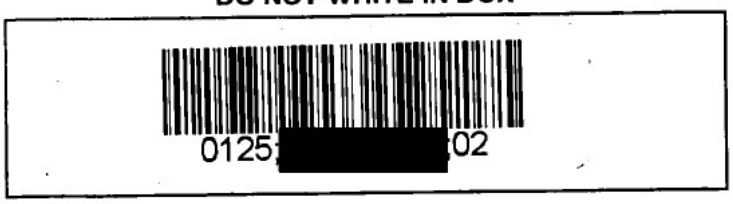
Lic#:
JENNINGS, VALERIE LAUREN
125 Cred #3227763 06/04/2012
By:LIC BY EXAM
SSN: [redacted]

DO NOT WRITE IN BOX



Profession Code _____ License # or SSN # _____

FILE ROUTE CARD

DO NOT WRITE ON FILE FOLDER

IL486-1327 10/04 (RS)

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

6/28/12 Dept to cash 1p

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

RECEIVED
CASH SECTION
MAY 29 2012
DIV. OF Professional Regulation

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. SEE **REFERENCE SHEET, CHART I, OR INSTRUCTIONS** PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
PHYSICIAN	1 2 5	NON-EXAMINATION	$100

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [X] This is the first time I have made application for this profession in Illinois.
- [ ] I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- [ ] Other: _____
- [ ] My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- [ ] I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
JENNINGS, VALERIE LAUREN	M.D.	[redacted]

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

[redacted]

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME
JENNINGS	[redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH	10. AGE
[redacted]	[redacted]	[redacted] [X] Female [ ] Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED	12. PREFERRED e-MAIL ADDRESS(ES) [If available]
Work: [redacted] Home: [redacted] Fax: [redacted] Fax: [redacted]	[redacted]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI):

SS#:

Profession:

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM	DATES OF ATTENDANCE TO	Did You Complete Training?
		Month/Year	Month/Year	☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

SS#:

Profession:

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

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

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
USMLE STEP 1	IL	[redacted]	
USMLE STEP 2 CK	IL		
USMLE STEP 2 CS	IL		

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

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		
2. Have you been convicted of a felony?		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		

NAME (Last, First, MI): [redacted]

05/29/2012 2050751 10

PART VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes. ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐

b) CHART III - Select the examination site you desire and enter Test Center Code: ☐☐☐☐

c) CHART IV - Find your School of Graduation and enter school code: ☐☐☐☐☐

d) Record the number of times you have taken this exam in Illinois or any other state: ☐☐

SS#:

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? [redacted]
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? [redacted]

Profession:

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in conn[redacted]owledge, they are true, correct, and complete.

[redacted]ant

03/27/2012
Date

I UND[redacted]ABLE. My signature above authorizes the Department of Financial and Professional Regu[redacted]e amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

STATE OF ILLINOIS
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
DIVISION OF PROFESSIONAL REGULATION

July 10, 2012

VALERIE LAUREN JENNINGS MD
UNIV OF ILLINOIS MEDICAL CENTER
DEPT OF GME
820 S WOOD ST MC 675
CHICAGO, IL 60612

The Illinois Temporary Medical License or Permit for the resident listed above has been approved and will be forwarded to your facility as soon as office routine permits. Information regarding all licensees is available instantly on our Web site at www.idfpr.com. Simply click on the Express Access License Look-up icon to verify a license.

LICENSE DETAILS

LICENSE NUMBER:	125.062425
PROGRAM START DATE:	07/10/2012
EXPIRATION DATE:	07/09/2015
PROGRAM:	Obstetrics and Gynecology
TRAINING FACILITY:	UNIV OF IL CHICAGO

Utilization of this license is limited to the training program listed above.

Temporary licenses and permits may not be used for any clinical medical practice which occurs outside of the residency program (i.e. moonlighting).

Temporary licenses and permits are **not** automatically transferred from one program/institution to another. Should the resident transfer to a different residency program within your facility or to a program in another institution, the license or permit must be updated. The resident may not begin a new program until the current temporary license or permit has been returned to the Division and a license or permit has been issued for the new program.

The Medical Practice Act sets forth the appropriate use of temporary licenses and permits. Any violation of the Act may result in disciplinary action by this Department.

