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PAGE ONE

RECEIVED
CASHIER'S OFFICE
APR 24 1998
DEPARTMENT OF PROFESSIONAL REGULATION

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

0 0 1 1 0 6 3 2 2 1

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.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.

B. The licensure and application fee are NOT refundable.

C. Disclosure of Social Security number is mandatory.

D. 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.

PART I: Application Category Information

046010 90

A. SEE REFERENCE SHEET, CHART I, 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

☒ 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 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: NELSON, Erica Elizabeth

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

3. SOCIAL SECURITY NUMBER: [redacted]

4. PERMANENT ADDRESS: [redacted]

(SEE D ABOVE) ADDRESS UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED:
Nelson, Erica Elizabeth

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

8. DATE OF BIRTH: [redacted]

9. AGE: 35 ☒ Female ☐ Male

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (2 1 7) 7 8 2 5 1 1 7 (AREA CODE)

Home [redacted]

IL486-1019 12/97 (LT)

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
La Canada High School	La Canada, California	0 5 / 8 1 (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
Pomona College	Claremont, California	9/81	5/85	BA
University of Vermont College of Medicine	Burlington, VT	9/86	5/90	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 Vermont~~ Error	~~Burlington, Vermont~~	~~8/86~~	~~5/90~~	☒ Yes ☐ No
Oregon Health Sciences University	Portland, OREGON	6/90	6/95	☒ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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 Oregon	Physician	MD 17244	7/91	active
State of Current Licensure where you most recently have been practicing Oregon				
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)

(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 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
3. 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
4. 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: ☐☐

e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated? ☐ Yes ☐ No

PART VIII: Child Support Information *(This part must be completed by all applicants)*

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.**

You **MUST** check one of the following:

☐ I am not more than 30 days delinquent in complying with a child support order.

☐ I am more than 30 days delinquent in complying with a child support order.

☒ I am not currently under any child support order.

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]
Signature of Applicant

May 26, 1998
Date

My signature above authorizes the Department of 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.

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WORK HISTORY

1011063021

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: Nelson — FIRST: Erica — MIDDLE: Elizabeth

2. DATE OF BIRTH: [redacted]

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.
Profession Name: Physician
Profession Code: 0 3 6

Nelson, Erica Elizabeth

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

8. DATE FORM COMPLETED

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: Oregon Health Sciences University
ADDRESS — STREET, CITY, STATE, ZIP CODE: 3181 Sam Jackson Park Road, Portland, OR 97201-3098
SUPERVISOR NAME: Mark Nichols, M.D., Dept. ObGyn
DATE OF EMPLOYMENT/ATTENDANCE: From 07/17/95 To 07/01/98
HOURS WORKED PER WEEK: 40
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month): 3 years
JOB TITLE: Assistant Professor
DESCRIPTION OF DUTIES PERFORMED: Patient care in ambulatory and inpatient settings Resident and medical student teaching and supervision.

B. NAME OF BUSINESS / INSTITUTION: Oregon Health Sciences University
ADDRESS — STREET, CITY, STATE, ZIP CODE: 3181 SW Sam Jackson Park Road, Portland, OR 97201-3098
SUPERVISOR NAME: Mark Nichols, M.D., Dept. ObGyn
DATE OF EMPLOYMENT/ATTENDANCE: From 06/26/91 To 06/30/95
HOURS WORKED PER WEEK: 80
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month): 5 years
JOB TITLE: Resident physician
DESCRIPTION OF DUTIES PERFORMED: Total patient care as house officer in ambulatory and inpatient settings.

IL 486-1071 6/93 (3 Front)

COMPLETE THE REVERSE SIDE OF THIS FORM

C. NAME OF BUSINESS / INSTITUTION
All Women's Health Clinic

JOB TITLE
consulting physician

ADDRESS STREET, CITY, STATE, ZIP CODE
1020 NE 2nd Ave, Suite 200
Portland, OR 97232

DESCRIPTION OF DUTIES PERFORMED
physician

SUPERVISOR NAME
Judi Hanson

DATE OF EMPLOYMENT/ATTENDANCE
From 0 9 / / 9 3
To 0 9 / / 9 7

HOURS WORKED PER WEEK
4

TYPE OF EMPLOYMENT
☐ Full-time ☑ Part-time

TOTAL TIME WORKED (Year/Month)

D. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE
From / /
To / /

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

E. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE
From / /
To / /

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

IL486-1071 6/93 (LT-Back)

