Lic#: 336.114215
BAUM, MARGARET ELIZABETH [redacted]

RECEIVED
HASH SECTION
AUG 17 2020
IDFPR
Division of Professional Regulation

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant deceptive or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

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

1. PROFESSION NAME	2. PROFESSION CODE - Check applicable box		3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist	☐346 Optometrist	Registration	$5
	☐316 Podiatrist	☐390 Veterinarian		
	☒336 Physician	☐377 APRN-FPA		

PART II: Applicant Identifying Information

1. NAME — LAST: BAUM; FIRST: MARGARET; MIDDLE: ELIZABETH

2. TITLE (e.g., M.D., O.D., etc.): MD

[redacted]

[redacted]

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES REGISTRATION IS TO BE ISSUED

Hope Clinic for Women
1002 21st Street Granite City, IL 62040

6. EMAIL ADDRESS (REQUIRED) [redacted]

7. If you will ***not*** be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

☐ I will ***not*** be storing or dispensing controlled substances, including samples.

8. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

9. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY [redacted]

PART III: Drug Schedule

Circle the schedules for which you are applying:

II III IV V

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 -
☐	Optometrist	046 -
☒	Physician	036 - 139616
☐	Podiatrist	016 -
☐	Veterinarian	090 -
☐	APN-FP	277 -

PART V: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. 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. *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.*		X
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		X
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.		X
4. Do you now have any disease or condition that presently limits 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? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		X
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.		X
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.		X
7. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		

PART VI: Child Support 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.")

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

8/24/20
Date of Application

[redacted]
Signature of Applicant

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.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

NAME (Last, First, MI): Baum, Mavaver E
SS#: 492-90-2575
Profession: physician

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.

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME — LAST: Baum — FIRST: Margaret — MIDDLE: Elizabeth

3. PROFESSIONAL LICENSE NUMBER (if any): 036-139616

[redacted]

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturists
- ☐ Advanced Practice Registered Nurses
- ☐ Advanced Practice Registered Nurse - Full Practice Authority
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Medication Aide
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☒ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☒
2) 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?	☐	☒
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☒
4) Are you currently charged with or have you been convicted of a forcible felony? *	☐	☒

*If **YES** to any of the above, 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.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information [redacted] ct, and complete.

[redacted]

6/24/20
Date

RECEIVED
CASH SECTION
DEC 07 2015
IDFPR
Div. of Professional Regulation

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 2[illegible] Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to do so 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, 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 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	0 3 6	Endorsement	$ 700.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [X] 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.

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.)
Baum	Margaret	Elizabeth	M.D.

4. [redacted] COUNTY

5. [redacted] COUNTY

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE) [redacted]

8. PLACE OF [redacted]

40 [X] Female [ ] Male

11. [redacted]

12. PREFERRED e-MAIL ADDRESS(ES) [If available] [redacted]

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

NAME (Last, First, MI): Baum, Margaret E

SS [redacted]

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? [X] 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
Webster Groves High School	St. Louis, MO	06 / 1993 (Month / Year)

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 (8) Graduated? [X] 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
Saint Louis University	St. Louis, MO	6/93	5/97	BA, BA
Johns Hopkins University School of Medicine	Baltimore, MD	8/97	6/01	MD

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?
University of Texas Southwestern	Dallas, TX	6/01	6/02	[X] Yes [ ] No
Washington University School of Medicine	St. Louis, MO	6/02	6/05	[X] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No

NAME (Last, First, MI): Baum, Margaret E

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: Texas	Physician	BP 100036021	6/2001	lapsed.
State of Current Licensure where you most recently have been practicing: Missouri	Physician	2004036069	6/2002	active
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 (Passed, Failed, Absent)
United States Medical Licensing Exam - Step 1	Maryland.	Sept, 1991	(Passed)
United States Medical Licensing Exam - Step 2	Maryland.	May, 2001	Passed.
United States Medical Licensing Exam - Step 3	Texas.	Feb, 2002	Passed.
Ob/Gyn Board Written Examination	Missouri	June, 2005	Passed
Ob/Gyn Board Oral Examination	Texas	Nov, 2007	Passed.

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

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. 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. *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.*		X
2. Have you been convicted of a felony?		X
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.*		X
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.*		X
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.*		X
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.*		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: ☐☐☐☐

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, [redacted] and all supporting documents submitted by me in connection therewith, an[redacted]orrect, and complete.

_____ 9/20/15
Date

I **UNDERSTAND THAT FEES** [redacted] thorizes 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.

NAME (Last, First, MI): Baum, Margaret E

SS#: [redacted]

Profession: Physician

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.

