



MEDICAL LICENSE ISSUANCE INFORMATION

Physician's Name Aurelie Rachel Cabou
First Middle Last

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

National Provider Identifier Number 1710159322

Medical Board Name ILLINOIS DIVISION OF PROFESSIONAL REGULATION

Member Board License Number 036.168049

Date License Issued 12/21/2023
mm/dd/yyyy

Date of Expiration 7/31/2026
mm/dd/yyyy

Member Board Signature



Name Karen S Schlindwein

Date 12/21/2023

Application for Expedited Licensure

I have read and understood the Qualifications to practice medicine in the Compact states. I attest that I am qualified and understand that pursuant to the IMLCC's rules, all fees are non-refundable.

If you have questions, please call your State of Principle License

I understand that inaccurate or missing information may be grounds for rejection of my application.

Please carefully review the Application documents before applying. **Yes**

I have reviewed the criteria to select a State of Principal License (SPL) and confirm eligibility to designate a Compact state as my SPL. **Yes**

I have a full and unrestricted license in a Compact State **Yes**

SPL WASHINGTON MEDICAL COMMISSION License 60094852 Expiration 01/28/2025

AND at least one of the below must APPLY (Please select all that apply)

- | | |
|--|------------|
| a. Your primary residence is in the SPL (State of Principal License) | Yes |
| b. At least 25% of your practice of medicine occurs in the SPL | No |
| c. Your employer is located in the SPL | No |
| d. You use the SPL as your state of residence for U.S. federal income tax purposes | No |

Please provide below information:

Residence Street address [REDACTED]

Residence City State Zip [REDACTED]

County [REDACTED]

Please describe your practice and location in the SPL selected

Please be prepared to provide documentation to the designated SPL for further verification. If you have any question, please contact your SPL.

You or your employer may be asked for additional documentation about your Employment.

Name of Employer

Employer Contact Phone

Employer Street address _

Employer City State Zip , ,

Please provide your Tax ID # (SS#, EIN) XXX-XX-XXXX (must be most recent return) Please be prepared to provide documentation to the designated SPL for further verification.

Are you a graduate of a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent? **Yes**

Medical School **Perelman School of Medicine at the University of Pennsylvania** Date of Degree Issued **05/14/2007** Medical Degree Received: **M.D.**

Have you passed each component or step of the USMLE, or the COMLEX-USA within three (3) attempts, or any of their predecessor examinations accepted by your SPL medical board as an equivalent examination for licensure purposes (if in question contact your SPL)? **Yes**

Which licensing exam did you pass? **USMLE**

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

Residency Program **Swedish Family Medicine, First Hill** Completion Date **06/30/2010**

What is the specialty of the program **Family Medicine**

Do you hold specialty certification, or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (AOABOS)? (Board eligibility does not qualify) **Yes**

Name of Specialty Board Certification **ABFM**

Lifetime **No** If not lifetime, Expiration Date **2/15/2024**

Have you ever been convicted, received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction? **No**

Have you ever held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal or foreign jurisdiction, excluding any action related to non-payment of fees related to a license? **No**

Have you ever had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration? **No**

Are you under investigation by a licensing agency or law enforcement authority in any state, federal or foreign jurisdiction? **No**



PHYSICIAN'S CORE DATA SHEET

(Must be the physician's accurate information to avoid delay or rejection)

Full Legal Name **Aurelie Rachel Cabou** ,

Other names used (maiden, birth)

Residential address

Office address

Where do you wish to receive mail. **Residential**

Physician's cellular or alternative telephone number

Physician's office or practice telephone number of public record

Date of Birth Gender: **Female**

Applicants personal email address

Email address delegated by applicant to receive correspondence

Social Security Number: XXX-XX-XXXX

Physician's National Provider Identifier Number **1710159322**

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

I, **Aurelie Rachel Cabou**, (full legal name) the undersigned, being duly sworn, hereby certify under oath that I am the person named in this Application for an IMLC Letter of Qualification and Medical Licenses in IMLC Member States (“Application”), that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my Application, and that all documents, forms, or copies thereof, furnished or to be furnished with respect to my application, are strictly true in every aspect.

I acknowledge that I have read and understand the Interstate Medical Licensure Compact (“Compact”) and the Application and have answered all questions contained in the Application truthfully and completely. I further acknowledge failure on my part to answer questions truthfully and completely may lead to disciplinary action against one or more medical licenses or permits I hold, as well as potential prosecution under appropriate federal and state laws.

I hereby apply to WASHINGTON MEDICAL COMMISSION (state) as my State of Principal License (“SPL”) for a Letter of Qualification (“LOQ”) to be issued a medical license in one or more Compact Member States. To permit the SPL to process my application for an LOQ, I authorize and request every person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, to furnish to the SPL any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the SPL, or any of its agents or representatives, to inspect and make, or receive, copies of such documents, records, and other information in connection with this Application. I also authorize the SPL to perform or obtain a criminal history background check with law enforcement on me as part of the determination of my eligibility to be licensed through the Compact.

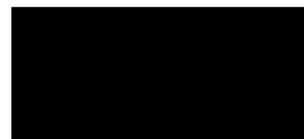
I hereby release, discharge, and exonerate the SPL and the Interstate Medical Licensure Compact Commission (“Commission”), their agents or representatives, and any person, entity, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me, of any and all liability of every nature and kind, arising out of an investigation made by the SPL.

I also hereby apply to the Compact Member States’ medical boards (“Member Boards”) I have designated in this Application. Additionally, I further authorize the SPL to process and release my application for medical licensure by one or more Member Boards including, but not limited to, personally identifiable information including my Social Security Number to be used for querying the National Practitioner Data Bank and in child support enforcement actions. I hereby release, discharge, and exonerate the SPL and the Commission, and their employees, agents, or representatives, of any, and all liability of every nature and kind, arising out of any disclosure to the Member Boards.

I will immediately notify the SPL and the Commission in writing of any changes to the answers to any of the questions contained in this application, if such a change occurs at any time prior to a medical license being issued by one or more of the Member Boards.

I understand my failure to answer questions contained in this Application truthfully and completely may lead to denial of my application for a LOQ, revocation, or other disciplinary sanctions of my license(s) or permit(s) to practice medicine, in one or more Compact Member States.

Applicant Signature



Type Applicant’s Name Aurelie Cabou
Applicant’s NPI 1710159322
Date 12/06/2023