Application - LICENSED PHYSICIAN AND SURGEON

Name	Terry Keith Grebe
Credential	LICENSED PHYSICIAN AND SURGEON

Fee Details

INITIAL APPLICATION FEE	$ 500.00
	$ 500.00

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 $500 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.**

Military Status

1. Check the box indicating the appropriate information regarding your application.

Military means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application.

NON-MILITARY

2. Please upload proof of your, or your spouse's, military status.

The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal.

Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

Application Method

3. Please select your desired application method.

Endorsement

Authorization for Third-Party Contact

4. 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

5. Name of Person/Business:

Katherine Logan/Medical License Pro

6. Phone Number:

[redacted]

7. Email Address:

[redacted]

8. 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

9. Please verify or enter your Public Address:

Attention Line	
Address Line 1	1203 Poplar Ave
Address Line 2	
City	Memphis
State	TN
Zip Code	38104-7241
County	
Country	UNITED STATES
Phone	901-274-3550
Cell Phone	

10. Please verify or enter y ess (address for license printout):

Attention Line	
Address Line 1	[redacted]
Address Line 2	
City	
State	
Zip Code	

County
Country [redacted]
Phone
Cell Phone

Personal Information

13. Birth City:
[redacted]

14. Birth State *(if foreign born choose UNKNOWN)*:
[redacted]

15. Birth Country
[redacted]

16. Gender:
Male

17. Which ethnicity best describes you?
Caucasian

Date of Birth

18. Date of Birth
[redacted]

Name Change

19. Do any of your supporting documents have a different name than your current legal name?
No

20. 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

21.

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

22. 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

23. 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	New Franklin High School	New Franklin	Tennessee	UNITED STATES	05/15/1964

24. 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?
Central Methodist University	Fayette	Missouri	UNITED STATES	09/01/1964	05/15/1968	Chemistry	[redacted]	

Proof of Pre-Medical Education

25. How will you deliver your proof of education to IDFPR?
My school will mail or electronically transmit my official transcripts directly to IDFPR.

26.

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

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

Note: If you graduated from a 6-year medical program, please proceed to question 24 to upload your official transcript.

Medical School Location

27.

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

28. If another country, please specify where.

Medical School Transcripts and Diploma

29.

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.

Placeholder Document.pdf

Postgraduate Clinical Training Information

31.

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
University of Missouri at Columbia Program	Dept. Obstetrics & Gynecology, 500 N Keene Street	Suite 400, DC612.00	Columbia	65201	Missouri	UNITED STATES	Residency	Obstetrics and Gynecology	07/01/1972	06/30/1976	Completed Entire Program	48

32.

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

Postgraduate Clinical Training

33.

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.

Placeholder Document.pdf

Verification of Professional Capacity

34.

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

35.

If you answered No, you must submit evidence to establish your present capacity to practice medicine 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 medical journals, public clinical research, federal clinical research, or other professional clinical activities related to the practice of 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

36.

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
Planned Parenthood - Joplin Health Center	710 S Illinois Ave		Joplin	UNITED STATES	Missouri	64801	11/01/2010	11/30/2018	No	Full-Time	Clinician, Medical Director	OB/GYN Physician, Medical Director	8	0
Planned Parenthood - Memphis Health Center	2430 Poplar Ave, Ste 100		Memphis	UNITED STATES	Tennessee	38112	01/01/2019	04/30/2020	No	Full-Time	Staff Physician	OB/GYN Physician	1	3
CHOICES Medical Services	1203 Poplar Ave		Memphis	UNITED STATES	Tennessee	38104	01/01/2019	02/21/2022	Yes	Full-Time	Physician, President	OB/GYN Physician, President	3	2

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.

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

Yes

Physician Exam History

38.

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

No

39.

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.

Explanation (Exam) - Grebe.pdf

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**.

42. 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

46. 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
Physician	Active	12848750	Memphis	Tennessee	UNITED STATES
Physician	Active	34582	Joplin	Missouri	UNITED STATES

Proof of Out-of-State Licensure

47. If you are applying for licensure via *Endorsement* you must submit license certifications from your state of *original licensure* and *current licensure*.