ILLINOIS DEPARTMENT OF [redacted]ANCIAL AND PROFESSIONAL REGULATION
PERSONAL HISTORY INFORMATION

SUPPORTING DOCUMENT

PH

NAME — LAST: Baum — FIRST: Margaret — MIDDLE: Elizabeth [redacted]

In order for your application to be evaluated, you must respond to each of the following questions:	YES	NO
1. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity? If yes, attach a separate sheet with complete and accurate explanation.		X
2. 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? *If yes, attach a separate sheet with complete and accurate explanation.*		X
3. 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. *If yes, attach a separate sheet with complete and accurate explanation AND request the hospital or health care facility to submit a report directly to the Department regarding the action.*		X
4. 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? If yes, attach a separate sheet with complete and accurate explanation.		X
5. 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. *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		X
6. 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? *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		X
7. 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. *If yes, attach a separate sheet with a complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.*		X

Certification Statement

Under penalties of perjur[redacted]ll supporting documents and/or information submitted by me in cor[redacted]dge, they are true, correct, and complete.

Signa[redacted] — Date: 9/20/15

IMPORTANT NOTICE: Completi[redacted] this form is necessary to accomplis[redacted] 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.

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME — LAST: Baum — FIRST: Margaret — MIDDLE: Elizabeth

3. PROFESSIONAL LICENSE NUMBER (if any) ____ - _____

2. [redacted]

[redacted]ation regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturists
- ☐ Advanced Practice Nurses
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☒ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

		Yes	No
1)	Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☒
2)	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?	☐	☒
3)	Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☒
4)	Are you currently charged with or have you been convicted of a forcible felony? *	☐	☒

*If **YES** to any of the above, 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.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in con[redacted] my knowledge, they are true, correct, and complete.

Signature of Ap[redacted]

Date 9/20/15

SAINT LOUIS UNIVERSITY

OFFICE OF THE UNIVERSITY REGISTRAR
ST. LOUIS, MISSOURI 63103

+ [redacted] of: Margaret E Baum
Date Issued:
University ID:
Social Security Number:
Date of Birth:

[redacted]

Course Level: Undergraduate

Primary Program
Honors Bachelor of Arts
College : College of Arts & Sciences
Major : English

Secondary Program(s)
Honors Bachelor of Arts
College : College of Arts & Sciences
Major : Biology

Degree Awarded Honors Bachelor of Arts 17-MAY-1997
Primary Degree
Major : English
Inst. Honors: Summa Cum Laude

Degree Awarded Honors Bachelor of Arts 17-MAY-1997
Primary Degree
Major : Biology
Inst. Honors: Summa Cum Laude

SUBJ NO.	COURSE TITLE	CRED GRD	PTS R

PRE-SYSTEM INSTITUTION SUMMARY HOURS:
Ehrs: 22.00 GPA-Hrs: 0.00 QPts: 0.00 GPA: 0.00

INSTITUTION CREDIT:

Term:	Summer 1993		
PL A 105	INTRO PHIL: ANCNT GREECE		
TH A 100	RELIGIOUS EXPERIENCE		
Term: Ehrs: 6.00 GPA-Hrs: 6.00 QPts:			
Term:	Fall 1993		
BL A 107	PRIN BIOL ADV STUDENT I		
CH A 107	GENERAL CHEM: ADVANCED I		
ENGA 322	WOMEN IN LITERATURE		
ENGA 363	19TH CENTRY AMERICAN LIT		
HR A 201	HONORS GENERAL PSYCH		
RM G 410	INTRO-INFERENTIAL STATS		
Term: Ehrs: 18.00 GPA-Hrs: 18.00 QPts:			
Term:	Spring 1994		
BL A 108	PRIN BL FOR ADV STUDENTS II		
BL A 109	LAB & RESEARCH EXPER FOR ADV S		
CH A 108	GEN CHEM-ADV STUDENT II		
CH A 208	INTRO RES METHODS CHEM		
ENGA 472	CONTEMPORARY AMERICAN NOVEL		

********** CONTINUED ON NEXT COLUM

[redacted]

SUBJ NO.	COURSE TITLE	CRED GRD	PTS R

Institution Information continued:

