0300007004

94914 rec'd 4/05/06

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, 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.** APR 17 2005

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 t… …be provided to th… …ons who are mor… …ild support orde… …ify persons who… …rest shown in a… …penalty or inter… …by the Illinois Department of Revenue, or to other entities for verification of identification.

WHITAKER, AMY KRISTEN MD
0036 file# 94914 05-01-06
By: ENDORSEMNT ASG: troberts
SSN: 292761933

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	$ 300.00

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.)	3. UNITED STATES SOCIAL SECURITY NO.
Whitaker	Amy	Kristen	M.D.	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: [redacted]

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: [redacted]

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

7. MOTHER'S MAIDEN NAME: [redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY: [redacted]

9. DATE OF BIRTH: [redacted] Month Day Year

10. AGE: 36 [X] Female [ ] Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED: Work [redacted] Home: [redacted] (Area Code)

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): Whitaker, Amy K.

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? ☒ 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
Hoban High School	Akron, Ohio	06/1987 (Month/Year)

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

1 2 3 4 5 (6) 7 8 Graduated? ☒ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
Northwestern University	Evanston, IL	09/1987	06/1991	B.A.
Mills College	Oakland, CA	08/1994	06/1996	Post-Bacc Pre-Med Certificate

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?
Magee-Womens Hospital Ob/Gyn Residency Univ. of Pittsburgh Med Ctr	Pittsburgh, PA	06/2002	03/2006	☐ Yes ☒ No Pending Expect 6/2006
Univ. of CA, San Francisco School of Medicine	San Francisco, CA	09/1997	06/2001	☒ Yes ☐ No MD
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Whitaker, Amy K.

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 PA	Physician	MD424773	07/07/2004	Active
State of Current Licensure where you most recently have been practicing. Same				
Other States of Licensure				
N/A				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
USMLE Step 1	CA	06/99	(Pass[redacted])
USMLE Step 2	CA	03/01	
USMLE Step 3	PA	11/02	

(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 any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		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? *(NOTE: If you are not subject to a child support order, answer "no.")* Yes ☐ No ☒

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☒

PART IX: Certifying Statement

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

[redacted]cant

3/31/06
Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

NAME (Last, First, MI): Whitaker, Amy K

SS#: [redacted]

Profession: Physician

PLEASE RETURN THIS NOTICE WITH YOUR PERMANENT LICENSE APPLICATION

Illinois Department of Financial and Professional Regulation
Attn: Division of Professional Regulation
320 West Washington, Med-1
Springfield, Illinois 62786

Re: Permission to Check Status of License Application

To Whom It May Concern:

I give my permission for Mary Ann Bryant, Program Coordinator, Office of Housestaff Affairs, at the University of Chicago to inquire as to the status of my Illinois Permanent Licensure Application.

Resident Name: Amy Whitaker
Please Print

Soc. Sec. # [redacted]

Signa[redacted]

3/14/06
Date

PermitItr

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

WORK HISTORY

SUPPORTING DOCUMENT

WH

APPLICANT: Complete Work History. If you have never been employed you may stop at box 8. You are authorized to photocopy this form if additional space is required.

1. NAME — LAST: Whitaker — FIRST: Amy — MIDDLE: Kristen

2. DATE OF BIRTH [redacted] Month Day Year

3. SOCIAL SECURITY NUMBER [redacted]

4. ADDRESS STREET CITY STATE ZIP CODE [redacted]

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Physician (Profession Name) — 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: Whitaker

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☐

8. DATE FORM COMPLETED: 3/31/06

9. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS / INSTITUTION: Magee - Womens Hospital

JOB TITLE: Resident in Obstetrics and Gynecology

ADDRESS STREET, CITY, STATE, ZIP CODE: 300 Halket Street, Pittsburgh PA 15213

DESCRIPTION OF DUTIES PERFORMED: Duties of resident in ob/gyn: outpatient clinic, gynecologic surgery, labor and delivery, in-patient care.