- ok

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.	CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM	SUPPORTING DOCUMENT CA-MED

NOTE: **An applicant shall not commence specialty/residency training before he or the hospital/institution receives written notice of the approval of his application from the Department of Financial and Professional Regulation.**

APPLICANT: Complete the applicant section of this form, then forward it to the hospital/institution that has accepted you for specialty/residency training, for completion of the remainder of the form.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH Month / Day / Year	3. SOCIAL SECURITY NUMBER
Jennings, Valerie Lauren	[redacted]	[redacted]

4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
6. MAIDEN OR GIVEN SURNAME	Physician (Profession Name) — 1 2 5 (Profession Code)

ADMINISTRATOR: Complete the remainder of this form and return it to the applicant.

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE Month Day Year	C. ENDING DATE Month Day Year
University of Illinois at Chicago	06 / 24 / 2012	06 / 23 / 2015

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE	E. SPECIALTY / RESIDENCY NAME
820 South Wood Street (MC 675) Chicago, Illinois 60612	**Obstetrics & Gynecology**
F. BUSINESS TELEPHONE NUMBER [redacted]	G. YEAR OF POSTGRADUATE TRAINING PGY1

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Financial and Professional Regulation, the applicant is found to be eligible for licensure.

[redacted]
Signature of Program Director

Valerie Swiatkowski, MD
Print Name of Program Director

SEAL

Program Director
Title

4/18/12
Date

IL486-0272 08/04 (MD)

-OK

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 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 GRADUATION

(Current Year Graduates of LCME and COCA-Accredited Programs Only)

SUPPORTING DOCUMENT

ED - MED

APPLICANT: ***Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.***

1. NAME LAST FIRST MIDDLE: JENNINGS VALERIE LAUREN

2. DATE OF BIRTH: [redacted] Month Day Year

3. SOCIAL SECURITY NUMBER: [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.

TEMPORARY PHYSICIAN (Profession Name) 125 (Profession Code)

6. MAIDEN OR GIVEN SURNAME

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the inform[redacted]

6/25/2012 Date

SCHOOL OFFICIAL: Complete the bottom portion of this page and return **ALONG** with a current official medical school transcript. **DO NOT** certify this form more than **30 days** prior to the graduation date.

A. MEDICAL SCHOOL INFORMATION

Name: UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE

Address: 1853 W. POLK ST

City, State, Zip: CHICAGO IL 60612

Phone: 312-996-8228

Fax: 312-996-8922

B. DATES OF ATTENDANCE: [redacted]

Degree: X MD ____ DO

C.

Applicant will complete all requirements for the medical degree as of 04 (Month) / 21 (Day) / 2012 (Year) and will graduate on 05 (Month) / 06 (Day) / 2012 (Year).

When this form is certified prior to the actual graduation of the applicant, the school official is responsible for notifying the Department of Financial and Professional Regulation of any failure on the part of the applicant to complete the requirements for graduation.

I certify that the information recorded herein is [redacted]n.

SCHOOL SEAL

SUSAN HUHNDORF

Print Name (School Official)

DIRECTOR, RECORDS & REGISTRATION

Title

6/25/12

Date

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VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

JENNINGS VALERIE LAUREN

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

5. SOCIAL SECURITY NUMBER

[redacted]

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

	Profession Code
☐ Permanent Physician License	036
☒ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

6. MAIDEN OR GIVEN SURNAME

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

A. NAME OF BUSINESS / INSTITUTION

UNIVERSITY OF ILLINOIS

JOB TITLE

RESIDENT PHYSICIAN

ADDRESS STREET, CITY, STATE, ZIP CODE

820 S. Wood St. Chicago, IL 60612

DESCRIPTION OF DUTIES PERFORMED

Resident physician in Obstetrics and Gynecology

DATE OF EMPLOYMENT/ATTENDANCE

From 06 / 25 / 2012 (Month / Day / Year)

To 06 / 30 / 2016 (Month / Day / Year)

HOURS WORKED PER WEEK

80

TYPE OF EMPLOYMENT

☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

Not yet begun

B. NAME OF BUSINESS / INSTITUTION

UNIVERSITY OF ILLINOIS

JOB TITLE

MEDICAL STUDENT

ADDRESS STREET, CITY, STATE, ZIP CODE

820 S. Wood Street, Chicago, IL 60612

DESCRIPTION OF DUTIES PERFORMED

Studied medicine

DATE OF EMPLOYMENT/ATTENDANCE

[redacted]