FPAA 141	VOICE - LOWER DV		
HS A 112	ORIGINS-MOD WORLD 1500-PRESENT		
PL A 205	ETHICS		
Term: Ehrs: 19.00 GPA-Hrs: 19.00 QPts:			
Term:	Summer 1994		
PH A 131	GENERAL PHYSICS I		
PH A 132	GENERAL PHYSICS I LAB		
PH A 133	GENERAL PHYSICS II		
PH A 134	GENERAL PHYSICS II LAB		
Term: Ehrs: 8.00 GPA-Hrs: 8.00 QPts:			
Term:	Fall 1994		
BL A 305	CELL STRUCTURE & FUNCTION		
BL A 306	CELL STRUCTURE & FUNCTION LAB		
CH A 340	PRIN-ORGANIC CHEMISTRY I		
CH A 340	LABORATORY		
ENGA 423	CHAUCER: THE CANTERBURY TALES		
ENGA 498	ADV INDEPENDENT STUDY		
FPAA 341	VOICE - UPPER DV		
FPAA 342	UNIVERSITY CHORALE		
HR A 251	APPROACHING ART:ART		
Term: Ehrs: 16.00 GPA-Hrs: 16.00 QPts:			
Term:	Spring 1995		
BL A 303	PRINCIPLES OF GENETICS		
[redacted]H A 341	PRIN-ORGANIC CHEM II		
[redacted]H A 341	LABORATORY		
[redacted]NGA 461	BRITISH LIT AFTER 1945		
[redacted]NGA 490	SR SEM:ISSUS 20THC AMER WOM WR		
[redacted]PAA 341	VOICE - UPPER DV		
[redacted]R A 481	FEMINIST PHILOSOPHY		
[redacted]erm: Ehrs: 18.00 GPA-Hrs: 18.00 QPts:			
[redacted] Term:	Fall 1995		
[redacted]L A 424	LABORATORY		
[redacted]L A 424	GENERAL AND MEDICAL ENTOMOLOGY		
[redacted]PAA 341	PRIVATE STUDY: VOICE		
[redacted]R A 241	ORIGINS OF THE MOD WRLD TO 150		
[redacted]R A 305	JOURNALISM AS LITERATURE		
[redacted]H A 444	NARRATIVE/LANGUAGE/FAITH		
[redacted]S A 197	INT W S: ART & CULTURE		
[redacted]S A 197	INT W S: THE SCIENCES		
[redacted]S A 197	INTRO WS: PHIL & THEOL		
[redacted]erm: Ehrs: 18.00 GPA-Hrs: 18.00 QPts:			

[redacted]ean's List

********** CONTINUED ON PAGE 2 **

[redacted]

ISSUED TO STUDENT
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Issued To:
Margaret Baum

[redacted]

[redacted]

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SAINT LOUIS UNIVERSITY

Office of the University Registrar
One Grand Boulevard
Saint Louis, MO 63103

Web	http://registrar.slu.edu
E-mail	registrar@slu.edu
University Registrar	314.977.2269
School of Law	314.977.3312
School of Medicine	314.977.9812
Madrid, Spain Campus	(+34) 91.554.5858 ext:246

FERPA Redisclosure Limitation: In accordance with U.S.C. 438(6)(4)(8) (The Family Educational Rights and Privacy Act of 1974) you are hereby notified that this information is provided upon the condition that you, your agents or employees, will not permit any other party access to this record without consent from the student.

Accreditation: Saint Louis University is accredited by The Higher Learning Commission. In addition, various programs, departments, colleges and schools within the University hold individual accreditation from their individual accrediting agencies.

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Hours of Credit: Credits for courses are given in terms of semester hours.

GPA: Beginning Fall 2014 the Grade Point Average (GPA) displayed is rounded, rather than truncated, with the exception of the School of Law.

Repeat Indicator: Codes under the column heading "R": "I" indicates included in Earned Hours and GPA; "E" indicates excluded from Earned Hours and GPA; "A" indicates excluded from Earned Hours, but included in GPA. Prior to fall 2015 all grades were included in the GPA; fall 2015 to the present only the latest grade is retained in the GPA. Not applicable to School of Law or Doctor of Medicine (MD).

Course Numbering System

Fall 2015 - Present

0000-0999	Developmental courses
Baccalaureate Level	
1000-1999	Introductory courses
2000-2999	Introductory / Intermediate courses
3000-3999	Intermediate / Advanced courses
4000-4999	Advanced courses
Post-Baccalaureate Level	
0000-0999	Doctor of Medicine (MD) courses
5000-5999	Post-Baccalaureate courses
6000-6999	Post-Baccalaureate courses
7000-9999	School of Law courses

Effective Fall 1976 – Summer 2015

001-099	Non-Degree
100-199	Lower-division UG / 1st & 2nd year Doctor of Medicine (MD)
200-299	Lower-division UG / 2nd year Doctor of Medicine (MD)
300-399	Upper-division UG / beginning Grad / 3rd & 4th year Doctor of Medicine (MD)
400-499	Upper-division UG / beginning Grad / 3rd & 4th year Doctor of Medicine (MD)
500-599	Graduate / Post-Baccalaureate
600-699	Graduate / Post-Baccalaureate
700-799	Master of Social Work / School of Law
800-899	Metropolitan College until Summer 1990 / Master of Social Work / School of Law
900-999	School of Law

Please see http://www.slu.edu/4digitcourses for information concerning the transition to 4-digit course numbering.

