October 26, 2022

Forrest Ranger
Protonmail.com
Sent via Electronic Mail to wiredwaves@protonmail.com

RE: Freedom of Information Act Request

Dear Forrest Ranger:

The Department of Financial and Professional Regulation ("Department") received your Freedom of Information Act (FOIA) [5 ILCS 140/1 et seq.] request on October 12, 2022, requesting "all documents in the file pertaining to physician" Nandini Datta MD; license nos. 036.121508 and 336.082754.

This letter is the Department's response to your request. PDFs of the requested documents in the Department's possession are enclosed. Your request is partially denied to the extent that the document contains personal and private information, including but not limited to signatures, birthdate, Social Security number, and personal contact information, which are exempt from disclosure pursuant to Sections 7(1)(a), (b) & (c) of FOIA and Section 1326.210(c) of the Illinois Administrative Code [5 ILCS 140/7(1)(a), (b) and (c); 2 Ill. Admin. Code 1326.210(c)].

Further, your request for *all complaints* is denied; complaints and investigations are exempt from disclosure pursuant to Sections 7(1)(a) of FOIA, Section 2105-117 of the Civil Administrative Code, and Sections 1326.220(b)(1) and (3) of the Illinois Administrative Code [5 ILCS 140/7(1)(a); 20 ILCS 2105/2105-117; 2 Ill. Admin. Code 136.220(b)(1) & (3)].

Section 7(1) of FOIA states in pertinent part as follows:

> Sec. 7. Exemptions.
>
> (1) When a request is made to inspect or copy a public record that contains information that is exempt from disclosure under this Section, but also contains information that is not exempt from disclosure, the public body may elect to redact the information that is exempt. The public body shall make the remaining information

available for inspection and copying. Subject to this requirement, the following shall be exempt from inspection and copying:

(a) Information specifically prohibited from disclosure by federal or State law or rules and regulations implementing federal or State law.

(b) Private information, unless disclosure is required by another provision of this Act, a State or federal law or a court order.

(c) Personal information contained within public records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, unless the disclosure is consented to in writing by the individual subjects of the information. "Unwarranted invasion of personal privacy" means the disclosure of information that is highly personal or objectionable to a reasonable person and in which the subject's right to privacy outweighs any legitimate public interest in obtaining the information. The disclosure of information that bears on the public duties of public employees and officials shall not be considered an invasion of personal privacy.

Section 2105-117 of the Civil Administrative Code states:

Sec. 2105-117. Confidentiality.

All information collected by the Department in the course of an examination or investigation of a licensee, registrant, or applicant, including, but not limited to, any complaint against a licensee or registrant filed with the Department and information collected to investigate any such complaint, shall be maintained for the confidential use of the Department and shall not be disclosed. The Department may not disclose the information to anyone other than law enforcement officials, other regulatory agencies that have an appropriate regulatory interest as determined by the Director, or a party presenting a lawful subpoena to the Department. Information and documents disclosed to a federal, State, county, or local law enforcement agency shall not be disclosed by the agency for any purpose to any other agency or person …

Section 1326.220 of the Illinois Administrative Code states in pertinent part:

In response to a request submitted pursuant to FOIA, the Department will not disclose certain records as provided in this section. Records covered under this section include, but are not limited to:

b) Division of Professional Regulation and Division of Real Estate:

1) Complaints received by the Department against licensees or unlicensed persons or entities, except as provided by statute.

3) Investigative files maintained by the Division.

This determination has been made by the Illinois Department of Financial and Professional Regulation, Acting FOIA Officer Brad E. Karlin.

You have the right to have the denial of your request reviewed by the Public Access Counselor ("PAC") at the Office of the Illinois Attorney General. You can file your Request for Review with the PAC by writing to:

Sarah Pratt
Public Access Counselor
Office of the Attorney General
500 S. 2nd Street
Springfield, Illinois 62706
(877) 299-3642

You also have the right to judicial review of your denial by filing a lawsuit in the State circuit court. 5 ILCS 140/11.

