Place Label Here or Name
Lic#: 336.090501 9/27/2004
NAGPAL, GEETA
336 Cred #3123660 08/17/2011
By:NON-EXAM
SSN: [redacted]

0336;336090501;03

Profession Code

336

~~License #~~ or SSN #

[redacted]

FILE ROUTE CARD

DO NOT WRITE ON FILE FOLDER

IL488-1327 10/04 (RS)

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

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.

FOR OFFICIAL USE ONLY

Lic#:
NAGPAL, GEETA
336 Cred #3123660 08/17/2011
By:NON-EXAM
SSN: [redacted]

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

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.
Nagpal	Geeta		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

~~NOT APPLICABLE~~ Northwestern Medical Faculty Foundation, Dept of Anesthesiology

251 E. Huron, Feinberg 5-704 Chicago, IL 60611

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.

☐ I will ***not*** be storing or dispensing controlled substances, including samples.

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

Nagpal

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

Work (415) 200-7382 (Area Code) FAX (617) 724-2719 (Area Code)

Home [redacted] (Area Code) FAX ( ) _____ (Area Code)

PART III: Drug Schedule

Circle the schedules for which you are applying:

II IIN III IIIN IV V

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

		Professional License Number
☐	Dentist	019 - _____
☑	Physician	036 - pending
☐	Podiatrist	016 - _____
☐	Veterinarian	090 - _____

PART V: 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.		
[redacted]		
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 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? Yes ☐ No ☑
   (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? Yes ☐ No ☑

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.

8/4/11
Date of Application

[redacted]
Signature of Applicant

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

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

NAME (Last, First, MI): Nagpal, Geeta

SS#: [redacted]

Profession: Physician

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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

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

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other 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:

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	036	Endorsement	$ 300.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☑ 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.
Nagpal	Geeta		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

15 Parkman Street WACC-340 Boston, MA 02114-2696 Suffolk

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

Nagpal

7. MOTHER'S MAIDEN NAME

[redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH	10. AGE	
San Clemente, CA USA	06 / 12 / 1980 (Month / Day / Year)	31	☒ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (415) 200-7382 (Area Code)

Home: [redacted] (Area Code)

Fax: (617) 724-2719 (Area Code)

Fax: (___) ____-____ (Area Code)

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

[redacted]

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

NAME (Last, First, MI): Nagpal, Geeta

SS#: [redacted]

Profession: Physician

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 (12) Graduated High School? ☒ Yes ☐ No Received OR G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
San Clemente High School	San Clemente, CA	06/1998 (Month / Year)

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 (8) Graduated? ☒ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
Massachusetts Institute of Technology	Cambridge, MA	09/98	6/02	Bachelor of Science
University of San Francisco, California School of Medicine	San Francisco, CA	09/02	6/06	M.D.

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
California Pacific Medical Center	San Francisco, CA	06/06	06/07	☒ Yes ☐ No
Brigham and Women's Hospital	Boston, MA	07/07	06/10	☒ Yes ☐ No
Massachusetts General Hospital	Boston, MA	10/10	current	☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI): Nagpal, Geeta

SS#:

Profession: Physician

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 Massachusetts	Physician	240549	5/19/2010	Active
State of Current Licensure where you most recently have been practicing. Massachusetts	Physician	240549	5/19/2010	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 1	CA	04/04	(Passed), Failed, Absent)
USMLE Step 2 CK	CA	02/06	Passed
USMLE Step 2 CS	CA	02/06	Passed
USMLE Step 3	CA	11/06	Passed

(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.*		
[redacted]		
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: ☐☐

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.")* Yes ☐ 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? Yes ☐ No ☑

PART IX: Certifying Statement

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

[redacted] 8/4/11

Signature of Applicant Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

NAME (Last, First, MI): Nagpal, Geeta

SS#: [redacted]

