Application - LICENSED PHYSICIAN AND SURGEON

Name	James Howard Hobby
Credential	LICENSED PHYSICIAN AND SURGEON

Fee Details

INITIAL APPLICATION FEE	$ 700.00
	$ 700.00

Licensed Physician Application Instructions

- **Applicants may apply to become a Licensed Physician on the basis of Acceptance of Examination or Endorsement.**
- **The licensure fee is $700 and is non-refundable. Payment may be made by eCheck or credit card. License applications are valid for 3 years from the date of receipt by the Department.**
- **Acceptance of Examination: Applicant has passed a National Exam, referred to by Illinois statute AND meets Illinois requirements in effect at the time of application. Applicant is not currently licensed to practice medicine in another state.**
- **Endorsement: Applicant is currently licensed to practice medicine in another state. Requirements to receive original physician license in other state were substantially equivalent to Illinois licensure requirements in effect when original physician license was issued.**

Application Method

1. Please select your desired application method.

Acceptance of Examination

Authorization for Third-Party Contact

2. I would like to authorize a person/business other than myself or my business to communicate with the IDFPR regarding my application for licensure.

Yes

Third-Party Contact Information

3. Name of Person/Business:

Elaine Hadley, Southern Illinois Healthcare Foundation

4. Phone Number:

[redacted]

5. Email Address:

[redacted]

6. I hereby authorize the following person/business to communicate with the Division regarding my application for initial licensure. I understand that information received from the person or business listed below shall be binding and that I will be responsible for the accuracy of all information and documents received as part of my application for initial licensure. This authorization shall expire upon issuance of the license, referral to enforcement or expiration of the application.

Yes

Public and Mailing Addresses

7. Please verify or enter your Public Address:

Address Line 1 [redacted]
Address Line 2 [redacted]
City [redacted]
State [redacted]
Zip Code [redacted]
County
Country UNITED STATES
Phone [redacted]
Cell Phone [redacted]

8. Please verify or enter your Mailing Address:

Address Line 1 [redacted]
Address Line 2 [redacted]
City [redacted]
State [redacted]
Zip Code [redacted]
County
Country UNITED STATES
Phone [redacted]
Cell Phone

Personal Information

11. Birth City:

Lebanon

12. Birth State *(if foreign born choose UNKNOWN)*:

Indiana

13. Birth Country

UNITED STATES

14. Gender:

Male

15. Which ethnicity best describes you?

Caucasian

Date of Birth

16. Date of Birth

09/21/1973

Name Change

17. Do any of your supporting documents have a different name than your current legal name?

No

18. If you answered *"Yes"* to the question above, please add proof of your name change in the grid below:

Previous Name on Document(s)	From	To	Supporting Document Type	Supporting Document Upload	Name Change Reason(s)

FCVS Physician Information Profile

19.

IDFPR accepts Physician Information Profiles compiled by the Federation Credentials Verification Service (FCVS). Will you be using the FCVS to verify your credentials?

If so, please contact FCVS to send your Physician Information Profile to IDFPR. This will include verification of the following:

- **Medical School Transcripts and Diploma**
- **ECFMG Certification**
- **Physician Exam**
- **Postgraduate Clinical Training**

No

Education Location

20. Were you educated in the U.S. or one of its Territories or were you Foreign Educated?

U.S. or one of its Territories

Education Information

21. Please list information on your primary school education in the grid below:

Primary School Type (High School, or GED)	School Name	City	State (If foreign, select Unknown)	Country	Date Graduated
Graduated	Columbia City High School	Columbia City	Indiana	UNITED STATES	06/14/1991

22. Please list information on your undergraduate, graduate and vocational training degree(s) earned in the grid below:

College, University, or Training School	City	State (If foreign, select Unknown)	Country	Attendance: From	Attendance: To	Degree Major	Degree Earned	Graduated?
Indiana University Purdue University	Indianapolis	Indiana	UNITED STATES	08/16/1993	08/02/1996	Mechanical Engineering	Bachelor of Science	Graduated
Saint Louis University	St. Louis	Missouri	UNITED STATES	05/16/2005	05/19/2006	Nursing	Bachelor of Science	Graduated

Proof of Pre-Medical Education

23.

Please upload an official transcript verifying completion of at least two academic years of instruction in a college university of other institution.

The transcript must bear the official seal and signature of the institution.

IUPUI Official Transcript.pdf
SLU Official Transcript.pdf

Medical School Location

24.