You may do this by uploading either:

1. **A License Certification (CT) Form Completed in the State of Licensure OR**
   - **A CT Form can be access Here**
2. **A State Agency or State Board's Official Certification**

State (If foreign, select Unknown)	State of Original Licensure?	My state of licensure:	Upload a copy of your license certification
Tennessee	No	Will forward certification directly to IDFPR	**TN License - Grebe.pdf**
Missouri	Yes	Will forward certification directly to IDFPR	**MO License - Grebe.pdf**

CCA

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

48. 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

49. 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

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

No

51. 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

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

No

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

54. 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

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

56. 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

57. 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.

58. 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

59. 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

60. 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

61. 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

62. 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

63. 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.

64. 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

65. 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.

66. 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

67. *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.*

68. Have you been convicted of a felony? (In general, a felony conviction by itself does not usually result in denial of licensure.)
No

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

70. Have you ever been discharged other than honorably from the armed services or from a city, county, state, or federal position?
No

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

Personal History pt. 2

72. 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?
[redacted]

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

74. 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

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

Child Support and Tax History

76. 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?
[redacted]

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

78. 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

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

Certifying Statements

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

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

82. 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.
Terry Keith Grebe

83. Today's Date
03/17/2022

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

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

IDPR

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
Grebe	Terry	Keith	[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.

Profession Name _____ Profession Code

6. MAIDEN OR GIVEN SURNAME

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 THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed 48 months of postgraduate clinical training in University of Missouri OB/GYN Residency Program
(Name of Specialty Program)

from 07/01/1972 (MM/DD/YYYY) to 06/30/1976 (MM/DD/YYYY) at the following hospital:

Hospital: University of Missouri Hospitals and Clinics

Number and Street: One Hospital Dr.

City, State and Zip Code: Columbia, MO 65212

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

- [x] the ACGME
- [ ] the AOA
- [ ] the CFPC, RCPSC or FMLAC (Canadian Programs)
- [ ] not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: Breton F. Barrier, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 4/8/22

Telephone No: (573) 817-3096

University/Hospital SEAL

(If no seal, attach letter on letterhead stating no seal exists.)

IL486-1535 10/06 (MD)

School of Medicine
University of Missouri-Columbia

Department of Obstetrics, Gynecology and Women's Health
Office of Resident and Medical Student Education

500 North Keene Street, Suite 400
Columbia, MO 65201
Telephone: (573) 817-3096
Facsimile: (573) 817-6645

Kimberly J. Bailey, Program Manager

June 7, 2022

RE: Terry K. Grebe, MD

To Whom It May Concern:

I am writing on behalf of the Department of Obstetrics, Gynecology and Women's Health at the University of Missouri to state that the department, nor the hospital, has an official seal to stamp the enclosed form for Dr. Grebe.

Please feel free to contact me if you have any questions or if I can be of further assistance.

Sincerely,

[redacted]

Kimberly J. Bailey
Program Manager

/kjb

enc.

Michael L. Parson
Governor
State of Missouri

Sheila Solon, Acting Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Missouri Department of
Commerce & Insurance
Chlora Lindley-Myers, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
573-751-3166 FAX
800-735-2966 TTY Relay Missouri
800-735-2466 Voice Relay Missouri

James Leggett
Executive Director
healingarts@pr.mo.gov
pr.mo.gov/healingarts

To:

Illinois Dept of Financial & Prof Reg-Medical
320 W Washington St 3rd Flr
Springfield, IL 62786

This is to certify that the records of the Missouri Board of Healing Arts indicate the following information regarding Terry K Grebe, M.D..

LICENSE TYPE:	Medical Physician & Surgeon
LICENSE NUMBER:	34582
DATE ISSUED:	6/24/1972
STATUS:	Active
EXPIRATION DATE:	1/31/2023
DISCIPLINARY ACTION:	None

[redacted]

Paige Watts
Verifications Clerk

03/22/2022

Date

This is the only form that will be used by the Missouri State Board of Registration for the Healing Arts for the purpose of license verification.

