STATE OF INDIANA
ONLINE RENEWAL RECORD

Renewal Submission Date:	July 28, 2023

Person Info

Name:	Murray Pelta
License Number:	01088052A

Address Info

Street Address:	1322 Williamsburg Drive
City:	Northbrook
State:	IL
Zipcode:	60062
County:	Cook
Phone:	
Email:	t

Question Response Summary

1.) Since you last renewed, has any health profession license, certificate, registration or permit you hold or have held been disciplined or are formal charges pending in any state or U.S. territory?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state or U.S. territory?	N
3.) Since you last renewed, and except for minor violations of traffic laws resulting in fines and arrests or convictions that have been expunged by a court, have you been arrested, entered into a diversion agreement, been convicted of, pled guilty to, or pled nolo contendere to any offense, misdemeanor, or felony in any state or U.S. territory?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff memberships or privileges in any hospital or clinic or have staff membership or privileges been revoked, suspended, or subjected to any restriction, probation, or other type of discipline or limitations?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N

Survey Response Summary

01.) What is your employment status?	Actively working in a position that requires a medical license
02.) What is your race? Mark one or more boxes.	White
03.) Are you of Hispanic, Latina/o, or Spanish origin?	N
04.) Where did you complete your medical degree?	Another State (not listed)
05.) Where did you complete your residency training?	Illinois
06.) Which of the following best describes the area of practice in which you spend most of your professional time? Please select only one response.	Gynecology Only
07.) Do you use telehealth to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; 'telehealth' means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including: (1) secure videoconferencing; (2) store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location)?	N
08.) What is the street address of your primary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A"	N/A
09.) In what city is your primary practice location? If this does not apply, please indicate "N/A"	N/A
10.) In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A"	IL
11.) What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"	N/A
12.) Which of the following categories best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable."	Office/Clinic – Multi Specialty Group
13.) Estimate the average number of hours per week spent in direct patient care at your primary practice location. If this does not apply, please select "not applicable."	21 – 24 hours per week
14.) Estimate the percentage of Indiana Medicaid patients at your primary practice location. If this does not apply, please select "not applicable."	Not applicable
15.) Are you accepting new Indiana Medicaid patients at any or all of your practice locations?	N
16.) If you selected no on the previous question, but you are enrolled as an Indiana Medicaid provider, please describe barriers to participation. If this does not apply, please indicate "N/A".	N/A
17.) Estimate the percentage of patients on a sliding fee scale at your primary practice location. If this does not apply, please select "not applicable."	Not applicable
18.) What is the street address of your secondary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A

19.) In what city is your secondary practice location? If this does not apply, please indicate "N/A".	N/A
20.) In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
21.) What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate "N/A".	N/A
22.) Which of the following categories best describes the practice setting at your secondary practice location? If this does not apply, please select "not applicable."	Not applicable
23.) Estimate the average number of hours per week spent in direct patient care at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
24.) Estimate the percentage of Indiana Medicaid patients at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
25.) Estimate the percentage of patients on a sliding fee scale at your secondary practice location. If this does not apply, please select "not applicable."	Not applicable
26.) What is the street address of your tertiary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A".	N/A
27.) In what city is your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
28.) In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please indicate "N/A".	N/A
29.) What is the 5-digit ZIP code of your tertiary practice location? If this does not apply, please indicate "N/A".	N/A
30.) Which of the following categories best describes the practice setting at your tertiary practice location? If this does not apply, please select "not applicable."	Not applicable
31.) Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
32.) Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
33.) Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. If this does not apply, please select "not applicable."	Not applicable
34.) Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purpose of this services list is to gather information on key health issues in Indiana) Please check all that apply.	None of the above
35.) Please indicate the population groups to which you provide services:	Adolescents (ages 11-19),Adults
36.) What are your employment plans for the next 2 years?	Continue as you are

https://www.fsmb.org

How To Authenticate This Official Program Verification from the Federation of State Medical Boards

This official program verification has been digitally signed and therefore contains special characteristics. If this document has been issued by the Federation of State Medical Boards, and this document is viewed using Adobe® Acrobat or Adobe® Reader, it will reveal a digital certification that has been applied to the program verification. This digital certification will appear in a pop-up or status bar on the document, display a blue ribbon, and declare that the document was certified by the Federation of State Medical Boards with a valid certificate issued by GlobalSign. This document certification can be validated by clicking on the Signature Properties of the document.

The blue ribbon symbol is your assurance that the digital certification is valid, the document is authentic, and the contents of the document have not been altered

If the document does not display a valid certification and signature message, reject this document immediately. An invalid digital certification display means either the digital signature is not authentic, or the document has been altered. A document with an invalid digital signature display should be rejected.