SUPERVISOR NAME: Gabriella Gosman M.D. / Program Director

DATE OF EMPLOYMENT/ATTENDANCE
From 06/17/2002 (Month Day Year)
To 03/31/2006 (Month Day Year)

HOURS WORKED PER WEEK: 80

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

TOTAL TIME WORKED (Year/Month): 3 years, 9 months

B. NAME OF BUSINESS / INSTITUTION: Vacation + move

JOB TITLE:

ADDRESS STREET, CITY, STATE, ZIP CODE:

DESCRIPTION OF DUTIES PERFORMED:

SUPERVISOR NAME:

DATE OF EMPLOYMENT/ATTENDANCE
From 06/03/2002 (Month Day Year)
To 06/17/2002 (Month Day Year)

HOURS WORKED PER WEEK:

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

TOTAL TIME WORKED (Year/Month): 2 weeks

NAME (Last, First, MI): Whitaker, Amy K.

SS#: [redacted]

Profession: Physician

C. NAME OF BUSINESS / INSTITUTION: Center for Reproductive Health Research + Policy

JOB TITLE: Research Assistant

ADDRESS STREET, CITY, STATE, ZIP CODE: 3333 California Street, ~~Suite~~ San Francisco CA 94143

DESCRIPTION OF DUTIES PERFORMED: Coordinated, implemented and recruited for many clinical research studies. Designed and implemented my own clinical research study

SUPERVISOR NAME: Alisa Goldberg, M.D.

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 25 / 2001 (Month / Day / Year)
To 06 / 03 / 2002 (Month / Day / Year)

HOURS WORKED PER WEEK: 40

TYPE OF EMPLOYMENT: [X] Full-time [ ] Part-time

TOTAL TIME WORKED (Year/Month): 11 months

D. NAME OF BUSINESS / INSTITUTION: Vacation

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 10 / 2001 (Month / Day / Year)
To 06 / 25 / 2001 (Month / Day / Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT: [ ] Full-time [ ] Part-time

TOTAL TIME WORKED (Year/Month): 2 weeks

E. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

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)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

April 5, 2006

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	AMY KRISTEN WHITAKER
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD424773
ORIGINAL LICENSURE DATE:	07/07/2004
EXPIRATION DATE:	12/31/2006
STATUS:	Active

The license is in good standing and the records indicate no derogatory information.

SEAL

[redacted]
Commissioner
Bureau of Professional and Occupational Affairs

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

APPLICANT: ***Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.***

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
Whitaker	Amy	Kristen	[redacted]	[redacted]

4. ADDRESS, STREET, CITY, STATE, ZIP CODE: [redacted]

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

Physician (Profession Name) — 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: Whitaker

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable): N/A

8. ISSUANCE DATE:

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
320 West Washington - MED-1
Springfield, Illinois 62786

This is to certify that the above-named applicant satisfactorily completed 46 ↓ 48 → as of 6/18/06 months of postgraduate clinical training in OB/GYN
(Name of Accredited Postgraduate Clinical Training Program)

from 6/20/02 to _____ at the following hospital:

Hospital: MAGEE-WOMENS HOSPITAL OF UPMC

Number and Street: 300 HALKET STREET

City, State and Zip Code: PITTSBURGH PA 15213-3180

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

- [x] the Accreditation Council for Graduate Medical Education;
- [ ] the Accreditation Council on Canadian Graduate Medical Education; or
- [ ] the American Osteopathic Association

Name of Postgraduate Clinical Training Program Director: GABRIELLA G. GOSMAN MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 4/10/06

SEAL

Telephone No: [redacted]

IL486-1535 08/04 (MD)

US·MLE
United States
Medical
Licensing
Examination
TM

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, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date : 03/31/2006

Recipient:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
3rd Floor, Unit IV
320 W Washington Street
Springfield, IL 62786

Examinee: Whitaker, Amy
Alt Name(s): Whitaker, Amy Kristen

Examinee ID#: [redacted]
Date of Birth:

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, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/09/1999	[redacted]	[redacted]	[redacted]			

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	03/08/2001	[redacted]	[redacted]	[redacted]			