Grade Points Computed in GPA

Undergraduate and Graduate - Summer 2011 to Present

Grade	Points	
A	4.00	
A-	3.70	
B+	3.30	
B	3.00	
B-	2.70	
C+	2.30	
C	2.00	
C-	1.70	
D	1.00	
F	0.00	
AF	0.00	(Failure due to Excessive Absence)

Grade Points Computed in GPA

School of Law - Fall 1994 to Present
(Grades followed by an X are excluded from GPA)

Grade	Points	
A+	4.00	
A	4.00	
A-	3.70	
B+	3.30	
B	3.00	
B-	2.70	
C+	2.30	
C	2.00	
C-	1.70	(Fall 2007 – Present)
D	1.00	
F	0.00	

Grades Not Computed in GPA

AC	1818 Advanced College Credit
AT	Attended
AU	Audit
CR	Credit
F	Pass/No Pass grading only
I	Incomplete
IP	In Progress
N	Not Reported
NC	No Credit
NG	No Grade
NP	No Pass
NR	Not Reported by Instructor
P	Pass
S	Satisfactory
U	Unsatisfactory
W	Withdraw
WP	Withdraw – Passing
X	Failed to take the scheduled Final Exam

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Doctor of Medicine (MD) - No grade points and no GPA calculated, therefore the "PTS" and "R" columns do not apply

2011 – Present*				2002 – 2011*				1987 – 2002	
H	Honors	FP	Remediated Fail	H	Honors	IP	In Progress	H	Honors
NH	Near Honors	I	Incomplete	NH	Near Honors	D	Deferred	P	Pass
P	Pass	IP	In Progress	P	Pass	W	Withdrawal	F	Fail
F	Fail	W	Withdrawal	F	Fail	W/P	Withdrawal Passing	F/P	Remediated Fail
CR	Credit	NC	No Credit	FP	Remediated Fail	W/F	Withdrawal Failing	CR	Credit Received
				I	Incomplete	-	Course Repeated	W	Withdrawal
				* 2009-2010: 1st year Courses were Pass/Fail				WP	Withdrawal Passing
* 2010 – Present: All 1st and 2nd year Courses are Pass/Fail								WF	Withdrawal Failing

SAINT LOUIS UNIVERSITY

OFFICE OF THE UNIVERSITY REGISTRAR
ST. LOUIS, MISSOURI 63103

[redacted] of: Margaret E Baum

[redacted]

SUBJ NO.	COURSE TITLE	CRED GRD	PTS R

Institution Information continued:

Term:	Spring 1996		
BL A 101	EVOLUTIONARY BIOLOGY		
ENGA 441	CRIME/PUNSMNT-ENG NOV. 1700-18		
ENGA 460	MOD. BRITISH LIT TO 1945		
FPAA 341	PRIVATE STUDY: VOICE		
PSYA 426	PSYCHOLOGY OF WOMEN		
Term: Ehrs:	14.00 GPA-Hrs: 14.00 QPts:		
Dean's List			
Term:	Fall 1996		
BL A 306	CELL STRUCTURE & FUNCTION LAB		
BL A 441	COMPARATIVE ANIMAL PHYSIOLOGY		
ENGA 491	WORLD LITERATURE		
HR A 411	AMERICAN CULTURE SINCE WWII		
MUSA 141	PRIVATE STUDY: VOICE		
TH A 203	ARCHEOLOGY AND BIBLE		
WS A 493	GENDER AND COMMUNICATION		
Term: Ehrs:	18.00 GPA-Hrs: 18.00 QPts:		
Dean's List			
Term:	Spring 1997		
BL A 307	BIOLOGICAL CHEMISTRY		
BL A 409	PLANT ECOLOGY		
BL A 495	SENIOR RESIDENCY		
ENGA 476	AM FILM:NY SCL:SCORSES,ALLEN,L		
ENGA 495	SENIOR RESIDENCY		
HR A 495	SENIOR RESIDENCY		
MUSA 341	PRIVATE STUDY: VOICE		
WS A 485	WOMEN STUDIES:CAPSTONE		
Term: Ehrs:	14.00 GPA-Hrs: 14.00 QPts:		
Dean's List			
**********			
TOTAL INSTITUTION			
TOTAL TRANSFER			
OVERALL			
**********			

[redacted]

OPEN TRANSCRIPT
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IN A SEALED ENVELOPE
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Jay Haugen
University Registrar

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D	1.00	
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Grade Points Computed in GPA

School of Law - Fall 1994 to Present
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A	4.00	
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B	3.00	
B-	2.70	
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C	2.00	
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WP	Withdraw – Passing
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F	Fail	W	Withdrawal	F	Fail	W/P	Withdrawal Passing	F/P	Remediated Fail
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				* 2009-2010: 1st year Courses were Pass/Fail				WP	Withdrawal Passing
* 2010 – Present: All 1st and 2nd year Courses are Pass/Fail								WF	Withdrawal Failing

THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE
Baltimore, Maryland 21205

Office of the Registrar
720 Rutland Avenue

CONFIDENTIAL RECORD
If you have no further use for this record please return it to the Johns Hopkins University School of Medicine but under no circumstances to the student.