Month Day Year

HOURS WORKED PER WEEK

40+

TYPE OF EMPLOYMENT

☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

3 years / 9 months

TEMPORARY APPLICATION CHECKLIST

APPLICATION FINDINGS
Application Complete

NEED $50 FEE

POSITIVE PERSONAL HISTORY INFO
Yes#_____ See Worksheet for documents
VE-PC from Grad to Present for PPH_____
MLB _____ ITD_____

LICENSE INFORMATION
CA-MED (125)
Start 6/24/2012
End 6/23/2015
Program OB/GYN

UIC

Non-approved Program – MLB Interview
_____Outline which includes but not limited to: staff info; description; pre-requisites; clinical goals, activities & responsibilities; educational goals, research info; evaluations; venue

EDUCATIONAL DOCUMENTATION

UIC 2012

Pre-Med + Final Med transcript moved to OSB app

DOMESTIC GRADUATES
Premedical Transcripts
ED-MED or Roster **CURRENT YEAR GRADUATES ONLY**
Medical Transcripts w/degree date Degree date_____

DATED 4/11/2012 — CHECK GRAD DATE

FOREIGN GRADUATES
___ECFMG _____5th Pathway _____Social Service
___Premedical Transcripts ___Translations
___Medical Transcripts ___Translations Degree date _____

___AF-MED Part A

AF-MED Part B DOCUMENTATION:
Int Med Hosp: _____
Evaluation: _____
AF-MED B_____ and Agreement_____
OR
Verbal Affidavits: Hospital ___School___

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

Ob/Gyn Hosp:_____
Evaluation: _____
AF-MED B_____ and Agreement_____
OR
Verbal Affidavits: Hospital ___School___

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

Peds Hosp: _____
Evaluation: _____
AF-MED B_____ and Agreement_____ OR Verbal Affidavits: Hospital ___School ___

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

SUPPORTING DOCUMENTS
___Verification of Professional Capacity (VE-PC) - active practice in 2-years preceding app
Last Active Practice_____over 5 yrs-VE-PC Graduation to present ___150 hours Cat 1 & Mgr Aprvl
___50 hours CME out 2-3 years
___100 hours CME out 3-4 years
___150 hours CME out 4-5 years
___ CT- Original Licensure State & Number_____ Discipline?_____
NA CT - Current Jurisdiction of Practice & Number_____ Discipline?_____
N/A Name Change NA Federation Check

Direct Inquiries to the
Technical Assistance Unit

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

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

Date: 6/18/2012
Initials: DR
License No: 125 Attn: Medical

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

TO:

VALERIE LAUREN JENNINGS MD
~~UNIV OF~~ ILLINOIS MEDICAL CENTER
DEPT OF GME
[redacted]

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Submit official transcript(s) verifying medical education with graduation date OR ED-MED form certified not more than 30 days prior to graduation. If you have or will graduate after 5/11/2012 please submit transcripts certified not more than 30 days prior to graduation.

Submit $50 application fee.

Has this gone thru cash handling yet? What is the status

RECEIVED
JUN 18 2012
By

front desk
6/29/12
Cyn

OK-

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

Susan

DENISE - IT WILL TAKE 1-2 WKS FOR FEE TO GO ON SYSTEM.

ALSO ED-MED IS CERTIFIED AFTER GRAD - WE NEED FINAL TRANSCRIPTS

-OK

2

Direct Inquiries to the
Technical Assistance Unit

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

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

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TO:

VALERIE LAUREN JENNINGS MD
UNIV OF ILLINOIS MEDICAL CENTER
DEPT OF GME
[redacted]

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Submit $50 application fee.

