

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 <u>Physician</u>	2. PROFESSION CODE <u>0 3 6</u>	3. LICENSURE METHOD <u>Acceptance of Examination</u>	4. FEE <u>\$ 300</u>
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B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> This is the first time I have made application for this profession in Illinois. | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements. |
| <input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying. | <input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language. |
| <input type="checkbox"/> Other: _____ | |

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 <u>ZITE NIKKI BETH</u>	2. TITLE (e.g., M.D., D.D.S., etc.) <u>M.D.</u>	3. UNITED STATES SOCIAL SECURITY NO. [REDACTED]
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4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY [REDACTED] _____ <u>COOK</u>	ZIP CODE COUNTY
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5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY <u>853 Jefferson Memphis TN</u>	ZIP CODE COUNTY <u>38103 Shelby</u>
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6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)

7. PLACE OF BIRTH CITY STATE/COUNTRY [REDACTED]	8. DATE OF BIRTH Month Day Year [REDACTED]	9. AGE <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male
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10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (901) 448-5495
(Area Code)

Home: ([REDACTED])
(Area Code)

NAME (Last, First, MI):

2 ITE, NIKKI B

SS#:

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: Niles North High School

3. LAST PRELIMINARY SCHOOL LOCATION (City and State): Skokie, IL

4. DATE OF GRADUATION: 05/19/90
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		TYPE OF DEGREE EARNED
		FROM	TO	
University of Illinois	Champaign, IL	8/90	5/94	B.S.
University of East Anglia	Norwich, England	10/92	6/93	none
Northwestern University medical school	chicago, IL	8/94	6/98	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		Did You Complete Training?
		FROM	TO	
University of Tennessee OB/GYN Residency	Memphis, TN	6/98	6/2002	scheduled <input type="checkbox"/> Yes <input type="checkbox"/> No 6/2002
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

NAME (Last, First, MI): ZITE, NIKKI B.
 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	N/A			
State of Current Licensure where you most recently have been practicing.	N/A			
Other States of Licensure	N/A			

(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	IL	6/96	(Passed, Failed, Absent)
USMLE STEP II	IL	8/97	[REDACTED]
USMLE STEP III	TN	5/99	[REDACTED]

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

NAME (Last, First, MI): ZITTE, NIKKI B.

SS#:

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 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.*

X

X

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:

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

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

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- 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?
(NOTE: If you are not subject to a child support order, answer "no.")

No Yes

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.

Signature of Applicant

2/24/2002
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.

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SUPPORTING DOCUMENT

WORK HISTORY

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 ZITE NIKKI BETH			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 036 Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME [REDACTED]			7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. <input type="checkbox"/>	8. DATE FORM COMPLETED 2/24/02
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 University of Tennessee Dept of OB/GYN		JOB TITLE Resident	
ADDRESS STREET, CITY, STATE, ZIP CODE 853 Jefferson Memphis, TN 38103		DESCRIPTION OF DUTIES PERFORMED Resident physician training in obstetrics and gynecology.	
SUPERVISOR NAME Robert L. Summitt, M.D.			
DATE OF EMPLOYMENT/ATTENDANCE From 06/19/1998 Month Day Year	HOURS WORKED PER WEEK average about 60		
To 06/30/2002 Month Day Year	TYPE OF EMPLOYMENT <input checked="" type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
TOTAL TIME WORKED (Year/Month) 4 yrs (when completed 6/2002)			

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	HOURS WORKED PER WEEK		
To ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> 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		HOURS WORKED PER WEEK	
From ___ / ___ / ___ Month Day Year			
To ___ / ___ / ___ Month Day Year		TYPE OF EMPLOYMENT	
		<input type="checkbox"/> Full-time <input type="checkbox"/> 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		HOURS WORKED PER WEEK	
From ___ / ___ / ___ Month Day Year			
To ___ / ___ / ___ Month Day Year		TYPE OF EMPLOYMENT	
		<input type="checkbox"/> Full-time <input type="checkbox"/> 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		HOURS WORKED PER WEEK	
From ___ / ___ / ___ Month Day Year			
To ___ / ___ / ___ Month Day Year		TYPE OF EMPLOYMENT	
		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
TOTAL TIME WORKED (Year/Month)			

NAME (Last, First, MI):

ZITTE, NICKY B.

SS#:

Profession:

physician