If you choose to file a Request for Review with the PAC, you must do so within 60 calendar days of the date of this denial letter. 5 ILCS 140/9.5(a). Please note that you must include a copy of your original FOIA request and this denial letter when filing a Request for Review with the PAC.

Should you have any questions or concerns, please do not hesitate to contact me. Thank you.

Sincerely,

Ronald A. Almiron

Ronald A. Almiron
Assistant General Counsel

RAA
Enclosures

Place Label Here or Name

DO NOT WRITE IN BOX

Profession Code

License # or SSN #

FILE ROUTE CARD

DO NOT WRITE ON FILE FOLDER

IL486-1327 10/04 (RS)

000500 08221

RECEIVED CASH [illegible]

APR 2 8 2008

IDFPR Professional Regulation

(DO NOT USE THIS APPLICATION FOR RENEWAL OF AN EXISTING LICENSE)

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.

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

CONTROLLED SUBSTANCES LICENSE WILL NOT BE ISSUED TO A TEMPORARY LICENSE HOLDER!

1. Every person who prescribes or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Financial and Professional Regulation in accordance with the Illinois Controlled Substances Act.
2. A separate controlled substances registration is required for each place of professional practice or [illegible] substances are stored or [illegible] ration is [illegible] bstances

Lic#:
DATTA, NANDINI
336 Cred #2822537 05/01/2008
By:NON-EXAM
SSN: [redacted]

A. Type or print legibly with black ink only.
B. The fee is $5 - Make check payable to the Department of Financial and Professional Regulation. THIS FEE IS NOT REFUNDABLE! (Separate application/fee is required for each registration.)
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.

CHECK A BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION.
(Do not use this form to renew existing Registration)

☒ First Time Applicant ☐ Additional Location (separate office where drugs are stored)

PART I: Application Category Information

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

PART II: Applicant Identifying Information

1. NAME LAST / FIRST / MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATE SOCIAL SECURITY NO.
DATTA NANDINI	MD	[redacted]

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

5. NAME OF BUSINESS AND LOCATION (STREET/CITY /ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED
820 SOUTH WOOD ST.
(MC808)
CHICAGO
IL 60612+____

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

7. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Work [redacted] FAX ( ) ____ Area Code
Home [redacted] FAX ( ) ____ Area Code

PART III: Professional Activity

Practitioner - Check and complete one of the following.

		Professional License Number
☐Dentist	019 -	121508
☒Physician	036 -	~~A8295 (CALIFORNIA)~~
☐Podiatrist	016 -	
☐Veterinarian	090 -	

Drug Schedule: (Circle the schedules for which you are applying)
(II) (IIN) (III) (IIIN) (IV) (V)

FOR OFFICIAL USE ONLY FEE $5

BNDD Number: ____ **Type:** ☐ **Suffix:** ☐

Schedule Codes: ____ **Additional Function:** A **Card Code:** K

Issuance Date (Month/Day/Year)

PART IV: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you ever been charged or convicted of any drug related criminal offense in any state or in federal court? *If yes, attach a statement for each conviction including dates and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.*		
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.*		
3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		
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.*		
5. Has any previous registration held by the applicant under the Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? *If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.*		

NAME (Last, First, MI): DATTA, NANDINI

SS#:

Profession: PHYSICIAN

PART V: 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.")

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?

PART VI: 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.

4-22-08
Date of Application

NANDINI DATTA, MD
Print Name of Applicant

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.

Place Label Here or Name

DO NOT WRITE IN BOX

Profession Code ______________

License # or SSN # ______________

FILE ROUTE CARD

DO NOT WRITE ON FILE FOLDER

IL486-1327 10/04 (RS)

03000006824

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 ... submit with your ... cuments is differ- ... you must submit ... opy of marriage ... order.

Lic#: 036.121508
DATTA, NANDINI 7/17/08
036 Cred #2822594 05/01/2008
By:ENDORSEMENT
SSN: [redacted]

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	$ 300

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.