-ok all-

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

Place Label Here

Lic#:
JENNINGS, VALERIE LAUREN
036 Cred #3493108 05/22/2015
By:ACCEPT EXAM
SSN: [redacted]

7.1.15

Profession Code

036

License # or SSN #

138546

FILE ROUTE CARD

DO NOT WRITE ON FILE FOLDER

IL486-1327 10/04 (RS)

RECEIVED
CASH SECTION

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. SEE **REFERENCE SHEET, CHART I, OR INSTRUCTIONS** PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician	0 3 6	Acceptance of Examination	$ 700

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [X] This is the first time I have made application for this profession in Illinois.
- [ ] I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- [ ] Other: _____
- [ ] My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- [ ] I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
Jennings	Valerie	Lauren	M.D.	[redacted]

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

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY: 820 S. Wood Street, Rm 277 Chicago, IL USA 60612-4325 Cook

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

7. MOTHER'S MAIDEN NAME: Grubbs

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

9. DATE OF BIRTH: [redacted] Month Day Year

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

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: [redacted] Home: [redacted]
Fax: [redacted] Fax: [redacted]

12. PREFERRED e-MAIL ADDRESS(ES) [If available]: [redacted]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI):

SS#:

Profession:

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure	Temporary Physician Licensure	125-062425	7/10/2012	Active
State of Current Licensure where you most recently have been practicing.	Temporary Physician Licensure	125-062425	7/10/2012	Active
Other States of Licensure				

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

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
USMLE Step I	IL	[redacted]	
USMLE Step II CK	IL		
USMLE Step II CS	IL		
USMLE Step III	IL		

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

NAME (Last, First, MI):

SS#:

Profession:

[redacted]

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM	DATES OF ATTENDANCE TO	Did You Complete Training?
[redacted]				
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. 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. *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		[redacted]
2. Have you been convicted of a felony?		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		

PART VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes. ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐

b) CHART III - Select the examination site you desire and enter Test Center Code: ☐☐☐☐

c) CHART IV - Find your School of Graduation and enter school code: ☐

d) Record the number of times you have taken this exam in Illinois or any other state: ☐☐

SS#:

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order?
   (NOTE: If you are not subject to a child support order, answer "no.") [redacted]

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? [redacted]

Profession:

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in [redacted] knowledge, they are true, correct, and complete.

_____ ant

3/11/2015
Date

I U[redacted]ABLE. My signature above authorizes the Department of Financial and Professional Re[redacted]e amount submitted is not correct. I understand this will be done only if the amount su[redacted]er, but in no event shall such reduction be made in an amount greater than $50.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION
PERSONAL HISTORY INFORMATION

SUPPORTING DOCUMENT

PH

NAME LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER
Jennings	Valerie	Lauren	[redacted]

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.	[redacted]	
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.*		
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.*		
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.		
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.*		
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.*		
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.*		

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]

3/11/2015
Date

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.

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE: Jennings Valerie Lauren

3. PROFESSIONAL LICENSE NUMBER (if any): 125-062425

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

4. SOCIAL SECURITY NUMBER: [redacted]

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturists
- ☐ Advanced Practice Nurses
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☒ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	[redacted]	
2) 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?		
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *		
4) Are you currently charged with or have you been convicted of a forcible felony? *		

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

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.

S[redacted]

Date 3/11/2015

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

Jennings Valerie Lauren

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

5. SOCIAL SECURITY NUMBER

[redacted]

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

	Profession Code
☒ Permanent Physician License	036
☐ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

6. MAIDEN OR GIVEN SURNAME

N/A

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment. Also list any breaks of six (6) months or longer in medical practice since graduation from medical school.

A. NAME OF PRACTICE / WORK LOCATION

University of Illinois

ADDRESS STREET, CITY, STATE, ZIP CODE

820 S. Wood St. Chicago, IL 60612

DATE OF EMPLOYMENT/ATTENDANCE

From 06 / 24 / 2012 (Month / Day / Year)

To ___ / ___ / Present (Month / Day / Year)

HOURS WORKED PER WEEK

60-80

TYPE OF EMPLOYMENT

☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

2 years, 8 months

JOB TITLE

Resident Physician

DESCRIPTION OF DUTIES PERFORMED

Resident Physician in Obstetrics and Gynecology

B. NAME OF PRACTICE / WORK LOCATION

University of Illinois

ADDRESS STREET, CITY, STATE, ZIP CODE

808 S. Wood St. Chicago IL 60612

DATE OF EMPLOYMENT/ATTENDANCE

[redacted]

HOURS WORKED PER WEEK

60-80

TYPE OF EMPLOYMENT

☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

3yr 9 month

JOB TITLE

Medical Student

DESCRIPTION OF DUTIES PERFORMED

Student.