OREGON BOARD OF MEDICAL EXAMINERS
1500 S.W. FIRST AVENUE, SUITE 620
PORTLAND, OR 97201-5826

DATE REQUESTED: 06/25/98

(503) 229-5770

VERIFICATION DATA FOR CERTIFICATE: MD17244

Type: MEDICAL PHYSICIAN AND/OR SURGEON

Status: ACTIVE

Expiration Date: 12/31/1999

Name: NELSON, ERICA ELIZABETH, MD

Address: OHSU SELLWOOD MORELAND HEALTH CENTER
6327 SE MILWAUKIE AVE

City, State Zip: PORTLAND, OREGON 97202

First License: 07/12/1991

Phone: 503-418-1800

Specialty: OBSTETRICS AND GYNECOLOGY

Birthdate: 03/02/1963

Graduate School: U/VT COL/MED

School Location: BURLINGTON,VT

Graduation Date: 05/19/1990

Advanced Education: 07/91 - RESIDENT
OHSU PORTLAND,OR
OBG OBSTETRICS AND GYNECOLOGY
06/90 - 06/91 INTERN
OHSU PORTLAND,OR
NONE

Basis Of Licensure: NATIONAL BOARD

State Of Reciprocity: NONE/UNKNOWN

Standing: GOOD

Limitations: NONE

Extensions:

[redacted]

BOARD OF MEDICAL EXAMINERS · ORGANIZED MAY 28, 1889 · STATE OF OREGON

Board Seal

JUN 29

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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
Nelson	Erica	Elizabeth	[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 — 0 3 6 — Profession Code

6. MAIDEN OR GIVEN SURNAME
Nelson, Erica Elizabeth

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:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 62786

This is to certify that the above-named applicant satisfactorily completed 48 months of postgraduate clinical training in OB-GYN
(Name of Accredited Postgraduate Clinical Training Program)
from 6/26/91 to 7/1/95 at the following hospital:

Hospital: OREGON HEALTH SCIENCES UNIVERSITY
Number and Street: 3181 SW SAM JACKSON PK RD.
City, State and Zip Code: PORTLAND, OR 97201

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: MARK NICHOLS
Signature of Postgraduate Clinical Training Program Director: [redacted]
Date of this Certification: 5/30/96
Telephone No: 503-494-3103

SEAL

JUN 0 9 1996

IL486-1535 4/96 (MD)

JUL 30 1992

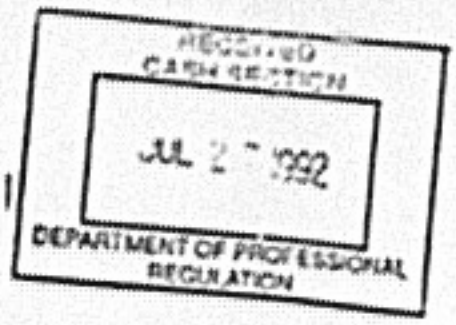
OREGON HEALTH SCIENCES UNIVERSITY

3181 S.W. Sam Jackson Park Road, L310BO
Portland, Oregon 97201-3098 (503) 494-8144

School of Medicine, Department of Psychiatry

0 0 1 1 0 6 3 0 2 2 1

July 22, 1992



To Whom It May Concern:

I have called the Administration Office at Oregon Health Sciences University and we are unaware of the existence of any Hospital Seal. Therefore, please accept the Notary Seal. Thank you.

Sincerely,

[redacted]

Administrative Assistant
Residency Training Program

Profession: 36

Date: 7/22/98 Initials: RL

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

0 0 1 1 0 6

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

1. Submit the required fee of $_____ made payable to the Department of Professional Regulation. This fee is *not* refundable.	21. Complete AF-MED form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s). 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
2. Your application is being returned for completion of Part _____.	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: _____ to _____.	24. The Department is unable to verify completion of 84 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).	25. Submit a list of your work experience from _____ to _____. You must account for entire time period since graduation from medical school (Supporting Document WH).
5. Submit proof that you are a lawfully admitted alien.	26. Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
7. When your application is complete, the Medical Licensing Board will review your qualifications.	28. Have your _____ scores forwarded directly from _____.
8. Your application will be reviewed by the Medical Licensing Board on _____.	29. Submit evidence of remedial training.
9. Submit completed CA-MED form which indicates beginning and ending program dates.	30. Submit TN-MED form signed by program director, with seal of hospital.
10. Submit CA-LTD form.	31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on official stationary must be attached verifying no seal exists.)
11. Submit ED-MED form (certification of education).	32. Sign form(s) where indicated.
12. Submit ED-NON form completed in its entirety.	33. Submit certification of original/current licensure (Supporting Document CT) from _____.
13. Affidavits, (ED-AFF forms) must be completed in accordance with DPR policy. Copy of policy attached.	34. Submit proof that you are Board-certified in a specialty.
14. Verification of Pass/Fail Exam History—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.	35. Submit restoration questionnaire (Supporting Document RS).
X 15. Submit official ~~undergraduate~~ medical transcript with school seal affixed.	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
16. Submit photocopy of your degree.	37. Returning original documents.
17. Submit proof of Titulo or Acta.	
18. Submit proof of Social Service or Fifth pathway.	
19. Submit proof of E.C.F.M.G. certification.	
20. Submit copy of evaluation form for each of the following core rotations: 1. _____ 4. _____ 2. _____ 5. _____ 3. _____	

Other Instructions:

Transcripts from the University of Vermont are required.