RECEIVED CASHIER APR 28 2008 IDFPR Div. of Professional Regulation

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.
DATTA, NANDINI	MD	[redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
820 SOUTH WOOD ST, MC808 CHICAGO, IL 60612-

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

7. MOTHER'S MAIDEN NAME [redacted]

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

9. DATE OF BIRTH [redacted] Month Day Year

10. AGE [redacted] [X] Female [ ] Male

11. [redacted]

Fax: (___) ___-____ (Area Code) Fax: (___) ___-____ (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): DATTA, NANDINI

SS#:

Profession: PHYSICIAN

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?
CEDARS-SINAI MEDICAL CENTER	LOS ANGELES, CA / USA	07/01	06/05	☒ Yes ☐ No
				☐ 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 CALIFORNIA	PHYSICIAN	A82959	05/02/2003	ACTIVE
State of Current Licensure where you most recently have been practicing. CALIFORINIA	"	"	"	"
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
USMLE STEP 1	WISCONSIN		
USMLE STEP 2	WISCONSIN		
USMLE STEP 3	CALIFORNIA		

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

NAME (Last, First, MI): DATTA, NANDINI

SS#:

Profession: PHYSICIAN

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.*		
2. Have you been convicted of a felony?		
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.*		
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.*		
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.*		
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.*		

NAME (Last, First, MI): DATTA, NANDINI

SS#:

Profession: PHYSICIAN

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.")

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?

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.

Signature of Applicant

4/22/08
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.

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 FIRST MIDDLE
DATTA, NANDINI

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
[X] Permanent Physician License	036
[ ] Temporary Physician Training License	125
[ ] Chiropractic Physician License	038

3. ADDRESS STREET, CITY, STATE, ZIP CODE

4. DATE OF BIRTH

5. SOCIAL SECURITY NUMBER

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION
ALTAMED HEALTH SERVICES

JOB TITLE
OBSTETRICIAN - GYNECOLOGIST

ADDRESS STREET, CITY, STATE, ZIP CODE
500 CITADEL DRIVE. LA, CA 90022

DESCRIPTION OF DUTIES PERFORMED
- CHAIR OF WOMEN'S AND CHILDREN'S HEALTH.
- STAFF OB-GYN

DATE OF EMPLOYMENT/ATTENDANCE
From 08/15/2005 (Month Day Year)
To 05/09/2008 (Month Day Year)

HOURS WORKED PER WEEK
40

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

TOTAL TIME WORKED (Year/Month)
2 YRS 9 MONTHS

B. NAME OF BUSINESS / INSTITUTION
UNIVERSITY OF SOUTHERN CALIFORNIA

JOB TITLE
CLINICAL ASSISTANT PROFESSOR

ADDRESS STREET, CITY, STATE, ZIP CODE
1200 N. MISSION RD, LA, CA 90033

DESCRIPTION OF DUTIES PERFORMED
- FACULTY TO RESIDENTS IN OB-GYN
- DIRECTOR OF RESIDENT RESEARCH

DATE OF EMPLOYMENT/ATTENDANCE
From 08/15/2005 (Month Day Year)
To 04/18/2008 (Month Day Year)

HOURS WORKED PER WEEK
20

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

TOTAL TIME WORKED (Year/Month)
2 YRS 9 MONTHS

IL486-1965 08/06 (MD)

C. NAME OF BUSINESS / INSTITUTION	JOB TITLE
CEDARS-SINAI MEDICAL CENTER	OBGYN RESIDENT
ADDRESS STREET, CITY, STATE, ZIP CODE DEPT OF OBGYN 8700 BEVERLY BLVD LA, CA 90048	DESCRIPTION OF DUTIES PERFORMED COMPLETED RESIDENCY
DATE OF EMPLOYMENT/ATTENDANCE From 07/01/2001 (Month Day Year) To 06/30/2005 (Month Day Year)	
HOURS WORKED PER WEEK: 100 TYPE OF EMPLOYMENT: [x] Full-time [ ] Part-time	
TOTAL TIME WORKED (Year/Month): 4 YEARS	

D. NAME OF BUSINESS / INSTITUTION	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)	

E. NAME OF BUSINESS / INSTITUTION	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)	

F. NAME OF BUSINESS / INSTITUTION	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)	

NAME (Last, First, MI): DATTA, NANDINI

SS#:

