Interstate Medical Licensure Compact
A faster pathway to medical licensure

Letter of Qualification

Date: 5/19/2022

Name: Kimberly Therese Remski

Address: 4711 Golf Rd #920

CityStZip: Skokie, ILLINOIS, 60076

Dear Dr.: Kimberly Therese Remski

RE: Your application for IMLC Letter of Qualification

The ILLINOIS DIVISION OF PROFESSIONAL REGULATION ("Board"), on behalf of the State of Principal Licensure ("SPL") you selected, has received and reviewed your application for a Letter of Qualification ("LOQ") for licensure through the Interstate Medical Licensure Compact ("IMLC").

Based upon the information you submitted with your application, data in the Board's files regarding your licensure by the Board, verifications of your credentials, and the results of the check of national databases, the Board has determined that you are ELIGIBLE to be licensed through the IMLC. Therefore, this notice will serve as your LOQ for licensure in IMLC Member States through the IMLC, and will remain in effect for 365 days from date of issuance, set out above.

An email has been sent to you with instructions regarding how to select the IMLC Member State(s) where you wish to be licensed. After you make your selection(s) and make payment for each license, your information will be forwarded to the selected board(s) ("Member Boards") for issuance of a medical license in by each.

All medical licenses issued by Member Boards through the IMLC are full and unrestricted licenses. You will be responsible for complying with all laws and regulations pertaining to holding each license and the practice of medicine in those jurisdictions including, but not limited to, each Member Board's continuing medical education requirements. It is also your obligation to keep your SPL, the Member Boards which have licensed you, and the IMLC Commission informed of any changes in your contact information or qualifications and eligibility for licensure through the IMLC.

Authorized Signature from SPL

Type Name Emily Wenneborg
Title of Authorized SPL Office Coordinator
Date 5/19/2022

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Application for Expedited Licensure

I have read and understood the Qualifications to practice medicine in the Compact states. I attest that I am qualified and understand that pursuant to the IMLCC's rules, all fees are non-refundable. **Yes**

If you have questions please call your State of Principle License

I understand that inaccurate or missing information may be grounds for rejection of my application.

Please carefully review the Application documents before applying. **Yes**

I have reviewed the criteria to select a State of Principal License (SPL) and confirm eligibility to designate a Compact state as my SPL. **Yes**

I have a full and unrestricted license in a Compact State **Yes**

SPL __**ILLINOIS DIVISION OF PROFESSIONAL REGULATION**__ License #__**036.141615**

AND at least one of the below must APPLY (Please select all that apply)

a. Your primary residence is in the SPL (State of Principal License) Yes
b. At least 25% of your practice of medicine occurs in the SPL Yes
c. Your employer is located in the SPL Yes
d. You use the SPL as your state of residence for U.S. federal income tax purposes Yes

Please provide below information:

Residence Street address______**1725 W. North Ave Apt 202**___________

Residence City State Zip ___**Chicago**______, ___**ILLINOIS**_____, ___**60622**________

Please describe your practice and location in the SPL selected__________**I currently practice in two locations in the state of Illinois. My primary practice (60%) is at carafe health center (4711 Golf Rd #920, Skokie, IL 60076).**_____________

Please be prepared to provide documentation to the designated SPL for further verification. If you have any question please contact your SPL.

You or your employer may be asked for additional documentation about your Employment.

Name of Employer________**carafem health center**______ Employer Contact Phone__**(855) 729 - 2272**___

Employer Street address___**4711 Golf Rd #920**___

Employer City State Zip _**Skokie**__, ___**ILLINOIS**__, _**60076**_

Please provide your Tax ID # (SS#, EIN) _[redacted]_ (must be most recent return)Please be prepared to provide documentation to the designated SPL for further verification.

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Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? Yes

Medical School __**Michigan State University College of Human Medicine**__ Date of Degree Issued _**5/1/2014**_ Medical Degree Received: M.D.

Have you passed each component or step of the USMLE, or the COMLEX-USA within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes (if in question contact your SPL)?

Which licensing exam did you pass? _

Have you successfully completed graduate medical education approved by the ACGME or the AOA? Yes

Residency Program _**University of Illinois at Chicago Family Medicine**__Completion Date__**6/30/2017**__

What is the specialty of the program ___**NA**________

Do you hold specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? (Board eligibility does not qualify) Yes

Name of Specialty Board Certification _**American Board of Family Medicine**_

Lifetime _**Yes**_ If not lifetime, Expiration Date _**4/15/2027**_

Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? No

Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? No

Have you ever had a controlled substance license or permit suspended or revoked by a state or

the United States Drug Enforcement Administration? No

Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? No

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PHYSICIAN'S CORE DATA SHEET

(*Must be the physician's accurate information to avoid delay or rejection*)

Full Legal Name __**Kimberly** , __**Therese** , _**Remski** , __

Other names used (maiden, birth) ____, __, __

Residential address__**1725 W. North Ave Apt 202** , _**Chicago** , _**ILLINOIS**__, _**60622** ,

Office address _**4711 Golf Rd #920** , _**Skokie** , _**ILLINOIS** , _**60076** ,

Where do you wish to receive mail. Office

Physician's cellular or alternative telephone number _**(734) 645 - 0421**

Physician's office or practice telephone number of public record _**(855) 729 - 2272**

Date of Birth [redacted] Gender: Female

Applicants personal email address _ [redacted]

Email address delegated by applicant to receive correspondence _____

Social Security Number: __ [redacted]

Physician's National Provider Identifier Number _**1073930137**

AFFIDAVIT AND AUTHORIZATION FOR RELEASE OF INFORMATION FOR APPLICATION FOR AN IMLC LETTER OF QUALIFICATION AND MEDICAL LICENSES IN IMLC MEMBER STATES

I, _Kimberly Therese Remski_ (full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States ("Application"), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof, furnished or to be furnished with respect to my application, are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact ("Compact") and the Application, and have answered all questions contained in the Application truthfully and completely. I further acknowledge failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as potential prosecution under appropriate federal and state laws.

I hereby apply to _**ILLINOIS DIVISION OF PROFESSIONAL REGULATION**_ (state) as my State of Principal License ("SPL") for a Letter of Qualification ("LOQ") to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I authorize and request every person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, to furnish to the SPL any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the SPL, or any of its agents or representatives, to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact.

I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission ("Commission"), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, of any and all liability of every nature and kind, arising out of an investigation made by the SPL.

I also hereby apply to the Compact Member States' medical boards ("Member Boards") I have designated in this Application. Additionally, I further authorize the SPL to process and release my application for medical licensure by one or more Member Boards including, but not limited to, personally-identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind, arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application, if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a LOQ, revocation, or other disciplinary sanctions of my license(s) or permit(s) to practice medicine, in one or more Compact Member States.

Applicant Signature *Kimberly Remski*

Type Applicant's Name Kimberly Remski
Applicant's NPI 1073930137
Date 4/13/2022

CREDENTIAL STATUS HISTORY SUMMARY

Name: Kimberly Therese Remski **Date:** 7/19/2022
License: Compact Physician CDR.0001783
License Status: Active
License Status Reason: CURRENT
First Issuance date: 05/20/2022
License expiration date: 04/30/2023

This is to certify that a good faith search of our records revealed the following information:

Status	Reason	Date Changed	User
Active	CURRENT	05/26/2022	Automated
Active - Needs HPPP	ACTIVE - NEEDS HPPP	05/20/2022	Automated
Pending	PENDING CHECKLIST		Automated