#: [redacted]

Profession: Temporary Physician's Extension

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	Temporary Physician License	125053?0	6/19/06	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 (Passed, Failed, Absent)
USMLE - Skp 1	NH	08/2004	[redacted]
USMLE - Skp 2 CK	MD	02/2006	
USMLE - Skp 2 CS	PA	02/2006	
USMLE - Skp 3	IL	03/2007	

(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 been convicted of a felony?		X
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.*		X
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.*	[redacted]	
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.*		X
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.*		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: [ ][ ]

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

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

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☒
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☒

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted] Signature of Applicant

01/12/2009 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.

NAME (Last, First, MI): Lapper, Justin, R.

SS#: [redacted]

Profession: Temporary Provision Optometrist

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.

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 Financial and 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: Lappen; FIRST: Justin; MIDDLE: Ross

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 Extension — Profession Name: 125 — Profession Code

6. MAIDEN OR GIVEN SURNAME:

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

A. HOSPITAL/INSTITUTION NAME: Northwestern University - McGaw Medical center

B. BEGINNING DATE: 06 / 19 / 2009 (Month / Day / Year)

C. ENDING DATE: 06 / 30 / 2010 (Month / Day / Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: 250 E. Superior St, Suite 05-2177, Chicago IL 60611

E. SPECIALTY / RESIDENCY NAME: Obstetrics and Gynecology

F. BUSINESS TELEPHONE NUMBER: Area Code (312) 472-4673

G. YEAR OF POSTGRADUATE TRAINING: 3

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 Financial and Professional Regulation, the applicant is found to be eligible for licensure.

SEAL

[redacted]
Signature of Program Director

Nagdy MiLAD
Print Name of Program Director

Program Director
Title

1/16/09
Date

IL486-0272 08/04 (MD)

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

FEBRUARY 10, 2009

JUSTIN ROSS LAPPEN MD
DEPT OF GME

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 06/19/2009. Assuming you remain in the training program listed below, this license will be valid until 06/18/2010.

PROGRAM: Obstetrics & Gynecology
TRAINING FACILITY: MCGAW MED CTR NORTHWESTERN

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 of 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 transferred 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 the 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's Springfield address indicated below.

Sandra Dunn, Manager
Medical Unit

Northwestern University
Feinberg School of Medicine

Division of Graduate Medical Education
Department of Obstetrics and Gynecology
Prentice Women's Hospital
and Maternity Center
250 East Superior Street, Suite 05-2177
Chicago, Illinois 60611

Magdy P. Milad, MD, MS
Division Head
Professor

mmilad@nmh.org
Phone 312-472-4673
Fax 312-472-4687

NORTHWESTERN
UNIVERSITY

January 16, 2009

Illinois Department of Professional Regulation
3rd Floor Medical Unit #1
320 West Washington Street
Springfield, IL 62786

RE: Justin Lappen

SS #: [redacted]
License # 125053570

To Whom It May Concern:

Dr. Justin Lappen began his residency at Northwestern McGaw Center for Graduate Medical Education on June 19, 2006 and will complete his 4-year residency on June 29, 2010.

His current license will expire on June 18, 2009. In order to complete the residency training program, she will need her current license extended from June 19, 2009 to June 29, 2010.

Please contact me should you have any questions or concerns at 312-472-4673.

Best Regards,

[redacted]

Magdy Milad, MD
Residency Program Director

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION

June 7, 2006

Justin Ross Lappen MD
[redacted]

Dear Dr. Lappen:

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 06/19/2006. Assuming you remain in the training program listed below, this license will be valid until 06/18/2009.

PROGRAM: Obstetrics & Gynecology
TRAINING FACILITY: McGaw Med Ctr Northwestern

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 Financial and Professional Regulation, Division of Professional Regulation, 320 West Washington Street, Springfield, Illinois 62786.

Sandy Dunn, Manager
Medical Unit

FC: lv3.125

01000001310 40703

APPLICATION FOR LICENSURE AND/OR EXAMINATION

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

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

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Department of Revenue for persons who are more than 30 days delinquent in child support orders, to identify persons who may have an interest in a tax penalty or interest shown in a tax penalty or by the Illinois Department of Revenue, or to other entities for verification of identification.