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
PENNSYLVANIA	11/14/2002	[redacted]	[redacted]	[redacted]			

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

036 APPLICATION CHECKLIST ENDORSEMENT ✓ ACCEPTANCE ___

APPLICATION FINDINGS

___Approved Program ✓6-Year
✓Application Complete
✓Personal History Yes#_____

OTHER INFORMATION/NOTES

Release: Mary Ann Bryant

DOMESTIC GRADUATES

✓Premedical Transcripts
✓Medical Transcripts
✓Diploma Date 6-10-01

FOREIGN GRADUATES

___ECFMG/5th Pathway/Social Service
___Premedical Transcripts
___Translations
___Medical Transcripts
___Translations
___Diploma Date_____
___Translation

6-Year Post Secondary Education

___AF-MED Part A
___AF-MED Part B
Evaluations: ___Med ___Ob/Gyn
___Peds ___Psych ___Surgery
Affiliations/Contracts
_____ _____ _____
_____ _____
___ED-NON _____Total Months
Core Rotations: ___Med ___Ob/Gyn
___Peds ____Psych ___Surgery

SUPPORTING DOCUMENTS

✓Work History
Professional Capacity OK ✓
✓Original Jurisdiction of Licensure PA
License State & Number MD 424773
No Discipline ✓ Active
✓Current Jurisdiction of Licensure
License State & Number same
No Discipline_____
✓Clinical Training 12 or 24 months
Seal ✓ RPD ✓ Accredited ✓
✓Acceptable Examination or Combination
___NBME ___NBOME ___FLEX
✓USMLE ___LMCC ___State-constructed
___American Board Certified
___Name Change
✓Federation Check

APPLICATION TRANSMITTAL - Physician

(This transmittal must accompany the application.)

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
Whitaker	Amy	Kristen	[redacted]	[redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

5. REFER TO BOXES A-1 AND A-2 IN PART I ON YOUR APPLICATON FOR LICENSURE/EXAMINATION.

Physician (Profession Name) — **0 3 6** (Profession Code)

In the area below, indicate whether you have enclosed the 4-page application and the other items listed below or if you have requested an item to be forwarded directly to the Department by another entity (i.e. exam scores).

Enclosed	Requested	Description
✓		4-page Application for Licensure and/or Examination
✓		Application Fee
✓		Form WH (required for all applicants)
[redacted]	N/A	FCVS Physician Profile
	✓	TN-MED Form
	N/A	ECFMG Certificate (Copy)
✓		Medical School Diploma (Copy)
	✓	Proof of Pre-Medical and Medical Education (Official transcript of grades issued by medical college or university with school seal affixed) from: ①Northwestern University ②Mills College ③Univ. of CA, San Francisco
	N/A	AF-MED
	N/A	ED-NON
	N/A	5th Pathway/Social Service
[redacted]	✓	Certification of Licensure (CT) from original and current state of licensure
[redacted]	✓	Exam Scores (Sent directly from USMLE, FLEX, National Board, LMCC or State Board)

The above Items are those documents most frequently requested. In the area below, list any other documentation you are submitting with your application that may be required for licensure.

✓		State Controlled Substance Application and fee

Remarks: _____

IL486-1914 05/02 (MD)

University of Chicago Hospitals
Office of Housestaff Affairs
5841 South Maryland, MC1052
Chicago, IL 60637
Office 773/702-6760
Fax 773/702-0861

Date: 04/14/06

Name: Whitaker, Lemy Kristen

SS#: [redacted]

LICENSE TYPE

____125 ✓ 036 ____130

✓ Application Jacket	✓ WH
____ TN-MED	____ CA-MED
____ ED-MED	____ ED-NON
✓ Diploma	____ AF-MED
____ Transcripts	____ ECFMG Certificate
✓ $300 Fee	____ $100 Fee
✓ Controlled Subs. Appl.	✓ $5 Fee
____ Addendum	✓ Other
____ Returning License	

- Physician Transmittal Sheet
- Permission slip to view License Application