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Division of Professional Regulation

Transcript record of MARGARET ELIZABETH BAUM [redacted]

First Year 9/2/97-6/12/98		Second Year 9/1/98-5/26/99	
Organ Systems (inc. Immunology)	[redacted]	Human Pathophysiology	[redacted]
Human Anatomy (inc. Dev. Biol.)		Pathology	
Molecules and Cells		Introduction to Medicine II-Clinical Skills	
Neuroscience /Behavior Sci.		Pharmacology	
Introduction to Medicine I		Physician & Society	
Physician & Society			
Clinical Epidemiology			

Third Year 9/8/99-6/2/00

Fourth Year 9/6/00- 5/23/01

	HOURS	GRADE	ACADEMIC YEAR	QUARTER
Required Clerkships				
Surgery	[redacted]	[redacted]	1998-99	4th
Medicine			1999-00	1st
Pediatrics/Neonatology			2000-01	1st
Gynecology/Obstetrics			1999-00	2nd
Psychiatry			2000-01	3rd
Neurology			2000-01	3rd
Ophthalmology			2000-01	3rd
Emergency Medicine			1999-00	4th
Ambulatory Internal Medicine	175		2000-01	2nd
		[redacted]		
Physician & Society (3rd. yr.)			1999-00	1st-4th
Physician & Society (4th. yr.)			2000-01	1st-4th
Rational Therapeutics			2000-01	1st-4th

Grading System: See attached key

Remarks: Received the degree Doctor of Medicine on May 24, 2001.

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Transcript of record of MARG[redacted]T ELIZABETH BAUM

* = Elective graded under Honors, Pass, Fail system.
Elective grades listed without * indicates taken under High Honors, Ho[redacted], Pass, Fail system.

ELECTIVE PROGRAM	QUARTER & YEAR	HOURS
"Pediatric Research" Dept. - Pediatrics Preceptor - Dr. A. Joffe	Summer 1998	312
Subinternship in Autopsy Pathology Dept. - Pathology Preceptor - Dr. B. Crain	Summer 1999	351
Clinical Clerkship in Endocrinology - Consult Service Dept. - Medicine Preceptor - Dr. P. Ladenson	Qtr. 3 1999-00	175
Subinternship in Geriatric Medicine Dept. - Geriatrics Preceptor - Dr. M. Bellantoni	Qtr. 3 1999-00	175
Advanced Clerkship in Internal Medicine Dept. - Medicine Preceptor - Dr. G. Sack	Qtr. 4 1999-00	175
Subinternship in GYN Oncology Dept. - OB/GYN Preceptor - Dr. F. Montz	Summer 2000	175
Clinical Clerkship in Dermatology Dept. - Dermatology Preceptor - Dr. C. Martins	Summer 2000	175
Gynecological Pathology Tutorial Dept. - Pathology Preceptor - Dr. R. Kurman	Qtr. 4 2000-01	175
Elected to Alpha Omega Alpha March 2001.		
ME: 150.805: Medicine in Literature	Qtr.3 & 4 1999-00	---
ME:150.805: Medicine in Literature	Qtrs. 1 & 2 1998-98 & 1999-00	---

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JANUARY 6, 2016

[redacted]

THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE
Baltimore, Maryland 21205

Office of the Registrar
720 Rutland Avenue

Transcript record of MARGARET ELIZABETH BAUM [redacted]

STUDENT COPY

First Year 9/2/97-6/12/98

	HOURS	GRADE
Organ Systems (inc. Immunology)	255	[redacted]
Human Anatomy (inc. Dev. Biol.)	242	
Molecules and Cells	228	
Neuroscience / Behavior Sci.	191	
Introduction to Medicine I	76	
Physician & Society	76	
Clinical Epidemiology	52	

Second Year 9/1/98-5/26/99

	HOURS	GRADE
Human Pathophysiology	328	[redacted]
Pathology	237	
Introduction to Medicine II-Clinical Skills	128	
Pharmacology	85	
Physician & Society	50	

Third Year 9/8/99-6/2/00

Fourth Year 9/6/00- 5/23/01

	HOURS	GRADE	ACADEMIC YEAR	QUARTER
Required Clerkships		[redacted]		
Surgery	351		1998-99	4th
Medicine	351		1999-00	1st
Pediatrics/Neonatology	351		2000-01	1st
Gynecology/Obstetrics	234		1999-00	2nd
Psychiatry	159		2000-01	3rd
Neurology	159		2000-01	3rd
Ophthalmology	33		2000-01	3rd
Emergency Medicine	175		1999-00	4th
Ambulatory Internal Medicine	175 XXX		2000-01	2nd
Physician & Society (3rd. yr.)	39		1999-00	1st-4th
Physician & Society (4th. yr.)	39		2000-01	1st-4th
Rational Therapeutics	39		2000-01	1st-4th

Grading System: See attached key

Remarks: Received the degree Doctor of Medicine on May 24, 2001.