Profession: Physician

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

Nagpal Geeta

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

06 / 12 / 1980
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

Nagpal

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

A. NAME OF BUSINESS / INSTITUTION

Massachusetts General Hospital

ADDRESS STREET, CITY, STATE, ZIP CODE

15 Parkman Street WACC-340 Boston, MA 02114

DATE OF EMPLOYMENT/ATTENDANCE

From 10 / 14 / 2010 (Month / Day / Year)

To __ / __ / ____ (Month / Day / Year)

HOURS WORKED PER WEEK

50

TYPE OF EMPLOYMENT

☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

9.5 months (current job)

JOB TITLE

Anesthesia and Critical Care Fellow

DESCRIPTION OF DUTIES PERFORMED

Clinic based care for patients with chronic pain focused on history & physical, medical management, interventional therapy, psychiatry, psychology, cancer pain, pediatrics, neurology, palliative care.

B. NAME OF BUSINESS / INSTITUTION

Brigham and Women's Hospital

ADDRESS STREET, CITY, STATE, ZIP CODE

75 Francis Street, CNN L1 Boston, MA 02115

DATE OF EMPLOYMENT/ATTENDANCE

From 07 / 01 / 2007 (Month / Day / Year)

To 06 / 30 / 2010 (Month / Day / Year)

HOURS WORKED PER WEEK

60

TYPE OF EMPLOYMENT

☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

3 years

JOB TITLE

Anesthesia Resident

DESCRIPTION OF DUTIES PERFORMED

Patient care in pre-op, operating room, post-op, acute/chronic pain, intensive care unit. as anesthesiologist specialties include: cardiac, thoracic, neuro, general surgery, obstetrics, gynecology, urology, surgical intensive care, emergencies, regional anesthesia, transthoracic echocardiography; vascular

NAME (Last, First, MI): Nagpal, Geeta

SS#: [redacted]

Profession: Physician

C. NAME OF BUSINESS / INSTITUTION
California Pacific Medical Center

JOB TITLE
Medical Intern

ADDRESS STREET, CITY, STATE, ZIP CODE 94115
2333 Buchanan Street, San Francisco, CA

DESCRIPTION OF DUTIES PERFORMED
Clinical duties caring for patients in the medical wards, medical intensive care unit, cardiac care unit, cardiology, hematology & oncology.

DATE OF EMPLOYMENT/ATTENDANCE
From 06 / 24 / 2006 (Month / Day / Year)
To 06 / 23 / 2007 (Month / Day / Year)

HOURS WORKED PER WEEK
70

TYPE OF EMPLOYMENT
☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
1 year

D. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE
From ___ / ___ / _____ (Month / Day / Year)
To ___ / ___ / _____ (Month / Day / Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

E. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE
From ___ / ___ / _____ (Month / Day / Year)
To ___ / ___ / _____ (Month / Day / Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

F. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE
From ___ / ___ / _____ (Month / Day / Year)
To ___ / ___ / _____ (Month / Day / Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

7/11/2011

To Whom It May Concern:

This certifies that Geeta Nagpal, M.D., a 2006 graduate of Univ. of California,San Francisco,School of Med., has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 240549 was issued to Dr. Nagpal on 05/06/2009. The license status is: Active. The expiration date is 6/12/2012.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

Closed Complaint Information

Our files contain 0 closed complaint(s) on this physician.

Final Board Disciplinary Action

Our files contain 0 disciplinary action(s) taken against this physician by the Board.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website:

www.mass.gov/massmedboard

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

[redacted]

SEAL

Staff Member, Board of Registration in Medicine

Michael Cox

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

(PR)

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
NAGPAL,	GEETA		06 / 12 / 1980 (Month / Day / Year)	[redacted]

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

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

6 MAIDEN OR GIVEN SURNAME: NAGPAL

Profession Name: PHYSICIAN — Profession Code: 036

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 36 months of postgraduate clinical training in Anesthesiology (Name of Specialty Program)

from 7/1/2007 (MM/DD/YYYY) to 6/30/2010 (MM/DD/YYYY) at the following hospital

Hospital: Brigham and Women's

Number and Street: 75 Francis Street

City, State and Zip Code: Boston MA 02115

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: [redacted]

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 7/15/2011

University/Hospital SEAL

Telephone No: [redacted]

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

IL468-1535 10/06 (MD)

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
NAGPAL, GEETA	06 / 12 / 1980 (Month / Day / Year)	[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.

