Interstate Medical Licensure Compact
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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 **TEXAS MEDICAL BOARD** License # **E3654**

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 [redacted]

Residence City State Zip [redacted]

Please describe your practice and location in the SPL selected **Direct patient care at Alamo Women's Reproductive Services, LLC**
7402 John Smith Drive
San Antonio, Texas 78229

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 **Alamo Women's Reproductive Services** Employer Contact Phone **(210) 614 - 4742**

Employer Street address **7402 John Smith Drive, Suite 101**

Employer City State Zip **San Antonio**, **TEXAS**, **78229**

Please provide your Tax ID # (SS#, EIN) **140360834** (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 __**University of Texas Health Science Center San Antonio**__ Date of Degree Issued _**6/3/1972**_ 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)? Yes

Which licensing exam did you pass? __**NBME**_

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

Residency Program _**U of Texas Health Science Center San Antonio**__Completion Date__**6/30/1976**__

What is the specialty of the program ___**Ob-Gyn**_____

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 Obstetrics and Gynecology**_

Lifetime _**Yes**_ If not lifetime, Expiration Date __

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 __**Alan** _, __**R** _, _**Braid** _, __

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

Residential address__[redacted] _[redacted]__, _[redacted] __, [redacted]_,

Office address _**6136 E 32nd Place** _, _**Tulsa** _, _**TEXAS** _, _**74135** _, [redacted]

Where do you wish to receive mail. Residential

Physician's cellular or alternative telephone number [redacted]

Physician's office or practice telephone number of public record [redacted]

Date of Birth [redacted]_ Gender: Male

Applicants personal email address _[redacted]

Email address delegated by applicant to receive correspondence _[redacted]__

Social Security Number: [redacted]

Physician's National Provider Identifier Number _**1205810447**_

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

I, _Alan_R_Braid__ (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 _**TEXAS MEDICAL BOARD**_ (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 [redacted]

Type Applicant's Name Alan R Braid, M.D.
Applicant's NPI 1205810447
Date 6/6/2022

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MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Alan R Braid

First Middle Last

Please fill in your respective Member Board's information for the qualified Physician named above.

National Provider Identifier Number 1205810447

Medical Board Name ILLINOIS DIVISION OF PROFESSIONAL REGULATION

Member Board License Number 036.161055

Date License Issued 6/27/2022
mm/dd/yyyy

Date of Expiration 7/31/2023
mm/dd/yyyy

Member Board Signature [redacted]

Name Karen S Schlindwein
Date 6/27/2022