RECEIVED CASH SECTION APR 25 2006

LAPPEN, JUSTIN ROSS MD
0125 file# 40703 05-01-06
By: NON-EXAM ASG: tbarker
SSN: [redacted]

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
Temporary Physician Licensure	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 Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
Lappen	Justin	Ross	MD	[redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: —

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

7. MOTHER'S MAIDEN NAME: [redacted]

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

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

10. AGE: 26 ☐ Female ☒ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work ( ) — (Area Code)

~~Home~~ CELL: ([redacted]) (Area Code)

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

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI): Lappen, Justin, 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
Hempfield Area High School	Greensburg, PA	06 / 1978 (Month / Year)

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

1 2 3 (4) 5 6 7 (8) = college + medical school 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
Columbia University	New York City, NY	08/1998	05/2002	BA, Mathematics
Johns Hopkins University School of Medicine	Baltimore, MD	08/2002	05/2006	MD

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

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

NAME (Last, First, MI): Lappen, Justin, 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				
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 (Passed, Failed, Absent)
USMLE - Step I	New Hampshire	08/2004	[redacted]
USMLE - Step II CK	Maryland	02/2006	
USMLE - Step II CS	Maryland	02/2006	

(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 been convicted of a felony?		X
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.*	[redacted]	
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.*		X
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.*		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: [ ][ ]

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] 03/17/06

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.

NAME (Last, First, MI): Lappen, Justin, R.

SS#: [redacted]

Profession: Physician

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.

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 Financial and 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: Lappen, Justin Ross

2. DATE OF BIRTH [redacted] 3. SOCIAL SECURITY NUMBER

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 (Profession Name) 125 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

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

A. HOSPITAL/INSTITUTION NAME: Northwestern McGaw Medical Center

B. BEGINNING DATE: 06 / 19 / 2006 (Month / Day / Year)

C. ENDING DATE: 06 / 18 / 2009 (Month / Day / Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE: 645 N Michigan Ave Suit 1058-A Chicago IL 60611

E. SPECIALTY / RESIDENCY NAME: obstetrics & gynecology

F. BUSINESS TELEPHONE NUMBER: Area Code (312) 503-7975

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 Financial and Professional Regulation, the applicant is found to be eligible for licensure.

SEAL

[redacted]
Signature of Program Director

Magdy Milad
Print Name of Program Director

Program Director
Title

3/16/06
Date

IL486-0272 08/04 (MD)

RECEIVED
JUN 02 2006
IDPR MEDICAL UNIT

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 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 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: Lappen; FIRST: Justin; MIDDLE: R

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.
Temporary Physician Licensure (Profession Name) — 125 (Profession Code)

6. MAIDEN OR GIVEN SURNAME:

7. NAME OF INSTITUTION ATTENDED: Johns Hopkins University School of Medicine

8. DATE OF GRADUATION / COMPLETION: 05 / 25 / 2006 (Month / Day / Year)

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

5/22/2006 (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: Johns Hopkins University School of Medicine

B. ADDRESS OF INSTITUTION — STREET, CITY, STATE, ZIP CODE: 733 North Broadway, Suite 147, Baltimore, MD 21205

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

From 09/03/2002 (Month/Day/Year) To 06/11/2003
From 09/03/2003 To 05/28/2004
From 08/31/2004 To 05/27/2005
From 08/30/2005 To 05/24/2006
From ___/___/_____ To ___/___/_____
From ___/___/_____ To ___/___/_____

D. Total academic years attended: 4 Years / ____ Months / ____ Days
OR
Total calendar years attended: ____ Years / ____ Months / ____ Days

E. TYPE OF DEGREE OR CERTIFICATE AWARDED: Doctor of Medicine

F. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET: 05 / 24 / 2006 (Month / Day / Year)

G. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED: 05 / 25 / 2006 (Month / Day / Year)

H. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

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

[X] Applicant will graduate on 05 / 25 / 2006 (Month / Day / Year)

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

[X] Applicant will complete program on 05 / 24 / 2006 (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): Lappin, Justin, R.

SS#: [redacted]

Profession:

WHEN THIS FORM IS CERTIFIED PRIOR TO THE ACTUAL GRADUATION OF THE APPLICANT, THE SCHOOL OFFICIAL IS RESPONSIBLE FOR NOTIFYING THE DEPARTMENT OF FINANCIAL AND 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

SCHOOL SEAL

Mary E. Foy

Print Name of School Official

Associate Dean/Registrar

Title

5/23/06

Date

RETURN THIS FORM TO APPLICANT

JOHNS HOPKINS
UNIVERSITY

School of Medicine

Suite 147
Broadway Research Building
733 N. Broadway
Baltimore MD 21205-2196
410-955-3080 / Fax 410-955-0826

Office of the Dean / Registrar

May 23, 2006

Illinois Department of Professional Regulation
320 West Washington, MED 1, 3rd Floor
Springfield, IL 62786

Dear Sir or Madam:

At the request of Justin Ross Lappen, I have completed the appropriate portion of the application for licensure in the State of Illinois.