Profession: PHYSICIAN

5/6/08

STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 EVERGREEN ST SUITE 1200
SACRAMENTO CA 95815-3831
TELEPHONE: (800) 633-2322
FAX: (916) 263-2944
www.mbc.ca.gov

RECEIVED
BUSINESS SERVICES
MAY 5 - 2008
IDFPR
Div. of Professional Regulation

April 30, 2008

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION
SPRINGFIELD OFFICE
320 W WASHINGTON ST 3RD FLOOR
SPRINGFIELD IL 62786

To Whom It May Concern:

This is to certify that on the date of this letter the records of the Medical Board of California (Board) indicate the following information:

Physician:	NANDINI DATTA
License No.:	A 82959
Issued:	May 2, 2003
Exam Type:	A written examination
Expiration Date:	August 31, 2008
Status:	Renewed/current
Board Discipline:	NO

Further public records pertaining to the above licensee may be available from the Board's Web site at www.mbc.ca.gov.

Kimberly Kirchmeyer
Deputy Director

RECEIVED
MAY 0 6 2008
IDPR-MEDICAL UNIT

SEAL

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: Cedars-Sinai Medical Center

Address: Department of Obstetrics and Gynecology
Los Angeles, CA 90048

Attention: **Program Director**

Affiliated University: University of California @ Los Angeles

Verification For:

Name: **Datta, Nandini**

DOB: [redacted]

Individual's Name on Record (If different from above): ______

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1 & 2 Specialty/Subspecialty: OBGYN

☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research

From: 06/24/2001 To: 06/23/2003

Successfully Completed?: ☒Yes ☐No ☐In Progress

Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐ FMRAC ☐None of these

PGY: 3 Specialty/Subspecialty: OBGYN

☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research

From: 06/24/2003 To: 06/23/2004

Successfully Completed?: ☒Yes ☐No ☐In Progress

Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐ FMRAC ☐None of these

PGY: 4 Specialty/Subspecialty: OBGYN

☐Internship ☐Residency ☒Chief Residency ☐Fellowship ☐Research

From: 06/24/2004 To: 06/23/2005

Successfully Completed?: ☒Yes ☐No ☐In Progress

Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐ FMRAC ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐Yes ☒No
2. Was this individual ever placed on probation? ☐Yes ☒No
3. Was this individual ever disciplined or placed under investigation? ☐Yes ☒No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐Yes ☒No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐Yes ☒No

Please explain any "Yes" response from above:

_____

_____

Certification:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Dotun Ogunyemi Signature: [redacted]

Title: Program Director Date of Signature: May 16,2008

E-Mail: [redacted]

PROVIDED BY
APPLICANT

Postgraduate Medical Education

Cedars-Sinai Medical Center

Hospital Cedars-Sinai Medical Center

Affiliated School (UCLA)

Department of OB/GYN
8700 Beverly Blvd
Los Angeles, CA 90048

Unusual Circumstances:

Interruptions: N

Probation: N

Disciplined: N

Negative Reports: N

Limitations: N

PGY

Year(s):1-4 Internship/Residency: Complete?: Yes

Obstetrics and Gynecology

Dates: 07/2001 to 06/2005

036 APPLICATION CHECKLIST

APPLICATION FINDINGS

___Approved Program ______6-Year
✓ Application Complete
___Release on File

POSITIVE PERSONAL HISTORY INFO

___Yes#______ See Worksheet for documents
VE-PC from Grad to Present for PPH______
MLB _____ ITD______

DOMESTIC GRADUATES

✓ Premedical Transcripts
✓ Medical Transcripts w/degree date 5/20/01

FOREIGN GRADUATES

___ECFMG _____5th Pathway _____Social Service
___Premedical Transcripts ___Translations
___Medical Transcripts ___Translations
Degree Date________

FCVS Profile ____________
IL TEMP LIC #____________

U of WI MS
MD

6-Year Post Secondary Education

___AF-MED Part A

AF-MED Part B DOCUMENTATION:

Int Med Hosp: ____________________
Evaluation: ______
AF-MED B_____ and Agreement______
OR
Verbal Affidavits: Hospital ___School___