COPY

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Transcript of record of [redacted] ELIZABETH BAUM

* = Elective [redacted] under Honors, Pass, Fail system.
Elective grad[redacted] without * indicates taken under High Honors, Ho[redacted], Pass, Fail system.

ELECTIVE PROGRAM	QUARTER & YEAR	HOURS	GRADE
"Pediatric Research" Dept. - Pediatrics Preceptor - Dr. A. Joffe	Summer 1998	312	[redacted]
Subinternship in Autopsy Pathology Dept. - Pathology Preceptor - Dr. B. Crain	Summer 1999	351	
Clinical Clerkship in Endocrinology - Consult Service Dept. - Medicine Preceptor - Dr. P. Ladenson	Qtr. 3 1999-00	175	
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ME:150.805: Medicine in Literature	Qtrs. 1 & 2 1998-98 & 1999-00	---	

STUDENT COPY

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JOHNS HOPKINS
UNIVERSITY

School of Medicine

Suite 147
Broadway Research Building
733 N. Broadway
Baltimore MD 21205-2196
410-955-3080 / Fax 410-955-0826

Office of the Dean / Registrar

KEY TO TRANSCRIPT

MD Graduates 1981-2003

GRADING SYSTEM – Effective March 30, 1981 through March 31, 2002 (Qtr. 3, 2001-02)

Grades in required courses and basic clerkships are designated A, B, C, D, and F (fail).
(+/- modifiers used for basic clerkships for Classes of 2001, 2002 and 2003, if taken before Qtr. 3 2002)

The A grade indicates exceptional performance, the
B grade indicates good to very good performance, the
C grade indicates satisfactory performance, the
D grade indicates that minimal course requirements have been fulfilled but that the achievement was marginal (grade initiated in March, 1981), the
F grade indicates failure to attain course requirements.

Grades in elective courses are given on an Honors-Pass-Fail basis. High Honors was added to the elective course grading system for graduates in the classes of 2001 and 2002.

GRADING SYSTEM - Effective April 1, 2002 (Qtr. 4, 2001-02)

Grades in required courses and basic clerkships are designated as follows: Honors(H), High Pass(HP), Pass(P), and Fail(F).

The Honors grade is awarded if a student demonstrates outstanding performance in all components of a course with achievement beyond the expected level of training, or extraordinary effort beyond the basic requirements of the curriculum. This grade identifies those students who have been consistently outstanding in their scholarship and professionalism.

The High Pass grade is awarded if a student has demonstrated an excellent performance.

The Pass The faculty are aware of the intellectual achievement of the students and have designed a rigorous and challenging curriculum. Students who fulfill requirements at the passing level are to be congratulated for this achievement.

The Fail grade is used for students who have failed to meet the minimum performance requirements of the coursework/clerkship as defined by the course director.

Honors- Pass-Fail grading is used occasionally in a required course, when in the judgement of the course director, the available information is insufficient for the finer distinctions needed for letter grades.

An Incomplete (Inc.) is given in lieu of a grade when a student has not completed all components of a course.

Advanced Placement (AP) is awarded to students who show evidence of satisfactory knowledge of the material of a required course.

The Johns Hopkins University

Upon the recommendation of the Faculty of

THIS IS A [redacted] E
DIPLOMA A[redacted]
ON MAY 24

Mary E. F[redacted]
Assistant Dean/Registrar

The School of Medicine

has conferred upon

Margaret Elizabeth Baum

the degree of

Doctor of Medicine

with all the rights, honors and privileges appertaining thereto.
Given under the seal of the University at Baltimore, Maryland
on May twenty-fourth, two thousand and one.

[redacted]
Dean of the Medical Faculty

[redacted]

[redacted]

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: Baum — FIRST: Margaret — MIDDLE: Elizabeth

[redacted]

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

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment. Also list any breaks of six (6) months or longer in medical practice since graduation from medical school.

A. NAME OF PRACTICE / WORK LOCATION: Affinia HealthCare - Lemp

JOB TITLE: ob/gyn physician.

ADDRESS STREET, CITY, STATE, ZIP CODE: 2220 Lemp Street, St. Louis, MO 63104

DESCRIPTION OF DUTIES PERFORMED:
- see office gynecologic and obstetric patients
- obstetric deliveries
- gynecologic surgeries.

DATE OF EMPLOYMENT/ATTENDANCE
From 05 / 15 / 2005 (Month / Day / Year)
To present. (Month / Day / Year)

HOURS WORKED PER WEEK: 40

TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month): 10 years, 1 month

B. NAME OF PRACTICE / WORK LOCATION

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	3. SOCIAL SECURITY NUMBER
Baum	Margaret	Elizabeth	[redacted]	

4. [redacted]

6. MAIDEN OR GIVEN SURNAME

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

Physician — Profession Name

036 — Profession Code

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)

8. ISSUANCE DATE

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 OBSTETRICS & GYNECOLOGY
(Name of Specialty Program)

from 06/24/2002 (MM/DD/YYYY) to 06/30/2005 (MM/DD/YYYY) at the following hospital:

Hospital: Barnes-Jewish Hospital in St. Louis

Number and Street: #1 Barnes Jewish Hospital Plaza

City, State and Zip Code: St. Louis, MO 63110

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: Erich A. Strand M.D.

