Application - LICENSED PHYSICIAN AND SURGEON

Name	Thomas Russell Horton, Jr.
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:

Heidi Kirk

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 **address for license printout):**

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

County
Country
Phone
Cell Phone

Personal Information

13. Birth City:

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

15. Birth Country

16. Gender:
Male

17. Which ethnicity best describes you?
Caucasian

Date of Birth

18. Date of Birth

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	McLean High School	McLean	Virginia	UNITED STATES	06/30/1981

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?
George Mason University	Fairfax	Virginia	UNITED STATES	09/01/1981	05/31/1993	Biology		
Eastern Virginia Medical School	Norfolk	Virginia	UNITED STATES	08/01/1994	05/16/1998	Medicine		

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.

MD Diploma - Horton, MD.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
Lehigh Valley Hospital	1627 W. Chew Street		Allentown	18102	Pennsylvania	UNITED STATES	Residency	Obstetrics and Gynecology	07/01/1998	06/30/2002	Completed Entire Program	36
University of Tennessee Health Science Center	875 Monroe Avenue		Memphis	38163	Tennessee	UNITED STATES	Fellowship	Female Pelvic Medicine and Reconstructive Surgery	07/01/2002	06/30/2004	Completed Entire Program	24

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.

Place Holder 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
CHOICES Medical Services	1203 Poplar Avenue		Memphis	UNITED STATES	Tennessee	38104	04/01/2019	05/24/2022	Yes	Full-Time	Staff Physician	Abortion and related services to clients	3	1
Carafem	5002 Crossings Circle	#260	Mt. Juliet	UNITED STATES	Tennessee	37122	04/01/2019	03/31/2020	No	Full-Time	Staff Physician	Abortion and related services for clients	0	11
Knoxville Center for Reproducitve Health	1547 Clinch Avenue		Knoxville	UNITED STATES	Tennessee	37916	12/01/2018	02/28/2020	No	Full-Time	Staff Physician	Abortion and related services for clients	1	3
Little Rock Family Planning Services	4 Office Park Drive		Little Rock	UNITED STATES	Arkansas	72211	02/01/2010	09/30/2019	No	Full-Time	Staff Physician	Abortion and related services for clients	8	7

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?
Yes

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.

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*?
Out-of-State Entity

Out-Of-State Fingerprint Vendor

44. Enter your Transaction Control Number (TCN):

1. **This number starts with the letters 'FRM', is 16 characters long and can be found on the "Fee Applicant Card" provided by the IDFPR.**
2. **For an example of where to find this number, click here.**
3. **Please retain a copy of all Out-of-State fingerprint documents until your license has been issued. The IDFPR may request additional information if any issues in the fingerprinting process arise.**

[redacted]

45. If you were fingerprinted out-of-state and did not utilize a *Fee Applicant Card*, upload form OOS-FP below.

An additional copy of form OOS-FP can be found here.

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
MD	Inactive	04-36956	Topeka	Kansas	UNITED STATES
MD	Active	E-3656	Little Rock	Arkansas	UNITED STATES
MD	Inactive	MD00044133	Olympia	Washington	UNITED STATES
MD	Active	101237059	Henrico	Virginia	UNITED STATES
MD	Active	36459	Nashville	Tennessee	UNITED STATES
MD	Inactive	MD072728L	Harrisburg	Pennsylvania	UNITED STATES
MD	Inactive	MT043784T	Harrisburg	Pennsylvania	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	Yes	Will forward certification directly to IDFPR	**TN License - Horton, MD.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.
Yes

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.*
Personal Statement - DUI.pdf

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.
Thomas Russell Horton, Jr.

83. Today's Date
05/27/2022

Review

4206843

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.

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
PERSONAL HISTORY INFORMATION

RECEIVED JUN 11 2022 IDFPR - MEDICAL UNIT

SUPPORTING DOCUMENT **PH**

NAME	LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
	Horton, Jr.	Thomas	Russell	228-68-4874

In order for your application to be evaluated, you must respond to each of the following questions:	YES	NO
1. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity? If yes, attach a separate sheet with complete and accurate explanation.		X
2. 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? *If yes, attach a separate sheet with complete and accurate explanation.*		X
3. 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. *If yes, attach a separate sheet with complete and accurate explanation AND request the hospital or health care facility to submit a report directly to the Department regarding the action.*		X
4. 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? If yes, attach a separate sheet with complete and accurate explanation.		X
5. 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. *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		X
6. 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? *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		X
7. 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. *If yes, attach a separate sheet with a complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.*		X

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted] 06/06/2022

Signature of Applicant — Date

IL486-2098 1/14

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

(DPR)

APPLICANT: ***Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.***

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
Horton	Thomas	Russell	[redacted]	[redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted]

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

Physician (Profession Name) — 0 3 6 (Profession Code)

6. MAIDEN OR GIVEN SURNAME

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 Obstetrics and Gynecology
(Name of Specialty Program)

from 6/24/1998 (MM/DD/YYYY) to 6/23/2002 (MM/DD/YYYY) at the following hospital:

Hospital: Lehigh Valley Health Network

Number and Street: 1200 S. Cedar Crest Blvd.

