03000008103

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, and/or any other

Lic#:
KENNEDY, SARA LYNNE
036 Cred #2823590 05/06/2008
By:ACCEPT EXAM
SSN: [redacted]

o submit with your

ocuments is differ-
, you must submit
copy of marriage
urt 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
Physician/Surgeon	0 3 6	licensure	$ 300.00

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.

RECEIVED CASHIERING
APR 30 2008
IDFPR
Div. of Professional Regulation

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.
Kennedy Sara Lynne	MD MPH	[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. [redacted] Month Day Year

10. AGE ☒ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: (312) 695-7702 (pager)
Home: [redacted]
Fax: ( ) - (Area Code)
Fax: ( ) - (Area Code)

12. PREFERRED e-MAIL [redacted]

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

NAME (Last, First, MI): Kennedy, Sara, L

SS#: [redacted]

Profession: Physician/Surgeon

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
Senior High School Grove City, PA	Grove City, PA	05 / 1995 (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
Allegheny College	Meadville, PA USA	08/95	05/99	B.S.
Penn State College of Medicine	Hershey, PA USA	07/00	05/05	M.D.
James Cook University	Townsville, Queensland, Australia	05/03	06/04	MPH

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 Memorial Hospital	Chicago, IL USA	07/05	07/09	☐ Yes ☒ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Kennedy, Sara, L.

SS#: [redacted]

Profession: Physician/Surgeon

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	Physician	125-049118	06/20/05	Active
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
usmle Step 1		06/2002	[redacted]
usmle Step 2 CK		07/2003	[redacted]
usmle Step 2 CS		01/05	
usmle Step 3		1/07	

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

NAME (Last, First, MI): Kennedy, Sara, L

SS#: [redacted]

Profession: Physician/Surgeon

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.*	[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.*		✓
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: [ ][ ]

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] 2/27/08

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.

PENNSTATE HERSHEY
College of Medicine

The Pennsylvania State University
College of Medicine
Milton S. Hershey Medical Center
Office of Medical Student Affairs, H060
500 University Drive, P.O. Box 850
Hershey, PA 17033-0850

Admissions: (717) 531-8755
Financial Aid: (717) 531-7052
Registrar: (717) 531-4105
Fax: (717) 531-6225

June 24, 2008

To Whom It May Concern:

This letter is to certify that Sara L. Kennedy, M.D., matriculated on August 14, 2000, at The Pennsylvania State College of Medicine. Dr. Kennedy completed all academic requirements and graduated on May 15, 2005, with an M.D. degree.

If further information is needed, please feel free to contact me.

Sincerely,

[redacted]

Diane E. Gill
Associate Director of Student
Affairs and Registrar

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

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

Kennedy Sara Lynne

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☒ Permanent Physician License	036
☐ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

5. SOCIAL SECURITY NUMBER

[redacted]

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION

Northwestern Memorial Hospital

ADDRESS STREET, CITY, STATE, ZIP CODE

250 E. Superior St. Chicago, IL 60611

JOB TITLE

Resident physician

DESCRIPTION OF DUTIES PERFORMED

Patient care, including outpatient clinics, rounding responsibilities, labor and delivery management of gynecology patients including performing/assisting in gynecological surgeries, management of post-operative patients, gynecology consultations, management of antepartum and postpartum patients; all under attending supervision

DATE OF EMPLOYMENT/ATTENDANCE

From 07 / 01 / 2005 (Month / Day / Year)

To 07 / 01 / 2009 (Month / Day / Year)

HOURS WORKED PER WEEK

80

TYPE OF EMPLOYMENT

☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

~~3 years~~ 2 years 10 months

B. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

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)

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
Kennedy	SARA	L.	[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.

Physician/Surgeon 036

Profession Name — Profession Code

6. MAIDEN OR GIVEN SURNAME

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)

125-049118

8. ISSUANCE DATE

06/20/05

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed 36 months of postgraduate clinical training in Northwestern McGaw Center for Graduate Medical Education

(Name of Specialty Program)

from 06/20/2005 (MM/DD/YYYY) to 06/20/2008 (MM/DD/YYYY) at the following hospital:

Hospital: Northwestern Memorial Hospital

Number and Street: 250 E. Superior Street, RM 05-2177

City, State and Zip Code: Chicago, IL 60611

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

- [x] the ACGME
- [ ] the AOA
- [ ] the CFPC, RCPSC or FMLAC (Canadian Programs)
- [ ] not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: Magdy Milad

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 06/20/08

University/Hospital SEAL

Telephone No: 312.472.4673

(If no seal, attach letter on letterhead stating no seal exists.)

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JUN 23 2008
IDPR-MEDICAL UNIT

IL486-1535 10/06 (MD)

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

June 20, 2008

Susan Irwin
Illinois Department of Professional Regulations
320 W. Washington
Springfield, IL 62786

Re: Sara Kennedy

Dear Mrs. Irwin,

Enclosed please find the TN Med form for Dr. Sara Kennedy. Please let me know if there if you need any other documents.

Sincerely,

[redacted]
Resident Program Coordinator
312-472-4673

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 6/23/2008

Initials: tb

License No: 036 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

SARA LYNNE KENNEDY MD

[redacted]

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Specialty/Residency program name (Internal Medicine, Surgery, etc.) must be listed on the TN-MED form.
Please submit new TN-MED form which indicates program name. Dept received 2 TN-MED forms and neither one of them indicates the program.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 5/20/2008

Initials: DR

License No: 036 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

SARA LYNNE KENNEDY MD
[redacted]

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Please submit new TN-MED form which indicates Specialty/Residency program name (Internal Medicine, Surgery, etc.)

Submit 8 ½ x 11 photocopy of your medical diploma/degree as transcripts do not indicate complete date of graduation.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.

Sara Kennedy

[redacted]

State of Illinois Department of Financial & Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786

Regarding: License No: 036 Attn: Medical Initials: DR

To whom it may concern:

Please find enclosed a photocopy of my medical school diploma from Penn State College of Medicine, as you informed me that the transcripts sent did not indicate the complete date of graduation. I was unable to include the 'deficiency form' with diploma as my diploma was stored at home with my parents and they have been kind enough to send a copy of it to you. Please find this letter acceptable in its absence and contact me immediately if there is any other information missing to complete my application. My TN-MED form will also be arriving to you shortly.

Thank you for your time!

Sara Kennedy MD MPH

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
Kennedy, Sara, L.	[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. Physician/Surgeon (Profession Name) 036 (Profession Code)	
6. MAIDEN OR GIVEN SURNAME		
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable) 125-049118	8. ISSUANCE DATE 06/20/05	

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed 35 months of postgraduate clinical training in Northwestern McGaw Center for Graduate Medical Education (Name of Specialty Program) Need program

from 06/20/2005 (MM/DD/YYYY) to 5/27/2008 (MM/DD/YYYY) at the following hospital:

Hospital: Northwestern Memorial Hospital

Number and Street: 250 E. Superior Street, RM 05-2177

City, State and Zip Code: Chicago, IL 60611 ok

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

- [x] the ACGME
- [ ] the AOA
- [ ] the CFPC, RCPSC or FMLAC (Canadian Programs)
- [ ] not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: Magdy Milad

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 05/27/2007

University/Hospital SEAL

Telephone No: 312.472.4673

(If no seal, attach letter on letterhead stating no seal exists.)

RECEIVED
MAY 30 2008
IDPR-MEDICAL UNIT

IL486-1535 10/06 (MD)