Psych Hosp: ____________________
Evaluation: _____
AF-MED B_____ and Agreement_______
OR
Verbal Affidavits: Hospital ___School___

Ob/Gyn Hosp:________________
Evaluation: ______
AF-MED B_____ and Agreement______
OR
Verbal Affidavits: Hospital ___School___

Surgery Hosp: __________________
Evaluation: _____
AF-MED B_____ and Agreement_______
OR
Verbal Affidavits: Hospital ___School___

Peds Hosp: __________________
Evaluation: ______
AF-MED B_____ and Agreement______ OR Verbal Affidavits: Hospital ___School ____

___**ED-NON** _____Total months -must be minimum of 36 w/premed; 54 combined
Minimum 4-weeks: IM _____ Ob/Gyn _____ Peds _____ Surgery _____
Psych _____Psych Affidavit _____

SUPPORTING DOCUMENTS

✓ VE-PC - Verification of Professional Capacity - active practice in 2-years preceding app
CME Required/Submitted____________
___CT - Original Jurisdiction of Licensure - State & Number CA A82959 Discipline N AU
NA CT - Current Jurisdiction of Licensure - State & Number Same Discipline_______
___TN-MED - Clinical Training - 12 months if **began program** prior to 1/1/1988; all others 24 months
Seal or Letter_____ Accredited____
___Acceptable Examination or Combination
NBME _____ NBOME/COMLEX _____ FLEX _____ LMCC _____
USMLE X Completed within 7-Rule_____ Not over 5 Failures _____(USMLE & FLEX)
State-constructed _____ must have American Board Certification_______
NA Name Change
___Federation Check

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

RECEIVED
JUL 1 2008
IDPR-MEDICAL UNIT

This report is compiled exclusively for:

Name: **Nandini Datta**
SSN:
DOB:
Packet ID:
Recipient: **Illinois Department of Financial and Professional Regulation**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

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Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name: **Nandini Datta**
Other Name Used: **N/A**

Gender: **Female**
Date of Birth:
Place of Birth:
SSN:

Current Address:

Permanent Address:

Telephone Numbers: Bus:
Fax:
Home:
Other:

Physical Description: Height:
Weight:
Eye Color:
Hair Color:

Physical Marks: Description:
Location:

Premedical Education (Reported by physician. Not verified by FCVS):

Institution: **University of Wisconsin - Madison, Madison, WI 53706**

Dates of Attendance:
Degree Conferred/Issued: **Bachelor of Science**

Medical Education:

Medical School: **University of Wisconsin Medical School**
21 N Park Street Suite 7223
Madison, WI 53715

Dates of Attendance:
Date Degree Conferred/Issued:
Degree Conferred/Issued: **Doctor of Medicine**

Unusual Circumstance: **None**

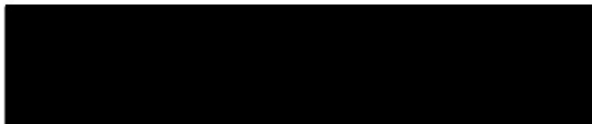
Post Graduate Medical Education:

Institution:	**Cedars-Sinai Medical Center** **Department of Obstetrics and Gynecology** **8700 Beverly Boulevard** **Los Angeles, CA 90048**
Post Graduate Year:	**1-3**
Program Type:	**Residency**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**06/24/2001 - 06/23/2004**
Completion:	**Yes**
Accreditation:	**ACGME**
Post Graduate Year:	**4**
Program Type:	**Chief Resident**
Department:	**Obstetrics and Gynecology**
Dates of Attendance:	**06/24/2004 - 06/23/2005**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:



Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Nandini Datta
DOB:	
SSN:	
Packet ID:	90790
Request ID:	19326814

OMISSIONS

There are none identified.

DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Medical Education**
Discrepancy:	The applicant reports the degree/diploma was issued/conferred/awarded by Univ Wisconsin Med Sch
Follow-Up:	FCVS reports the date the degree/diploma was issued/conferred/awarded from the medical school diploma on the Physician Information Report.