If the document displays an "Author Unknown" message, then this can have two possible meanings: The certificate is a self-signed certificate or has been issued by an unknown or untrusted certificate authority, or the revocation check could not be completed. If you receive this message, make sure you are properly connected to the internet. If you have an internet connection and you cannot validate the digital certificate, reject the document.

The current version of Adobe® Reader is free of charge and available for immediate download at https://www.adobe.com

If you require further information regarding the authenticity of this program verification, you can visit our website at https://certs.fsmb.org

DocuSign Envelope ID: D9715141-25CF-431E-938E-4F53B419058E

Updated August 2017

VERIFICATION OF GRADUATE MEDICAL EDUCATION & TRAINING

Section I: Verification of training and performance during training
(To be completed for EACH trainee)
****The information in this document is deemed source equivalent per FSMB's agreement with the institution listed.***

Trainee's Full Name:	DOB:	NPI:
Murray Pelta		**1720180342**

Program Specialty or Subspecialty: **Obstetrics & Gynecology**

Residency Program Date From/To: **07/01/1972** **06/30/1976**

Training Program Accreditation: **ACGME**

Program ID #: **2201611087** **Michael Reese Hospital and Medical Center Program**

Did the above-named trainee successfully complete the training program which she/he entered?

Yes

In addition to completion of full specialty training, completion of a transitional year or a planned preliminary year(s) would constitute completion of a program.

(If NO, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

Was the trainee subject to any of the following during training?

(i)	Conditions or restrictions beyond those generally associated with the training regimen at your facility;	**No**
(ii)	Involuntary leave of absence;	**No**
(iii)	Suspension;	**No**
(iv)	Non-promotion/non-renewal;	**No**
(v)	Dismissal; or	**No**
(vi)	Resignation.	**No**

(If YES to any of the above, please provide an explanation in the "Additional Comments" section below or enclose a separate document.)

DocuSign Envelope ID: D9715141-25CF-431E-938E-4F53B419058E

Upon completion of the training program, the individual was deemed to have demonstrated sufficient competence in the specialty/subspecialty to enter practice without direct supervision.

Yes

(If NO, please provide an explanation in the section below or enclose a separate document.)

Did the program endorse this trainee as meeting the qualifications necessary for admission to the specialty's board certification examination? **Yes**

If NO, indicate the reason(s):

- ☐ This trainee was a preliminary resident.
- ☐ Trainee was not eligible for certification.
- ☐ Trainee involuntarily or voluntarily left this program before completion. *
- ☐ No certification is available for this subspecialty.
- ☐ Other. *

DocuSign Envelope ID: D9715141-25CF-431E-938E-4F53B419058E

Section II: Additional Comments (Part A)

Please utilize this comment area to provide additional information in response to the questions noted above on this form. *(If additional space is needed, please enclose a separate document.)*

Explanation for:
Conditions or restrictions beyond those generally associated with the training regimen at your facility

Explanation for: Involuntary leave of absence

Explanation for: Suspension

DocuSign Envelope ID: D9715141-25CF-431E-938E-4F53B419058E

Section II: Additional Comments (Part B)

Please utilize this comment area to provide additional information in response to the questions noted above on this form. *(If additional space is needed, please enclose a separate document.)*

Explanation for: Non-promotion / Non-renewal

Explanation for: Dismissal

Explanation for: Resignation

Would you like to upload an additional attachment? **No**

DocuSign Envelope ID: D9715141-25CF-431E-938E-4F53B419058E

Section III: Attestation

The information provided on this form is based on review of available training records and evaluations.

Signature: DocuSigned by: Misty Wolfe 14B31437EBDE435...

Printed Name: **Misty Wolfe**

GME Title: **Director, FCVS**

Professional Credentials: **-**

Phone Number: **(817) 868-5104**

Email: **ClosedPrograms@fsmb.org**

In an effort to improve and streamline the credentialing process, the Accreditation Council for Graduate Medical Education (ACGME), American Hospital Association (AHA), National Association Medical Staff Services (NAMSS), and Organization of Program Directors Associations (OPDA) have collaborated to create a standardized "Verification of Graduate Medical Education Training (VGMET)" form designed to be completed once at the completion of training (or at the first opportunity thereafter when the program is asked to complete a verification/credentialing form).This VGMET is then time-stamped and inserted in the trainee's file. This time-stamped form, along with a cover letter from the current program director or institutional official, serves as the program's verification of training. The form will not include detailed lists of current procedural or technical competencies.