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	3. SOCIAL SECURITY NUMBER
Jennings	Valerie	Lauren	[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) — 036 (Profession Code)

6. MAIDEN OR GIVEN SURNAME
N/A

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)
125-062425

8. ISSUANCE DATE
7/10/2012

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 33 months of postgraduate clinical training in Obstetrics & Gynecology (Name of Specialty Program)

from 06/24/2012 (MM/DD/YYYY) to 03/16/2015 (MM/DD/YYYY) at the following hospital:

Hospital: University of Illinois at Chicago

Number and Street: 820 S. Wood St.

City, State and Zip Code: Chicago, IL 60612

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: Valerie Swiatkowski, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 3/16/2015

University/Hospital SEAL

Telephone No: 312-996-0532

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

IL486-1535 10/06 (MD)

Jennings, Valerie

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Date : 05/15/2015

Recipient:

Illinois Department of Financial and Professional Regulation
ATTN: Sandy Dunn, Manager of Med Licensure
320 W Washington Street
3rd Floor
Springfield, IL 62786

Examinee ID#: 5-245-833-8
Examinee: Jennings, Valerie
Date of Birth: [redacted]
Alt Name(s): Jennings, Valerie Lauren

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. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. 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, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

[redacted]

USMLE STEP 2

Clinical Knowledge (CK) [redacted]

Clinical Skills (CS)* [redacted]

USMLE STEP 3

[redacted]

FLORIDA

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

RECEIVED ELECTRONICALLY

RECEIVED
MAY 19 2015
IDFPR - MEDICAL UNIT

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

036 APPLICATION CHECK-LIST

FILES SET-UP IN THIS ORDER (Some exceptions) DO NOT KEEP BLANK OR DUPLICATE DOCUMENTS

APPLICATION FINDINGS

3/11/15

X Application Complete
Address checked ____

— SSN Affidavit

X PH Form X CCA Form

N Fingerprint ____ Clear ____ HIT ISP- Clear FBI - No results

____ FCVS Profile ____ Name Change

____ IL Temp License ____

____ Release on File ____

POSITIVE PERSONAL HISTORY INFO

Yes # ____ ITD ____ MLB ____

Documentation:

EDUCATION DOCUMENTATION

X Premedical Transcripts

____ Translations

X Medical Transcripts [redacted]

____ Translations

Degree Date [redacted]

____ Copy of diploma if applicable

____ Copy of ECFMG (IMG)

____ Social Service (IMG)

____ 5th Pathway, if applicable (Mexico only)

____ ED-NON (IMG)

____ # of months – Minimum 36 months w/premed verified; minimum 54 months if combined

Internship year ____

Basic Sciences ____

Degree Date ____

Clinical Rotations – minimum of four (4) weeks each

Internal Medicine ____

Pediatrics ____

Obstetrics-Gynecology ____

Psychiatry ____

Psychiatry Affidavit ____ if applicable

Surgery ____

____ Signed by Dean and seal affixed - cannot be certified prior to graduation

PROFESSIONAL CAPACITY

X VE-PC – Five (5) years from app date

X Been in active practice past two (2) years

X No breaks over 6 months

NO Professional Capacity review required

CLINICAL TRAINING DOCUMENTATION

X TN-MED - 24 months* Clinical Training

US/Canada accredited X

Seal or Letter X

Completed full year(s) X

*(Proof of 12 months is required if **entered** program on or before 12/31/1987)

Activated temp

LICENSURE DOCUMENTATION

— CT - Original Jurisdiction of Licensure
State & Number ____
No discipline ____

— CT - Current Jurisdiction of Practice
State & Number ____
No Discipline ____

EXAMINATION DOCUMENTATION

[redacted] Exam history –not 5 or more failures (all exams except state constructed)
Remedial training required ____

USMLE – Completed within 7 yrs of the first Step passed (either Step 1 or 2)

Waiver requested ____ (MLB Review)

FLEX ____ NBME ____

COMLEX ____ LMCC ____

State-constructed* ____

*Must have passed clinical competency exam; be American Board certified in a specialty, or request waiver

____ Copy of certificate or verified on web site

____ Requested waiver ____ (MLB Review)

X Federation Check

Direct Inquiries to the
IDFPR Call Center

Telephone No.: 1-800-560-6420

Attn: Medical Services Section

STATE OF ILLINOIS
Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, Illinois 62786
www.idfpr.com

Date: 6/16/2015

Initials: DO

License No: 036

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

TO:

VALERIE LAUREN JENNINGS MD

[redacted]

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Your State criminal history background check has been received. However, the results of your FBI criminal history background check have not been received. Contact your licensed fingerprint vendor to ensure that your fingerprints were taken and submitted for a FBI criminal history background check. It may be necessary for you to have your fingerprints retaken for submission to the FBI only. See enclosed notice.