City, State and Zip Code: Allentown, PA 18103

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: Christina M. Black, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 7/19/2022

University/Hospital SEAL

Telephone No: 484-862-3118

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

MPORTANT NOTICE: Completion of this form s necessary for consideration for licensure nder 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is OLUNTARY. However, failure to comply may esult in this form not being processed.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(OPR)

PPLICANT: *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
Horton	Thomas	Russell	[redacted]	[redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE [redacted]

MAIDEN OR GIVEN SURNAME

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

Physician (Profession Name) — 0 3 6 (Profession Code)

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 Obstetrics and Gynecology
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Hospital: Lehigh Valley Health Network

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- [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: Christina M. Black, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 7/19/2022

University/Hospital SEAL

Telephone No: 484-862-3118

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

86-1535 10/09 (HP)

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Recipient: ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

Date: 06/15/2022

Examinee: Horton Jr, Thomas Russell
Alt Name(s):

Examinee ID: [redacted]
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, two-digit scores will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale. Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/11/1996	Pass	[redacted]	(176)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/26/1997	Pass	[redacted]	(170)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/11/1999	Pass	[redacted]	(177)	

End of Exam History

NOTE: The USMLE Step 2 CS examination was last administered March 16, 2020. Examinees with a failing outcome may not have had an opportunity to retest. The USMLE defines successful completion of its examination sequence as passing Step 1, Step 2 CK, and Step 3.

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Examinee: Horton Jr, Thomas Russell

Examinee ID: [redacted]
Date of Birth:

INTERPRETATION OF RESULTS
USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 1 AND STEP 2 CLINICAL SKILLS (CS)
Step 1 examinations taken on or after January 26, 2022 are reported as pass/fail, with no numeric score; Step 1 examinations taken before January 26, 2022 will continue to be reported with a 3-digit score. All Step 2 CS results are reported as pass or fail, with no numeric score. Test results reported as passing represent an exam score of 75 or higher on a two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"
Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"
Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"
The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Illinois Division of Professional Regulation	As of Date:7/19/2022

PRACTITIONER INFORMATION

Name:	Horton Jr, Thomas Russell
DOB:	[redacted]
Medical School:	Eastern Virginia Medical School Norfolk, Virginia, UNITED STATES
Year of Grad:	1998
Degree Type:	MD
NPI:	1891904827

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
1891904827	Individual			06/04/2018

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Illinois Division of Professional Regulation As of Date:7/19/2022

Practitioner Name: Horton Jr, Thomas Russell

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ARKANSAS	E-3656	02/05/2010	09/30/2022	07/15/2022
	FSMB License Status: Active			
ILLINOIS	036			06/30/2022
	FSMB License Status: Applicant			
KANSAS	04-36956	12/11/2013	07/31/2021	07/06/2022
	FSMB License Status: Canceled			
PENNSYLVANIA	MT043784T	05/19/1999	06/23/2002	07/08/2022
	FSMB License Status: Inactive			
PENNSYLVANIA	MD072728L	11/22/2000	12/31/2002	07/08/2022
	FSMB License Status: Inactive			
TENNESSEE	36459	05/16/2002	09/30/2023	06/21/2022
	FSMB License Status: Active			
VIRGINIA	0101237059	08/13/2004	09/30/2022	07/15/2022
	FSMB License Status: Active			
WASHINGTON	MD00044133	08/19/2004	09/24/2005	06/30/2022
	FSMB License Status: Expired			

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
FH5255129	22N 33N 4 5	MEMPHIS,TN 38104	10/31/2023	01/05/2022

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Illinois Division of Professional Regulation	As of Date:7/19/2022
Practitioner Name:	Horton Jr, Thomas Russell	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
POST OFFICE BOX 2649
HARRISBURG, PA 17105-2649
www.dos.pa.gov

06/15/2022

Verification/Certification of License

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	THOMAS RUSSELL HORTON JR
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE #:	MD072728L
LICENSE STATUS:	Inactive
LICENSE ISSUE DATE:	11/22/2000
LICENSE EXPIRATION DATE:	12/31/2002
DISCIPLINARY HISTORY:	No Disciplinary Action Exists

[redacted]

Acting Commissioner Arion R. Claggett
Bureau of Professional and Occupational Affairs

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

June 23, 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: Thomas R Horton JR MD

RANK: Medical Doctor

LICENSE NUMBER: 36459

ISSUE DATE: May 16, 2002

EXPIRATION DATE: September 30, 2023

CURRENT STATUS: Licensed

STATUS DATE: August 24, 2017

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

COMMONWEALTH of VIRGINIA

General District Court of Fauquier County

J. GREGORY ASHWELL
GENERAL DISTRICT JUDGE

6 Court Street
Warrenton, Virginia 20186-3299
Phone: (540) 422-8035
Fax: (540) 422-8033

ASHLEY GATCHELL, Clerk

Pursuant to VA CODE 16.1-69.54 and 16.1-69.55, this notice is to advise the Fauquier County General District Court has destroyed records dated prior to 2003. We have no way to verify any information that may have been contained in the case file.