Application - LICENSED PHYSICIAN AND SURGEON

Name	Montida Fleming
Credential	LICENSED PHYSICIAN AND SURGEON

Fee Details

INITIAL APPLICATION FEE	$ 500.00
	$ 500.00

Licensed Physician Application Instructions

- **Applicants may apply to become a Licensed Physician on the basis of Acceptance of Examination or Endorsement.**
- **The licensure fee is $500 and is non-refundable. Payment may be made by eCheck or credit card. License applications are valid for 3 years from the date of receipt by the Department.**
- **Acceptance of Examination: Applicant has passed a National Exam, referred to by Illinois statute AND meets Illinois requirements in effect at the time of application. Applicant is not currently licensed to practice medicine in another state.**
- **Endorsement: Applicant is currently licensed to practice medicine in another state. Requirements to receive original physician license in other state were substantially equivalent to Illinois licensure requirements in effect when original physician license was issued.**

Military Status

1. Check the box indicating the appropriate information regarding your application.

Military means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application.

NON-MILITARY

2. Please upload proof of your, or your spouse's, military status.

The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal.

Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

Application Method

3. Please select your desired application method.

Endorsement

Authorization for Third-Party Contact

4. I would like to authorize a person/business other than myself or my business to communicate with the IDFPR regarding my application for licensure.

Yes

Third-Party Contact Information

5. Name of Person/Business:

Jon Itskov

6. Phone Number:

[redacted]

7. Email Address:

[redacted]

8. I hereby authorize the following person/business to communicate with the Division regarding my application for initial licensure. I understand that information received from the person or business listed below shall be binding and that I will be responsible for the accuracy of all information and documents received as part of my application for initial licensure. This authorization shall expire upon issuance of the license, referral to enforcement or expiration of the application.

Yes

Public and Mailing Addresses

9. Please verify or enter your Public Address:

Address Line 1	[redacted]
Address Line 2	[redacted]
City	[redacted]
State	[redacted]
Zip Code	[redacted]
County	
Country	UNITED STATES
Phone	[redacted]
Cell Phone	

10. Please verify or enter your Mailing Address:

Address Line 1	[redacted]
Address Line 2	[redacted]
City	[redacted]
State	[redacted]
Zip Code	[redacted]
County	
Country	UNITED STATES

Phone [redacted]

Cell Phone

Personal Information

13. Birth City:
Evanston

14. Birth State *(if foreign born choose UNKNOWN)*:
Illinois

15. Birth Country
UNITED STATES

16. Gender:
Female

17. Which ethnicity best describes you?
Asian

Date of Birth

18. Date of Birth
[redacted]

Name Change

19. Do any of your supporting documents have a different name than your current legal name?
Yes

20. If you answered *"Yes"* to the question above, please add proof of your name change in the grid below:

Previous Name on Document(s)	From	To	Supporting Document Type	Supporting Document Upload	Name Change Reason(s)
Montida Supanya Fleming	01/27/1989	07/13/2019	Copy of Marriage Certificate	**mai fleming Marriage License.pdf**	Marriage

FCVS Physician Information Profile

21.

IDFPR accepts Physician Information Profiles compiled by the Federation Credentials Verification Service (FCVS). Will you be using the FCVS to verify your credentials?

If so, please contact FCVS to send your Physician Information Profile to IDFPR. This will include verification of the following:

- **Medical School Transcripts and Diploma**
- **ECFMG Certification**
- **Physician Exam**
- **Postgraduate Clinical Training**

Yes

Education Location

22. Were you educated in the U.S. or one of its Territories or were you Foreign Educated?
U.S. or one of its Territories

Education Information

23. Please list information on your primary school education in the grid below:

Primary School Type (High School, or GED)	School Name	City	State (If foreign, select Unknown)	Country	Date Graduated
Graduated	Grayslake Central High School	Grayslake	Illinois	UNITED STATES	06/01/2007

24. Please list information on your undergraduate, graduate and vocational training degree(s) earned in the grid below:

College, University, or Training School	City	State (If foreign, select Unknown)	Country	Attendance: From	Attendance: To	Degree Major	Degree Earned	Graduated?
New York University	New York	New York	UNITED STATES	08/01/2007	06/01/2011		B.A.	Graduated

Proof of Pre-Medical Education

25. How will you deliver your proof of education to IDFPR?
My school will mail or electronically transmit my official transcripts directly to IDFPR.

26.

Please upload an official transcript verifying completion of at least two academic years of instruction in a college, university, or other institution.

The transcript must bear the official seal and signature of the institution.

Note: If you graduated from a 6-year medical program, please proceed to question 24 to upload your official transcript.

Medical School Location

27.

Did you graduate from a medical or osteopathic college located in the United States/Canada or in another foreign country?
United States/Canada

28. If another country, please specify where.

Verification of Professional Capacity

34.

Have you been actively engaged in the practice of medicine or been a student engaged in a formal program during the 2 years immediately preceding today's date?
Yes

35.

If you answered No, you must submit evidence to establish your present capacity to practice medicine with reasonable judgement, skill, and safety. The following may be considered as evidence of your present capacity: specialized training or education, publications of original work in learned medical journals, public clinical research, federal clinical research, or other professional clinical activities related to the practice of medicine. Please upload a detailed statement which clearly identifies each activity specified above that you are claiming to meet the professional capacity requirement. The statement must be signed and dated. Also provide official documentation that verifies completion of each activity.

Physician Verification of Employment/Experience

36.

Please record your work history chronologically for the five (5) years preceding the date of application, starting with present employment. For each position held, please provide complete information including the name of each practice/work location along with the address where patient care was provided, your dates of employment, job title, description of duties performed, and time employed.