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 10/27/15

Telephone No: [redacted]

erhead

IL486-1535 10/

BAUM, MARGARET

Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Kathleen (Katie) Steele Danner, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
website: www.pr.mo.gov/healingarts.asp

Connie Clarkston
Executive Director

[redacted]

To:

Illinois Department of Financial & Professional Regulation Public Acco
320 W. Washington Street, 3rd Floor
Springfield, IL 62786

This is to certify that the records of the Missouri Board of Healing Arts indicate the following information regarding Margaret Elizabeth Baum, M.D..

LICENSE TYPE:	Medical Physician & Surgeon
LICENSE NUMBER:	2004036069
DATE ISSUED:	12/22/2004
STATUS:	Active
EXPIRATION DATE:	1/31/2016
DISCIPLINARY ACTION:	None

RECEIVED
OCT 06 2015
IDFPR - MEDICAL UNIT

MISSOURI BOARD OF REGISTRATION FOR THE HEALING ARTS

[redacted]
Verifications Clerk

09/30/2015
Date

This is the only form that will be used by the Missouri State Board of Registration for the Healing Arts for the purpose of license verification.

United States Medical Licensing Examination (USMLE)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Recipient:

Date: 09/22/2015

ILLINOIS DEPARTMENT OF FINANCIAL AND
PROFESSIONAL REGULATION

RECEIVED
SEP 24 2015
IDFPR - MEDICAL UNIT

Examinee: Baum, Margaret Elizabeth

Examinee ID: 50617596

Alt Name(s):

Date of Birth: 04/23/1975

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Comments
9/3/1999	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Comments
5/18/2001	

USMLE STEP 3

Test Date	Comments
2/27/2002	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

RECEIVED ELECTRONICALLY

Baum, Margaret

United States Medical Licensing Examination (USMLE)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Examinee: Baum, Margaret Elizabeth

Examinee ID: 50617596

Date of Birth: 04/23/1975

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

036 APPLICATION CHECK-LIST

FILES SET-UP IN THIS ORDER (Some exceptions) DO NOT KEEP BLANK OR DUPLICATE DOCUMENTS

APPLICATION FINDINGS

✓ Application Complete 9/20/15
Address checked ✓
✓ SSN Affidavit
✓ PH Form ✓ CCA Form
✓ Fingerprint ✓ Clear _____ HIT
_____ FCVS Profile _____ Name Change
_____ IL Temp License _____
_____ Release on File _____

POSITIVE PERSONAL HISTORY INFO

Yes # _____ ITD _____ MLB _____
Documentation:

EDUCATION DOCUMENTATION

✓ Premedical Transcripts ~~Need official / trans~~
_____ Translations
N/A Medical Transcripts Johns Hopkins V SOM
_____ Translations
Degree Date 5/24/01
✓ Copy of diploma if applicable
_____ Copy of ECFMG (IMG)
_____ Social Service (IMG)
_____ 5th Pathway, if applicable (Mexico only)
_____ ED-NON (IMG)
_____ # of months – Minimum 36 months w/premed verified; minimum 54 months if combined
Internship year _____
Basic Sciences _____
Degree Date _____
Clinical Rotations – minimum of four (4) weeks each
Internal Medicine _____
Pediatrics _____
Obstetrics-Gynecology _____
Psychiatry _____
Psychiatry Affidavit _____ if applicable
Surgery _____
____ Signed by Dean and seal affixed - cannot be certified prior to graduation

PROFESSIONAL CAPACITY

✓ VE-PC – Five (5) years from app date
✓ Been in active practice past two (2) years
✓ No breaks over 6 months
_____ Professional Capacity review required

CLINICAL TRAINING DOCUMENTATION

✓ TN-MED - 24 months* Clinical Training
US/Canada accredited ✓
Seal or Letter ✓
Completed full year(s) ✓
*(Proof of 12 months is required if **entered** program on or before 12/31/1987)

LICENSURE DOCUMENTATION

N/A CT - Original Jurisdiction of Licensure
State & Number TX TRAINING PERMIT
No discipline _____
✓ CT - Current Jurisdiction of Practice
State & Number MD 200403606 4
No Discipline ✓

EXAMINATION DOCUMENTATION

✓ Exam history –not 5 or more failures
(all exams except state constructed)
Remedial training required _____
✓ USMLE – Completed within 7 yrs of the first Step passed (either Step 1 or 2)
Waiver requested _____ (MLB Review)
FLEX _____ NBME _____
COMLEX _____ LMCC _____
State-constructed* _____
*Must have passed clinical competency exam; be American Board certified in a specialty, or request waiver
_____ Copy of certificate or verified on web site
_____ Requested waiver _____ (MLB Review)