Did you graduate from a medical or osteopathic college located in the United States/Canada or in another foreign country?

United States/Canada

25. If another country, please specify where.

Medical School Transcripts and Diploma

26.

Please upload an official transcript issued by your medical school verifying your medical education including your degree conferred and graduation date. If the transcript does not include your date of graduation and degree conferred, upload a copy of your diploma. Official transcripts must be submitted from each medical school attended.

PSU Transcript.pdf

Postgraduate Clinical Training Information

28.

Please list information on your postgraduate clinical training in the grid below:

Name of Sponsoring Institution	Address 1	Address 2	City	ZIP	State	Country	Program Name	Specialty	Start Date	End Date	Program Completion	Total Months Completed
Indiana University	400 East Seventh Street		Bloomington	47405	Indiana	UNITED STATES	Indiana University	OB/GYN	07/01/2014	06/15/2018	Completed Entire Program	48

29.

If you have selected Completed Partial Program, please provide a detailed statement with the date and signature, explaining partial completion.

Postgraduate Clinical Training

30.

Please have the education program director of your graduate medical program complete the TN-MED form in its entirety. The form must verify that you have completed at least 24 months of post-graduate clinical training as approved by the Department. Incomplete forms will not be accepted by the Department. You may download the form here.

TNM form.pdf
IU Seal Letter.pdf

Verification of Professional Capacity

31.

Have you been actively engaged in the practice of medicine or been a student engaged in a formal program during the 2 years immediately preceding today's date?

Yes

32.

If you answered No, you must submit evidence to establish your present capacity to practice chiropractic with reasonable judgement, skill, and safety. The following may be considered as evidence of your present capacity: specialized training or education, publications of original work in learned chiropractic journals, public clinical research, federal clinical research, or other professional clinical activities related to the practice of chiropractic medicine. Please upload a detailed statement which clearly identifies each activity specified above that you are claiming to meet the professional capacity requirement. The statement must be signed and dated. Also provide official documentation that verifies completion of each activity.

Physician Verification of Employment/Experience

33.

Please record your work history chronologically for the five (5) years preceding the date of application, starting with present employment. For each position held, please provide complete information including the name of each practice/work location along with the address where patient care was provided, your dates of employment, job title, description of duties performed, and time employed.

Name of Practice/Work Location	Employer Address	Employer Address	Employer City	Employer Country	Employer State	Employer Zip	Dates of Employment - Start Date	Dates of Employment - End Date	Currently Employed	Were you a full-time employee or a part-time employee?	Please state your job title at the time of your employment.	Please provide a description of the duties you performed during your employment.	Total Number of Years Employed	Months Employed
Indiana University, Department of OB/GYN	550 University Blvd		Indianapolis	UNITED STATES	Indiana	46202	07/01/2014	06/15/2018	Yes	Full-Time	Resident physician	Under direct supervision of attending physician, evaluate and treat patients within inpatient and outpatient settings.	4	0
Penn State College of	500 University		Hershey	UNITED STATES	Pennsylvania	17033	08/01/2010	05/16/2014	No	Full-Time	Medical student	Completed all required	4	0

Medicine	Dr											didactic and clinical duties required for graduation.		
Saint Louis University Hospital	3635 Vista Ave		St. Louis	UNITED STATES	Missouri	63110	03/01/2009	06/01/2010	No	Full-Time	Registered Nurse	Direct patient care in medical ICU	1	3
Grace Hill Neighborhood Health Centers, Inc.	1717 Biddle		St. Louis	UNITED STATES	Missouri	63106	10/01/2006	09/01/2008	No	Full-Time	Registered nurse, Health Center Manageer	Manage clinical aspects of adult medicine department, oversee and evaluate ancillary staff	2	0
United Technologies Corporation	7310 W Morris St		Indianapolis	UNITED STATES	Indiana	46231	01/01/1997	02/01/2004	No	Full-Time	Project Engineer	Product design and development, manufacturing cost improvements	8	0

Physician Exam Scores

Please certify that you have requested the appropriate testing agency to forward your entire pass/fail exam history to IDFPR. Click HERE for more information regarding Illinois' examination requirements.

34. I certify that I have instructed the appropriate testing agency to forward my scores and exam history to IDFPR.

Yes

Physician Exam History

35.

Have you passed all steps of the USMLE examination within 7 years after passing the first step taken, either Step 1 or Step 2?