Discrepancy 2:

Section of Profile:	**Post-Graduate Education**
Discrepancy:	The applicant reports program type for PGY 1-4 is Internship/Residency. Cedars-Sinai Medical Center reports program type for PGY 4 is Chief Resident.
Follow-Up:	Left to Recipient's discretion.

Discrepancy 3:

Section of Profile:	**Examination History**
Discrepancy:	The applicant reports sitting for USMLE
Follow-Up:	Left to Recipient's discretion.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile:

Issue:

Follow-Up:

End of report for Nandini Datta

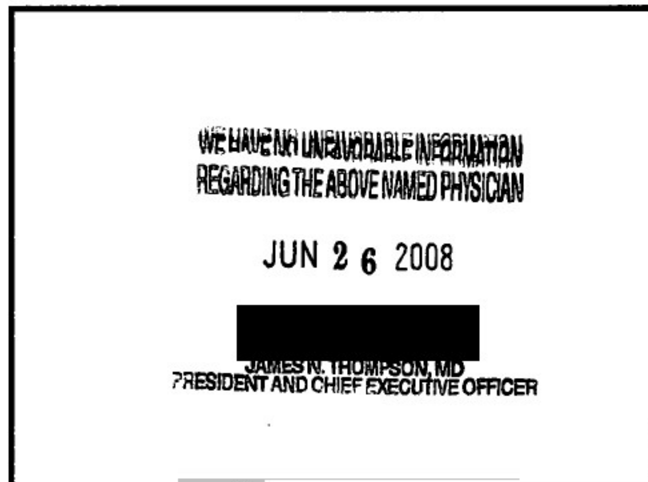
Packet Id: 90790 Request Id: 19326814 Report Created By: YDC

Board Action Databank Search

As of: 6/20/2008

State Queried For:	**Illinois Department of Financial and Professional Regulation**
Physician's Name	**Datta, Nandini**
Date of Birth:	
Medical School:	**050020 - University of Wisconsin Medical School**
Year of Graduation:	
Social Security Number:	
ECFMG Number:	**N/A**

Results:



AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 6/20/2008

State Queried For:	Illinois Department of Financial and Professional Regulation
Physician Name:	Nandini Datta
Date of Birth:	
Year of Graduation:	(Doctor of Medicine)
Social Security Number:	
ABMSU ID:	853962

Certification:

Board:	Obstetrics and Gynecology
Specialty:	Obstetrics and Gynecology
Status:	ACTIVE
Initial Certification:	01/09/2007

Section II

Identity

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor 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 "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, 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 Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, 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 investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

Applicant's Signature (must be signed in the presence of a notary)

DATTA
Applicant's Printed Last Name

NANDINI
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

4-28-08
Date of Signature

Date of Birth

Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of California County of Los Angeles

SUBSCRIBED AND SWORN TO before me this 28th day of April, 2008

My commission expires: Feb. 05 2011

(NOTARY PUBLIC SIGNATURE & SEA

Notary Public signature:

I certify that on the date set forth above th ... rsonally before me and that I did identify this applicant by: (a) comparing his/her physical appearanc ... g document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The Secretary of State of the United States of America hereby requests all whom it may concern to permit the citizen/national of the United States named herein to pass without delay or hindrance and in case of need to give all lawful aid and protection.

Le Secrétaire d'Etat des Etats-Unis d'Amérique prie par les présentes toutes autorités compétentes de laisser passer le citoyen ou ressortissant des Etats-Unis titulaire du présent passeport, sans délai ni difficulté et, en cas de besoin, de lui accorder toute aide et protection légitimes.

El Secretario de Estado de los Estados Unidos de América por el presente solicita a las autoridades competentes permitir el paso del ciudadano o nacional de los Estados Unidos aquí nombrado, sin demora ni dificultades, y en caso de necesidad ...