_____ Federation Check

Texas Medical Board
MAILING ADDRESS: P.O. BOX 2029 • AUSTIN TX 78768-2029
PHONE: (512) 305-7010

State Board Verification of Postgraduate Resident Permit

December 21, 2015

ILLINOIS DIVISION OF PROFESSIONAL REGULATION
320 W WASHINGTON ST 3RD FLOOR
SPRINGFIELD, IL 62786

NAME: MARGARET ELIZABETH BAUM MD

POSTGRADUATE RESIDENT PERMIT NUMBER: BP10003621

DATES OF PERMIT:
Begin Date: 07/01/2001
Expiration Date: 06/30/2002

RECEIVED
DEC 28 2015
IDFPR - MEDICAL UNIT

PROGRAM: UNIV OF TX SOUTHWESTERN MED CTR (4 YR PROGRAM)

DISCIPLINARY ACTION: NONE

For further information, please contact Registration at (512) 305-7030.

Sincerely,

[redacted]

Cyrese Morell
Registration
Texas Medical Board

Regional Office of Education
MADISON COUNTY ROE #41

11/20/2015 12:51:15 PM

REGIONAL SUPERINTENDENT OF SCHOOLS

Robert A. Daiber Ed. D.

[redacted]

Receipt Number	39675	Date	11/20/2015	Total Items	1
Name	Margaret Baum	Pmt. Type	Cash	Receipt Total	$42.00
Rcd. By	KB				

Qty	Description	Price	Item Total
1	Fingerprinting - Public	$42.00	$42.00
	PHY		
		Receipt Total	$42.00

Regional Office of Education [redacted]

Public Fingerprinting

Location: 157 North Main Street, Suite 438 Edwardsville, IL 62025
Phone: 618-296-4530
Location Note: You will find us in the Administration Building next to the Madison County Courthouse
Hours: Monday – Friday, 8:30 – 4:00pm and break from 1:00 – 2:00 for lunch
Cost: $42.00 Cash Only

First Name	Last Name	Middle Initial
Margaret	Baum	E

Maiden Name/ Other Names Used	SSN	DOB	State of Birth
	[redacted]		

Address	City	State	Zip
[redacted]			

Gender	Race	Eye Color	Hair Color	Height	Weight
F	Caucasian	green	red	5'5"	130#

[redacted]

Applicant Verification and Authorization

I, the undersigned, hereby authorize the release of any criminal history record information that may exist regarding me from any agency organization, institution, or entity having such information on file. I authorize the Regional Office of Education in Madison County to capture and securely transmit my fingerprints to the Illinois State Police and/or Federal Bureau of Investigations for the purpose of checking my criminal history record information. I further understand that my fingerprints may be retained by the Illinois State Police and/or Federal Bureau of Investigation pursuant to applicable statute.
If your fingerprints are AFIS unacceptable and reprinting is necessary to receive results, the customer is required to pay the reprint fee.

Signature of Applicant [redacted] 11/20/15 Date

[redacted]

RECEIVED
CASH SECTION
FEB 01 2010
Div. of Professional Regulation

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

FOR OFFICIAL USE ONLY

[redacted]

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

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

1. PROFESSION NAME	2. PROFESSION CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☐346 Optometrist ☐316 Podiatrist ☐390 Veterinarian ☒336 Physician	Registration	$5

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. [redacted]
Baum	Margaret	Elizabeth	MD	

4. [redacted]

5. [redacted]

LICENSE IS TO BE ISSUED

Hope Clinic for Women
1602 21st Street Granite City, IL 62040

6. If you will ***not*** be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

☒ I will ***not*** be storing or dispensing controlled substances. including samples.

7. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

8. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY [redacted]

PART III: Drug Schedule

Circle the schedules for which you are applying:

II III IV V

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 -
☐	Optometrist	046 -
☒	Physician	036 -
☐	Podiatrist	016 -
☐	Veterinarian	090 -

PART V: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. 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. *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.*		X
2. Have you been convicted of a felony?		X
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.		X
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.		X
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.		X
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.		X
7. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		X

PART VI: 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 VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this applica[redacted]

1/27/10
Date of Application

[redacted]

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.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

NAME (Last, First, MI):

SS#:

Profession:

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.

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST: Baum FIRST: Margaret MIDDLE: Elizabeth

3. PROFESSIONAL LICENSE NUMBER (if any) [redacted]

2. ADDRESS STREET, CITY, STATE, ZIP CODE [redacted]

4. SOCIAL SECURITY NUMBER

Pu[redacted] information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturists
- ☐ Advanced Practice Nurses
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☒ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☒
2) 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?	☐	☒
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☒
4) Are you currently charged with or have you been convicted of a forcible felony? *	☐	☒

*If **YES** to any of the above, 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.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of [redacted]

Date 1/27/16