RETURN INFORMATION WITH A COPY OF THIS NOTICE.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 65/1 et.seq. of (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**CERTIFYING STATEMENT OF FINGERPRINT SUBMISSION**	SUPPORTING DOCUMENT **FP-MED**

APPLICANT: ***This form must be completed by out-of-state residents unable to utilize the livescan process for fingerprinting in the State of Illinois. Attach this certifying statement with the four-page Application for Licensure and/or Examination as proof of having submitted the required fingerprint cards to the proper authorities.***

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
JENNINGS	VALERIE	LAUREN	[redacted]	[redacted]

4. ADDRESS, STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
[redacted]	☒ **Physician** **036**
6. MAIDEN OR GIVEN SURNAME N/A	☐ **Chiropractic Physician** **038**

CERTIFYING STATEMENT

Under penalties of perjury, I declare that I, Valerie Jennings, have subm itted the required fingerprints pursuant to Sectio n 60-9.7 of the Medical Practice Act of 1988 (225 ILCS 60) and the Rules for the Administration of the Act (68 Ill. Adm. Code 1285) to the designated agent of the Illinois State Police for processing.

Date: 4/20/15 Signature: [redacted]

Lic#: 336.101407
JENNINGS, VALERIE LAUREN
336 Cred #3564537 03/01/2016
By:NON-EXAM
SSN: [redacted] 3.14.16

DO NOT WRITE IN BOX

Profession Code

License # or SSN #

0336-336101407-3

FILE ROUTE CARD

DO NOT WRITE ON FILE FOLDER

IL486-1327 10/04 (RS)

RECEIVED
CASH SECTION

FEB 29 2016

IDFPR
Div. of Professional Regulation

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

Lic#: 336.101 407
JENNINGS, VALERIE LAUREN
336 Cred #3564537 03/01/2016
By:NON-EXAM
SSN: [redacted] 3.14.16

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

Disclosure of your U.S. social security number, if you have one, is ***mandatory***, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

1. PROFESSION NAME	2. PROFESSION CODE - Check applicable box	3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist ☐346 Optometrist ☐316 Podiatrist ☐390 Veterinarian ☒336 Physician	Registration	$5

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
Jennings	Valerie	Lauren	M.D.	[redacted]

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

[redacted]

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED

6. If you will ***not*** be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

[redacted] I will ***not*** be storing or dispensing controlled substances, including samples.

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

N/A

8. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work [redacted] FAX ( ) Area Code

Home [redacted] FAX ( ) Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:

II III IV V

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 -
☐	Optometrist	046 -
☒	Physician	036 - 138546
☐	Podiatrist	016 -
☐	Veterinarian	090 -

NAME (Last, First, MI):

PART V: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. 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. *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		[redacted]
2. Have you been convicted of a felony?		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.		
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? If yes, attach a detailed explanation.		
7. 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. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		

SS#:

PART VI: Child Support and/or Student Loan Information (every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? [redacted]
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? [redacted]

Profession:

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

2/11/16
Date of Application

[redacted]

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature a[redacted]sional Regulation to reduce the amount of this check if the amount submitted is [redacted]ount submitted is greater than the required fee hereunder, but in no event shall [redacted].

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

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.

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST	FIRST	MIDDLE	3. PROFESSIONAL LICENSE NUMBER (if any)
Jennings	Valerie	Lauren	036-138546
2. ADDRESS STREET, CITY, STATE, ZIP CODE			4. SOCIAL SECURITY NUMBER
[redacted]			[redacted]

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturists
- ☐ Advanced Practice Nurses
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☒ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	[redacted]	
2) 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?		
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *		
4) Are you currently charged with or have you been convicted of a forcible felony? *		

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submi[redacted] to the best of my knowledge, they are true, correct, and complete.

Si[redacted]

Date 2/11/16