SIG... OF BEARER/SIGNATURE DU TITULAIRE/FIRMA DEL TITULAR

NOT VALID UNTIL SIGNED

PASSPORT
PASSEPORT
PASAPORTE

USA

UNITED STATES OF AMERICA

Type / Type / Tipo: P
Code / Code / Código: USA
Passport No. / No. du Passeport / No. de Pasaporte:
Surname / Nom / Apellidos: DATTA
Given names / Prénoms / Nombres: NANDINI
Nationality / Nationalité / Nacionalidad: UNITED STATES OF AMERICA
Date of birth / Date de naissance / Fecha de nacimiento:
Sex / Sexe / Sexo: F
Place of birth / Lieu de naissance / Lugar de nacimiento:
Date of issue / Date de délivrance / Fecha de expedición: 14 Jan 2004
Authority / Autorité / Autoridad: National Passport Center
Date of expiration / Date d'expiration / Fecha de caducidad: 13 Jan 2014
Amendments / Modifications / Enmiendas: See Page 24

P<USADATTA<<NANDINI<<<<<<<<<<<<<<<<<<<<

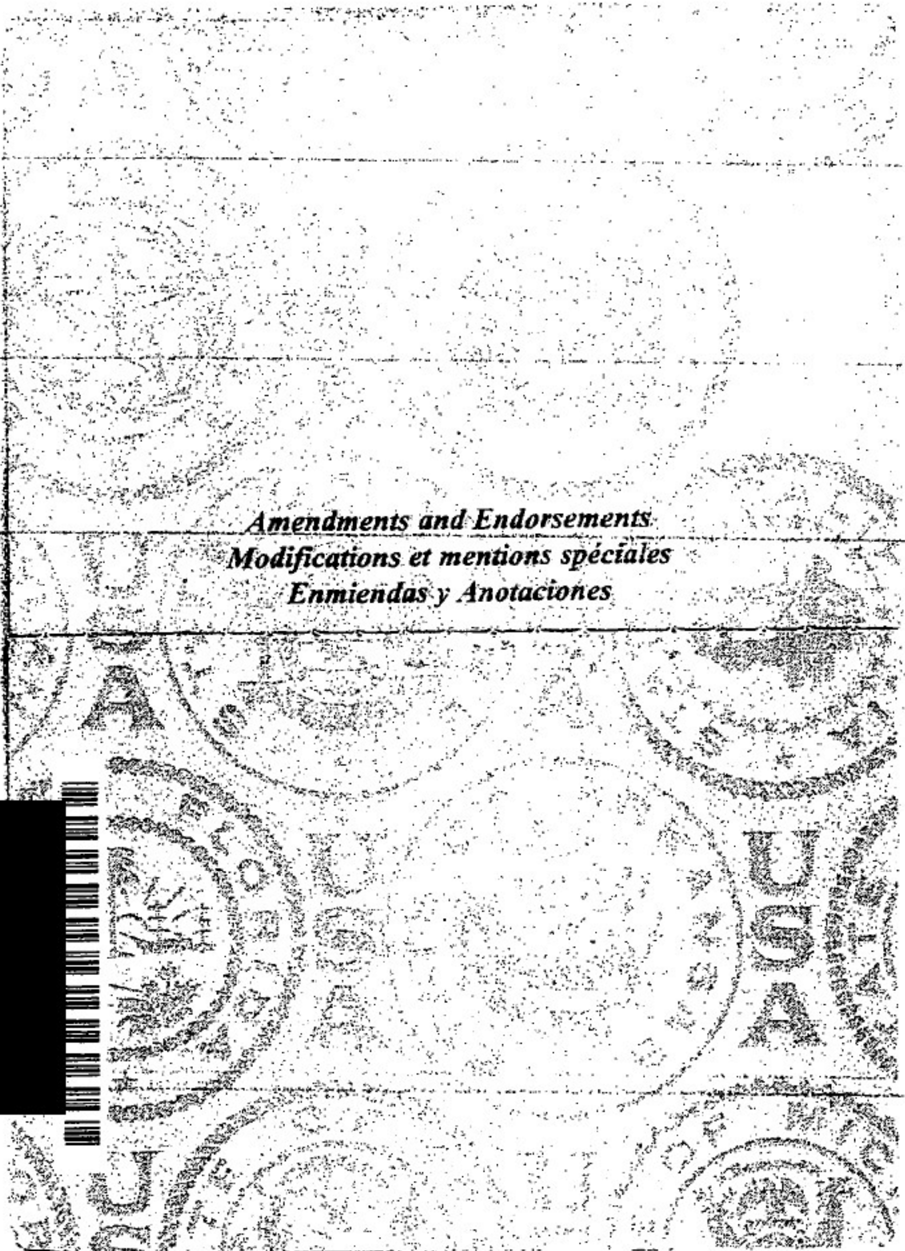
THE FEDERATION OF STATE MEDICAL BOARDS · MCMXII · UNITED STATES

The Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Kevin Caldwell
Federation Credentials Verification Service

June 03, 2008

Date



The Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Kevin Caldwell
Federation Credentials Verification Service

June 03, 2008

Date

Section III

Medical Education

RATION CREDENTIALS VERIFICATION SERVI CVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: UW School of Medicine and Public Health

Complete Address: Office of Student Services, Rm 2141 HSLC

Street Address: 750 Highland Avenue

Madison, WI 53705-2221

City: ______ **al Code):** ______

If name of institution was different when this individual attended, please note this name below: ______

Premedical Education:

Years of education required for admission to your medical school: No pre-med requirement.

Credential/degree presented by the applicant for admission to your medical school: BS

Enrollment and Participation: Our records indicate that DATTA, NANDINI
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 148 weeks of medical education on the following dates (mm/dd/yy):

From ______

This individual (check one):

Was awarded the degree of Doctor of Medicine, M.D.

Was NOT awarded a degree because: ______
(please explain - attach additional pages if necessary)

Certification: By my signature, I, Sharon J. Greuel (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Signature: ______

Title: Certification Officer

Date of Signature: May 20, 2008

Email: ______