6. MAIDEN OR GIVEN SURNAME: NAGPAL

PHYSICIAN (Profession Name) — 086 (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 12 months of postgraduate clinical training in Internal Medicine (Name of Specialty Program)

from 6/24/2006 (MM/DD/YYYY) to 6/23/2007 (MM/DD/YYYY) at the following hospital:

Hospital: California Pacific Medical Center

Number and Street: 2351 Clay St. # 380

City, State and Zip Code: San Francisco, CA 94115

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: [redacted]

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 4/8/11

University/Hospital SEAL

Telephone No: [redacted]

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

036 APPLICATION CHECKLIST

APPLICATION FINDINGS
___Approved Program _____6-Year
___Application Complete
___Release on File

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

DOMESTIC GRADUATES
___Premedical Transcripts ___Medical Transcripts w/degree date 6/11/04

FOREIGN GRADUATES
___ECFMG ___5th Pathway _____Social Service
___Premedical Transcripts ___Translations FCVS Profile _____
___Medical Transcripts ___Translations
Degree Date_____ IL TEMP LIC #_____

6-Year Post Secondary Education
___AF-MED Part A

UofC SOM SF. CA.

AF-MED Part B DOCUMENTATION:

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

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

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

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

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

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

SUPPORTING DOCUMENTS
___VE-PC - Verification of Professional Capacity - active practice in 2-years preceding app
CME Required/Submitted_____
___CT - Original Jurisdiction of Licensure - State & Number MA 240549 Discipline MD Act.
___CT - Current Jurisdiction of Licensure - State & Number_____ Discipline_____
___TN-MED - Clinical Training - 12 months if **began program** prior to 1/1/1988; all others 24 months
Seal or Letter ✓ Accredited ✓
___Acceptable Examination or Combination
NBME _____ NBOME/COMLEX _____ FLEX _____ LMCC _____
USMLE ✓ Complete w/in 7-Rule(USMLE only)_____ Not over 5 Failures _____(All exams)
State-constructed _____ must have American Board Certification_____
___Name Change
___Federation Check

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 AFFILIATION

SUPPORTING DOCUMENT

AF-MED

APPLICANT: Complete the applicant section of this form, then forward it to the appropriate official for completion of A or B.

1. NAME LAST	FIRST	MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
NAGPAL	GEETA		06 / 12 / 1980 (Month / Day / Year)	[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
NAGPAL

DEAN OR ADMINISTRATOR OF CLINICAL TEACHING FACILITY

Read A and B below, then complete either A or B and return form to the applicant.

A. MEDICAL COLLEGE: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was owned or operated by the medical college from which he graduated, sign the certification below.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility owned or operated [redacted] applicant was enrolled in the medical college during the course o

University of California, San Francisco
Name of Medical College

Signature of Dean of Medical College

SEAL OF COLLEGE

M. Papadakis, MD
Type Name of Dean of Medical College

8/01/2011
Date

513 Parnassus Ave., S-245
Street Address

San Francisco, CA 94143-0454
City State Zip Code

B. CLINICAL TEACHING FACILITY: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was formally affiliated or contracted with the medical college from which he graduated, sign the certification below. Further, you must submit a copy of the affiliation agreement between the hospital and the medical college which conferred the degree and a copy of an evaluation form for each core clerkship rotation, which was completed by the supervising physician of that rotation.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility formally affiliated or contracted with the medical college from which the applicant graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

Signature of Administrator of Clinical Teaching Facility

Name of Clinical Teaching Facility

SEAL OF INSTITUTION

Type Name of Administrator of Clinical Teaching Facility

Street Address

Date

City State Zip Code