DocuSign Envelope ID: D9715141-25CF-431E-938E-4F53B419058E

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Federation Credentials Verification Service Addendum

Accreditation Code: 2201611087
Institution Name: Michael Reese Hospital and Medical Center Program
Affiliated University: Michael Reese Hospital and Medical Center
City: Chicago **State:** Illinois
Verification For: Murray Pelta **Date of Birth:**

Program Participation:
PGY: 1-4 Program Type: Residency

Unusual Circumstances

1. Did this individual ever take a leave of absence from his/her training? No

2. Was this individual ever placed on probation? No

FID: 208466037

DocuSign Envelope ID: D9715141-25CF-431E-938E-4F53B419058E

3. Was this individual ever disciplined or placed under investigation?	No
4. Were any negative reports for behavioral reasons ever filed by instructors?	No
5. Were any limitations or special requirements placed uponthis individual because of academic incompetence, disciplinary problems, or any other reason?	No

Would you like to upload an additional attachment (e.g. Rotation Schedule)? No

Attestation of Person completing Verification of Postgraduate Training document (Program Director): I hereby attest that the information contained herein accurately reflects the training records of the above - named physician.

Name: Misty Wolfe

Signature: Misty Wolfe (DocuSigned by: 14B31437EBDE435...)

Title: Director, FCVS

Date of Signature: 5/10/2022

FID: 208466037

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Mario Treto, Jr.
Acting Secretary

Cecilia Abundis
Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

1322 WILLIAMSBURG DR
NORTHBROOK, IL 60062

Licensee: License	MURRAY PELTA MD
Number:	036.051083
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	06/24/1975
Expiration Date:	07/31/2023
License Status:	ACTIVE
License Method:	LIC BY EXAM
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 02/28/2022

Cecilia Abundis
Director
Division of Professional Regulation

02/28/2022
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

MEDICAL BOARD OF CALIFORNIA

LICENSING DETAILS FOR: G 40685

NAME: PELTA, MURRAY
LICENSE TYPE: PHYSICIAN AND SURGEON G
PRIMARY STATUS: LICENSE CANCELED
SCHOOL NAME: NEW YORK MEDICAL COLLEGE
GRADUATION YEAR: 1972
ADDRESS OF RECORD
111 N WABASH AVE STE 2013
CHICAGO IL 60602
COOK COUNTY

ISSUANCE DATE
AUGUST 24, 1979
EXPIRATION DATE
N/A
CURRENT DATE / TIME
JUNE 17, 2022
6:36:21 AM

PUBLIC RECORD ACTIONS

› ADMINISTRATIVE DISCIPLINARY ACTIONS (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› COURT ORDER (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› MISDEMEANOR CONVICTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› PROBATIONARY LICENSE (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› FELONY CONVICTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› MALPRACTICE JUDGMENT (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› HOSPITAL DISCIPLINARY ACTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› LICENSE ISSUED WITH PUBLIC LETTER OF REPRIMAND (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› ADMINISTRATIVE CITATION ISSUED (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› ADMINISTRATIVE ACTION TAKEN BY OTHER STATE OR FEDERAL GOVERNMENT (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› ARBITRATION AWARD (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

› MALPRACTICE SETTLEMENTS (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

PUBLIC DOCUMENTS

› DOCUMENTS (NO RECORDS)

SURVEY INFORMATION

THE FOLLOWING INFORMATION IS SELF-REPORTED BY THE LICENSEE AND HAS NOT BEEN VERIFIED BY THE BOARD.

ARE YOU RETIRED?	NOT IDENTIFIED
ACTIVITIES IN MEDICINE	NO ACTIVITIES IDENTIFIED
PATIENT CARE PRACTICE LOCATION	NOT IDENTIFIED
PATIENT CARE SECONDARY PRACTICE LOCATION	NOT IDENTIFIED
TELEMEDICINE PRACTICE LOCATION	NOT IDENTIFIED
TELEMEDICINE SECONDARY PRACTICE LOCATION	NOT IDENTIFIED
CURRENT TRAINING STATUS	NOT IDENTIFIED
AREAS OF PRACTICE	NO AREAS OF PRACTICE IDENTIFIED
BOARD CERTIFICATIONS	NO BOARD CERTIFICATIONS IDENTIFIED
POSTGRADUATE TRAINING YEARS	NOT IDENTIFIED
CULTURAL BACKGROUND	DECLINED TO DISCLOSE
FOREIGN LANGUAGE PROFICIENCY	DECLINED TO DISCLOSE
GENDER	DECLINED TO DISCLOSE