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during **any part** of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

   Response YES ☐ NO ☒

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: ____________

2. Do this individual's official records reflect that he/she was ever placed on a[redacted] during his/her medical education? Response [redacted]

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: ____________

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response [redacted]

   If YES, please provide detailed documentation/information about th[redacted].

4. Do this individual's official records reflect that he/she was ever the subject of n[redacted] or an investigation by the medical school or parent university? Response [redacted]

   If YES, please provide detailed documentation/information about th[redacted]

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

   Response [redacted]

   If YES, please provide detailed documentation/information about th[redacted] requirements.

PROVIDED BY
APPLICANT

Medical Education

School	050020 - University of Wisconsin Medical School
Dates	[redacted]
Clinical Training	*No information reported.*
Grad Date	[redacted]
Degree	MD

Completed clinical clerkship in a country other than where my medical school was located: N

Unusual Circumstances:

Interruptions: N

Probation: N

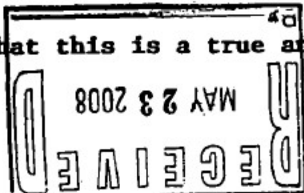
Disciplined: N

Negative Reports: N

Limitations: N

Attended a Fifth Pathway Program: N

I certify that this is a true and correct copy of the original diploma of Nandini Datta, M.D.



Sharon J. Greder
Certification Officer
May 20, 2008

SEAL
VERIFIED

Section IV

Postgraduate Training

Section V

Examination History/Score Transcripts

Direct Inquiries to the
Technical Assistance Unit

Telephone No.: 217-782-8556
TDD No.: 217-524-6735

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL & PROFESSIONAL REGULATION
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 5/15/2008

Initials: DR

License No: 036 Attn: Medical

YOUR APPLICATION OR REQUEST CANNOT BE PROCESSED DUE TO ERRORS OR DEFICIENCIES. NO FURTHER ACTION CAN BE TAKEN ON YOUR APPLICATION UNTIL SUCH TIME AS ALL DEFICIENCIES HAVE BEEN MET.

TO:

NANDINI DATTA MD

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Submit TN-MED verifying 24-months postgraduate clinical training.

Request your USMLE pass/fail history be sent directly from the Federation of State Medical Boards.

RETURN INFORMATION IN THE ENCLOSED ENVELOPE WITH A COPY OF THIS NOTICE.