Name of Practice/Work Location	Employer Address	Employer Address	Employer City	Employer Country	Employer State	Employer Zip	Dates of Employment - Start Date	Dates of Employment - End Date	Currently Employed	Were you a full-time employee or a part-time employee?	Please state your job title at the time of your employment.	Please provide a description of the duties you performed during your employment.	Total Number of Years Employed	Months Employed
UCSF at San Francisco General Hospital	1001 Portero Ave		San Francisco	UNITED STATES	California	94110	10/15/2019		Yes	Part-Time	Staff Physician	Conduct patient visits; teach and provide clinical supervision for family medicine residents	0	10
Whole Woman's Health	4100 Duval Rd		Austin	UNITED STATES	Texas	78759	12/03/2019		Yes	Part-Time	Independent Contractor, Physician	Provide medication and aspiration abortion	0	7
Plume	150 Pearl St.	Apt 324	Oakland	UNITED STATES	California	94611	06/18/2020		Yes	Part-Time	Telehealth Provider	Provide gender affirming hormone therapy to transgender and gender expansive communities on a telehealth platform focused on expanding access to care through reducing barriers.	0	1
University Health Services, Tang Center - UC Berkeley	2222 Bancroft Way		Berkeley	UNITED STATES	California	94720	12/17/2019		Yes	Part-Time	Physician	Conduct urgent and primary care visits and sexual and reproductive health, behavioral health, and personal safety screenings	0	7

Fingerprint Background Check

This profession requires a fingerprint criminal background check.

1. Further instructions on how to complete this requirement can be found **here**.
2. Fingerprints must be taken within 60 days from the date that the application is submitted.
3. A list of licensed Illinois Fingerprint Vendors can be found **here**.

42. Were your fingerprints taken by a licensed *Illinois Fingerprint Vendor* or were they taken by an *Out-of-State Entity*?
Fingerprints not yet completed

Record of Licensure

46. Please list all other related or non-related professional licenses held in Illinois or another state(s).

Please be sure to list all temporary, trainee or apprenticeship licenses or permits.

License Type	License Status	License Number	City	State (If foreign country, select UNKNOWN)	Country
Doctor of Medicine	Active	S3072	Austin	Texas	UNITED STATES
Doctor of Medicine	Active	A-152800	San Francisco	California	UNITED STATES
Trainee	Inactive	BP10065823	Austin	Texas	UNITED STATES

Proof of Out-of-State Licensure

47. If you are applying for licensure via *Endorsement* you must submit license certifications from your state of *original licensure* and *current licensure.*

You may do this by uploading either:

1. **A License Certification (CT) Form Completed in the State of Licensure OR**
   - **A CT Form can be access Here**
2. **A State Agency or State Board's Official Certification**

State (If foreign, select Unknown)	State of Original Licensure?	My state of licensure:	Upload a copy of your license certification
California	Yes	Only provides license certifications online	

CCA

Applicants are not obligated to disclose sealed or expunged records of a conviction or arrest.

48. Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act as a part of a criminal sentence?
No

49. Are you currently charged with or have you been convicted of a criminal battery against any patient in the course of patient care or treatment, including any offense based on sexual conduct or sexual penetration?
No

50. Are you currently charged with or have you been convicted of a forcible felony?
No

51. If you answered yes to any of the above statements, please attach a certified copy of the court records regarding your conviction, description of the nature of the offense, date of discharge, if applicable, and a statement from the probation or parole office.

Personal History - Medical Specific pt.1

52. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity?
No

53. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated.

54. Have you ever resigned in lieu of discipline or while under investigation that could lead to any restriction, suspension, or termination by any hospital or health care entity?
No

55. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated.

56. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended? You must answer yes if any of these actions are currently pending or if you have withdrawn or failed to proceed with an application for privileges/memberships.
No

57. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated AND request the hospital or health care facility to submit a report directly to the Department regarding the action.

58. Has your provider status ever been restricted, suspended or terminated by any insurance carrier, including but not limited to Medicare, Medicaid, Tricare or any private carrier?
No

59. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated.

Personal History - Medical Specific pt.2

60. Have you ever voluntarily surrendered a license to practice medicine in any state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee.
No

61. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department

62. Have you ever withdrawn an application for a license to practice medicine or any temporary/resident license in any other state, country, or U.S. federal jurisdiction?
No

63. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.

64. Have you ever been admonished, reprimanded, censured and/or disciplined in any way by any professional or medical society or association or committee thereof, or by any non-licensing governmental agency including but not limited to any governmental assistance agency? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Disclose any stipulation to informal disposition in response to this question.
No

65. If you answered yes to the question above, upload a signed/dated complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.

Personal History pt. 1

Applicants are not obligated to disclose sealed or expunged records of a conviction or arrest.

66. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.
No

67. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*

68. Have you been convicted of a felony? (In general, a felony conviction by itself does not usually result in denial of licensure.)
No

69. *If yes, attach a detailed explanation or a copy of the Certificate of Relief from Disabilities by the Prisoner Review Board.*

70. Have you ever been discharged other than honorably from the armed services or from a city, county, state, or federal position?
No

71. *If yes, attach a detailed explanation.*

Personal History pt. 2

[redacted]

Child Support and Tax History

76. In accordance with 5 ILCS 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.

Are you more than 30 days delinquent in complying with a child support order?
No

77. *If yes, upload a detailed explanation.*

78. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

Are you delinquent in the filing of state taxes?
No

79. *If yes, upload a detailed explanation.*

Certifying Statements

80. I attest that I will respond to the Division's requests for supplemental information.
Yes

81. I understand that the fees for this application are not refundable.
Yes

82. By entering my full legal name and today's date in the fields below I certify and attest under penalty of perjury that the information provided to the Department in this application is true and accurate to the best of my knowledge.
Montida Fleming

83. Today's Date
07/31/2020

Review