Michael L. Parson
Governor
State of Missouri

Sheila Solon, Acting Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Missouri Department of
Commerce & Insurance
Chlora Lindley-Myers, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
573-751-3166 FAX
800-735-2966 TTY Relay Missouri
800-735-2466 Voice Relay Missouri

James Leggett
Executive Director
healingarts@pr.mo.gov
pr.mo.gov/healingarts

April 13, 2022

Illinois Medical Board
320 W Washington St., 3rd Floor
Springfield, IL 62786
Email: fpr.medicalunit@illinois.gov

To Whom It May Concern:

This is to verify that Terry K. Grebe, MD, holds a Missouri license number 34582 that was issued June 24, 1972. The state board exam was taken May 25 and 26, 1972. The results are listed below:

Anatomy & Histology	[redacted]
Physiology	
Chemistry	
Pathology	
Bacteriology	
Sanitation & Hygiene	
Physical Diagnosis	
Medicine	
Surgery	
Obstetrics	
Gynecology	
Pediatrics	
General Average	

If you have any questions, please feel free to contact our office at (573) 751-0098.

Sincerely,

Licensure Section/ RH

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 Mainstream Drive, Second Floor
Nashville, TN 37243
http://www.tn.gov/health

Board of Medical Examiners
Medical Doctors
1-800-778-4123 or 615-532-4384

March 24, 2022

TO WHOM IT MAY CONCERN:

This verification can be considered primary source. To expedite the verification process, this is the standard format used by the Board of Medical Examiners. The Board of Medical Examiners is pleased to furnish the following information from our files:

PROFESSION:	Medical Doctors
NAME:	TERRY KEITH GREBE MD
RANK:	Medical Doctor
LICENSE NUMBER:	52756
ISSUE DATE:	June 17, 2015
EXPIRATION DATE:	February 29, 2024
CURRENT STATUS:	Licensed
STATUS DATE:	June 17, 2015
SPECIAL ENDORSEMENTS:	Obstetrics and Gynecology

COMMENTS: There is no history of disciplinary action on this license. The State of Tennessee only provides the above information. Any other information needed must be obtained from the licensee.

Sincerely,

[redacted]

Board of Medical Examiners
VERIFICATN

ABOG
American Board of Obstetrics & Gynecology
First in Women's Health®

Monday, February 21, 2022

RE: Certification Status of Terry Keith Grebe, MD

To Whom It May Concern:

The certification status for Terry Keith Grebe, MD is as follows:

ABOG ID Number: 16366

Obstetrics and Gynecology Certification

Original Certification Date: 2/1/1979

Certification Status: Non-Expiring

Participating in Maintenance of Certification: No

Physicians certified by the ABOG in Obstetrics and Gynecology prior to 1986 or subspecialty certified prior to November 1987 hold non-time-limited (non-expiring) certificates. They are not required to participate in Maintenance of Certification.

Sincerely,

George D. Wendel, Jr. M.D.
Executive Director

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Illinois Division of Professional Regulation	As of Date:5/19/2022

PRACTITIONER INFORMATION

Name:	Grebe, Terry Keith
Alternate Name(s):	Grebe, Terry K
DOB:	[redacted]
Medical School:	University of Missouri School of Medicine Columbia, Missouri, UNITED STATES
Year of Grad:	1968
Degree Type:	MD
NPI:	1497722771

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1497722771	Individual			03/28/2019

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ILLINOIS	036			04/22/2022
	FSMB License Status: Applicant			
MISSOURI	34582	06/24/1972	01/31/2023	05/04/2022
	FSMB License Status: Active			
TENNESSEE	52756	06/17/2015	02/29/2024	04/20/2022
	FSMB License Status: Active			

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Illinois Division of Professional Regulation	As of Date:5/19/2022
Practitioner Name:	Grebe, Terry Keith	

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
[redacted]		MEMPHIS,TN 38104	09/30/2023	01/05/2022

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Illinois Division of Professional Regulation	As of Date:5/19/2022
Practitioner Name:	Grebe, Terry Keith	

ABMS® CERTIFICATION HISTORY

Certifying Board:	American Board of Obstetrics and Gynecology
Certificate:	Obstetrics and Gynecology
Certification Type:	General
Certification Status:	Certified
Participating in MOC:	Not Required

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Lifetime	08/01/1993			Recertification	04/28/2022
Active	Lifetime	1979			Initial	04/28/2022

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AOA® CERTIFICATION HISTORY

No AOA Certifications found.