Yes

36.

Please upload a detailed statement explaining why you were delayed from completing the USMLE examinations during the 7 year period.

Include complete and accurate information for IDFPR to consider when making a decision regarding your variance request. The statement must be signed and dated.

Fingerprint Background Check

This profession requires a fingerprint criminal background check.

1. Further instructions on how to complete this requirement can be found **here**.
2. Fingerprints must be taken within 60 days from the date that the application is submitted.
3. A list of licensed Illinois Fingerprint Vendors can be found **here**.

39. Were your fingerprints taken by a licensed *Illinois Fingerprint Vendor* or were they taken by an *Out-of-State Entity*?

Fingerprints not yet completed

Record of Licensure

43. Please list all other related or non-related professional licenses held in Illinois or another state(s).

Please be sure to list all temporary, trainee or apprenticeship licenses or permits.

License Type	License Status	License Number	City	State (If foreign country, select UNKNOWN)	Country
Visiting Resident Permit	Active	188.000752	Granite City	Illinois	UNITED STATES
Medical Residency Permit	Active	11017874A	Indianapolis	Indiana	UNITED STATES

CCA

Applicants are not obligated to disclose sealed or expunged records of a conviction or arrest.

45. Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act as a part of a criminal sentence?

No

46. Are you currently charged with or have you been convicted of a criminal battery against any patient in the course of patient care or treatment, including any offense based on sexual conduct or sexual penetration?

No

47. Are you currently charged with or have you been convicted of a forcible felony?

No

48. If you answered yes to any of the above statements, please attach a certified copy of the court records regarding your conviction, description of the nature of the offense, date of discharge, if applicable, and a statement from the probation or parole office.

Personal History - Medical Specific pt.1

49. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity?

No

50. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated.

51. Have you ever resigned in lieu of discipline or while under investigation that could lead to any restriction, suspension, or termination by any hospital or health care entity?

No

52. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated.

53. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended? You must answer yes if any of these actions are currently pending or if you have withdrawn or failed to proceed with an application for privileges/memberships.

No

54. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated AND request the hospital or health care facility to submit a report directly to the Department regarding the action.

55. Has your provider status ever been restricted, suspended or terminated by any insurance carrier, including but not limited to Medicare, Medicaid, Tricare or any private carrier?

No

56. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated.

Personal History - Medical Specific pt.2

57. Have you ever voluntarily surrendered a license to practice medicine in any state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee.

No

58. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department

59. Have you ever withdrawn an application for a license to practice medicine or any temporary/resident license in any other state, country, or U.S. federal jurisdiction?

No

60. If you answered yes to the question above, upload a complete and accurate explanation that has been signed/dated and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.

61. Have you ever been admonished, reprimanded, censured and/or disciplined in any way by any professional or medical society or association or committee thereof, or by any non-licensing governmental agency including but not limited to any governmental assistance agency? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Disclose any stipulation to informal disposition in response to this question.

No

62. If you answered yes to the question above, upload a signed/dated complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.

Personal History pt. 1

Applicants are not obligated to disclose sealed or expunged records of a conviction or arrest.

63. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.

No

64. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*

65. Have you been convicted of a felony? (In general, a felony conviction by itself does not usually result in denial of licensure.)

No

66. *If yes, attach a detailed explanation or a copy of the Certificate of Relief from Disabilities by the Prisoner Review Board.*

67. Have you ever been discharged other than honorably from the armed services or from a city, county, state, or federal position?

No

68. *If yes, attach a detailed explanation.*

Personal History pt. 2

69. Have you had or do you 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?

■

70. ***If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.***

71. 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?

No

72. ***If yes, attach a detailed explanation.***

Child Support, Student Loan and Tax History

73. In accordance with 5 ILCS 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.

Are you more than 30 days delinquent in complying with a child support order?

No

74. ***If yes, upload a detailed explanation.***

75. In accordance with 20 ILCS 2105-15(a)(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."

Have you ever been or are you currently in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State?

No

76. ***If yes, upload a detailed explanation and proof of a satisfactory repayment record (if applicable).***

77. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

Are you delinquent in the filing of state taxes?

No

78. ***If yes, upload a detailed explanation.***

Certifying Statements

79. I attest that I will respond to the Division's requests for supplemental information.

Yes

80. I understand that the fees for this application are not refundable.

Yes

81. By entering my full legal name and today's date in the fields below I certify and attest under penalty of perjury that the information provided to the Department in this application is true and accurate to the best of my knowledge.

James Howard Hobby

82. Today's Date

02/28/2018

Review

Print

Application - LICENSED PHYSICIAN CONTROLLED SUBSTANCE

Name	James Howard Hobby MD
Credential	LICENSED PHYSICIAN CONTROLLED SUBSTANCE

Fee Details

INITIAL APPLICATION FEE	$ 5.00
	$ 5.00

Physician Controlled Substance Application

Please review all of the information you provided in this application to ensure it is accurate. If there are any issues please be sure to make edits before proceeding to payment.

Public and Mailing Addresses

1. Please verify or enter your Public Address:

Attention Line
Address Line 1 [redacted]
Address Line 2
City [redacted]
State [redacted]
Zip Code [redacted]
County
Country UNITED STATES
Phone [redacted]
Cell Phone [redacted]

2. Please verify or enter your Mailing Address (address for license printout):

Attention Line
Address Line 1 [redacted]
Address Line 2
City [redacted]
State [redacted]
Zip Code [redacted]
County
Country UNITED STATES
Phone [redacted]
Cell Phone

Personal Information

3. Birth City:
Lebanon

4. Birth State *(if foreign born choose UNKNOWN)*:
Indiana

5. Birth Country
UNITED STATES

6. Gender:

Male

7. Which ethnicity best describes you?

Caucasian

Name Change

11. Do any of your supporting documents have a different name than your current legal name?

No

12. If you answered *"Yes"* to the question above, please add proof of your name change in the grid below:

Previous Name on Document(s)	From	To	Supporting Document Type	Supporting Document Upload	Name Change Reason(s)

Controlled Substance Drug Schedule

13. Please select all controlled substance schedules that you will be applying for (You may choose more than one).

II
III
IV
V

Controlled Substance Storage

14. Will you be storing or dispensing controlled substances including samples?

Yes, I will be storing or dispensing controlled substances.

Controlled Substance Location

15. Will you be storing controlled substances at the location listed below or at a different location?

Yes, the location listed below.

16. If you answered "Yes" to the question above, please confirm the information below is correct.

Attention Line
Address Line 1 [redacted]
Address Line 2
City [redacted]
State [redacted]
Zip Code [redacted]
County
Country UNITED STATES
Phone [redacted]
Cell Phone [redacted]

CCA

Applicants are not obligated to disclose sealed or expunged records of a conviction or arrest.

18. Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act as a part of a criminal sentence?

No

19. Are you currently charged with or have you been convicted of a criminal battery against any patient in the course of patient care or treatment, including any offense based on sexual conduct or sexual penetration?

No

20. Are you currently charged with or have you been convicted of a forcible felony?

No

21. If you answered yes to any of the above statements, please attach a certified copy of the court records regarding your conviction, description of the nature of the offense, date of discharge, if applicable, and a statement from the probation or parole office.

Controlled Substance Personal History Pt. 1

22. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.

No

23. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*

24. Have you been convicted of a felony? (In general, a felony conviction by itself does not usually result in denial of licensure.)

No

25. *If yes, attach a detailed explanation or a copy of the Certificate of Relief from Disabilities by the Prisoner Review Board.*

26. Have you ever been discharged other than honorably from the armed services or from a city, county, state, or federal position?

No

27. *If yes, attach a detailed explanation.*

Controlled Substance Personal History Pt. 2

Applicants are not obligated to disclose sealed or expunged records of a conviction or arrest.

28. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition?

■

29. *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*

30. 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?

No

31. *If yes, attach a detailed explanation.*

32. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license.

No

33. If yes to the question above, please attach a complete and accurate explanation and certified documentation from the appropriate entity regarding the action.

Child Support and Tax History

34. In accordance with 5 ILCS 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.

Are you more than 30 days delinquent in complying with a child support order?

No

35. *If yes, upload a detailed explanation.*

36. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

Are you delinquent in the filing of state taxes?

No

37. *If yes, upload a detailed explanation.*

Certifying Statements

38. I attest that I will respond to the Division's requests for supplemental information.

Yes

39. I understand that the fees for this application are not refundable.

Yes

40. By entering my full legal name and today's date in the fields below I certify and attest under penalty of perjury that the information provided to the Department in this application is true and accurate to the best of my knowledge.

James Howard Hobby

41. Today's Date

02/21/2022

Review

Print