Also enclosed is an official transcript of his record in The Johns Hopkins University School of Medicine.

Sincerely,

[redacted]

Mary E. Foy
Associate Dean/Registrar

MEF\we
Enc

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: Lappen — FIRST: Justin — MIDDLE: Ross

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.
Temporary Physician Licensure — Profession Name
1 2 5 — Profession Code

6. MAIDEN OR GIVEN SURNAME

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

8. DATE FORM COMPLETED: 03/17/2006

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

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)

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)

NORTHWESTERN

MCGAW Center for Graduate Medical Education

January 27, 2009

Illinois Department of Professional Regulation
3rd Floor Medical Unit#1
320 W. Washington Street
Springfield, IL 62786

RE: Justin Lappen, MD
SS# [redacted]

Dear Director:

Dr. Justin Lappen is requesting an Extension of Temporary License with the State of Illinois.
Enclosed you will find the following documents to process her request.

- Complete application
- Letter for program
- Check – 100.00
- CA-Med

If you have any questions or need additional information, please feel free to call me at 1-312-503-4748.

Sincerely,

[redacted]

Andre'a Robinson
Visa/Licensing Coordinator
Graduate Medical Education

Office of Graduate Medical Education
645 North Michigan Avenue, Suite 1058-A
Chicago, Illinois 60611
Tel: (312) 503-7975
Fax: (312) 503-5230

Profession: **125**

Date: **5/22/06**

Initials: **tr**

DEFICIENCY NOTICE FOR TEMPORARY PHYSICIAN LICENSURE APPLICATION

TO:

McGaw Medical Center/Northwestern

Obstetrics-Gynecology

RE: Justin Lappen, M.D.

Return this form with the requested materials to:

Dept of Financial & Professional Regulation
Division of Professional Regulation
320 West Washington Street, MED 1
Springfield, Illinois 62786

Technical Assistance 217-782-8556

	1	Submit required fee of $_____ made payable to the Dept of Financial & Professional Regulation. This fee is not refundable.		14	Submit **AF-MED** form completed in its entirety.
	2	Application is being returned for completion of Part_____.		15	Submit **ED-NON** form completed in its entirety.
	3	Submit certificate of acceptance for specialty/residency program (**CA-MED** form) completed in its entirety.		16	Part F of **ED-NON** form verifies completion of 2 weeks of Psychiatry core rotation. Illinois requires completion of 4 weeks within each core clerkship rotation. Submit psychiatry affidavit or advise the Department in writing if unable to complete affidavit.
X	4	Johns Hopkins University must submit certification of education (**ED-MED** form) completed in its entirety.			
	5	Submit proof of current E.C.F.M.G. certification.		17	Submit copy of affiliation agreement along with copy of core rotation evaluation form.
	6	Submit proof of Social Service or Fifth Pathway.		18	Submit a list of work experience from _____ to _____ on Supporting Document **WH**. List complete dates (month/day/year) with no gap in time over 30 days.
	7	Submit official premedical transcript with school seal affixed verifying 2 academic years of education.			
	8	Submit official medical transcript with school seal affixed.		19	Submit certification of original licensure (Supporting Document **CT**) from _____.
	9	Submit copy of medical diploma.		20	Submit certification of current licensure (Supporting Document **CT**) from _____.
	10	Submit proof of Titulo or Acta.		21	Submit proof of professional capacity. See copy of attached instructions for specific information that must be submitted.
	11	All documents in a foreign language must be accompanied by an original, notarized translation. Translations must be by a person other than yourself who is fluent in both English and the language of the document.		22	Submit documentation due to affirmative response to Personal History Question #__ of the application.
	12	Affidavits, (**ED-AFF** forms) must be completed in accordance with DPR policy. Copy of policy attached.		23	The Department is returning all original documents.
	13	Submit proof of name change from _____ to _____.		24	The Medical Licensing Board will review your qualifications when your application is complete.

Other Instructions: