STATE OF ILLINOIS
Department of Financial and Professional Regulation
Division of Professional Regulation

May 20, 2015

SARAH MARIE VALLIERE DO
McGaw Med Ctr-Northwestern
Dept of GME
240 E Huron Ste 1-203
Chicago, IL 60611-2909

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:	125.066650
PROGRAM START DATE:	06/23/2015
EXPIRATION DATE:	06/22/2018
PROGRAM:	Family Medicine
TRAINING FACILITY:	McGaw Medical Ctr/Northwestern

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.

RECEIVED
BUSINESS SERVICES
APR 7 2015
Div. of Professional Regulation

RECEIVED
CASH SECTION
APR 07 2015
Div. of Professional Regulation

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
Temporary Physician Licensure	1 2 5	Nonexamination	$ 230.00

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: Valliere — FIRST: Sarah — MIDDLE: Marie

2. TITLE (e.g., M.D., D.D.S., etc.): D.O.

[redacted]

CITY STATE/COUNTRY ZIP CODE COUNTY

— 203
240 East Huron Street, Suite ~~1-200~~
Chicago, Illinois 60611
—

S) UNDER WHICH SUPPORTING STRUCTIONS #5 ABOVE)

[redacted]

[redacted] Month Day Year

10. AGE 27 ☑ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

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

Home: [redacted]

Fax: (___) ___-____ (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):

SS#:

Profession:

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
Plano Senior High School	Plano, Texas	05 / 2004 (Month / Year)

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

1 2 3 4 (5) 6 7 8 (w/graduate - 9) 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
Collin County Community College	Plano, Texas, USA	08/05	05/07	
University of North Texas	Denton, Texas, USA	08/07	12/10	BS Biology
University of North Texas Health Science Center, Texas College of Osteopathic Medicine	Fort Worth, Texas, USA	07/11	05/15	Doctor of Osteopathy

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?
				☐ 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	Texas	06/2013	[redacted]
USMLE Step 2 CK	Texas	08/2014	
COMLEX Level 1	Texas	06/2013	
COMLEX Level 2 PE	Texas	04/2014	
~~USMLE Step 2 CS~~	Texas		
COMLEX Level 2 CE	Texas	08/2014	

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

NAME (Last, First, MI):

PART VI: Personal History Information *(This part must be completed by all applicants)*

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.*
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.")

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?

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 connection therewith, and to the best of my knowledge, they are true, correct, and complete.

03/24/2015
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.

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: Valliere FIRST: Sarah MIDDLE: Marie [redacted]

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

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.
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.*

[redacted]

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] Signature of Applicant

03/24/295 Date

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

SUPPORTING DOCUMENT

CCA

1. NAME LAST: Valliere FIRST: Sarah MIDDLE: Marie

3. PROFESSIONAL LICENSE NUMBER (if any) ___-_____

[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:

1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *
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? *

[redacted]

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.

[redacted]

03/24/2015
Date

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

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 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 form.

1. NAME LAST FIRST MIDDLE
Valliere, Sarah M.

[redacted]

[redacted]

[redacted]

6. MAIDEN OR GIVEN SURNAME
—

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

Temporary Physician (Profession Name) 1 2 5 (Profession Code)

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

A. HOSPITAL/INSTITUTION NAME
McGaw Medical Center of Northwestern University

B. BEGINNING DATE
06 (Month) 23 (Day) 2015 (Year)

C. ENDING DATE
06 (Month) 22 (Day) 2018 (Year)

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE
240 East Huron, McGaw Pavilion, Suite 1-203
Chicago, IL 60611

D. SPECIALTY / RESIDENCY NAME
Family Medicine

G. YEAR OF POSTGRADUATE TRAINING
Post Graduate Year 1

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 Depar[redacted]cant is found to be eligible for licensure.

[redacted]

Signature of Program Director

Deborah Edberg, MD
Print Name of Program Director

Residency Program Director
Title

March 20, 2015
Date

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: Valliere — FIRST: Sarah — MIDDLE: Marie

[redacted]

[redacted]

...FER TO REFERENCE SHEET. Record profession name and three ...t profession code for which you are making Illinois application.

6. MAIDEN OR GIVEN SURNAME

Temporary Physician Licensure — Profession Name: 1 2 5 — Profession Code

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 information requested below.

3/24/2015 — Date

[redacted] — Signature

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: UNT Health Science Center/TCOM

Address: 3500 Camp Bowie Blvd

City, State, Zip: Fort Worth TX 76107

Phone: 817-735-2505

Fax: 817-735-0448

B. DATES OF ATTENDANCE

Start: 07 (Month) / 25 (Day) / 2011 (Year)

End: 05 (Month) / 16 (Day) / 2015 (Year)

Degree: ____ MD X DO

C.

Applicant will complete all requirements for the medical degree as of 05 (Month) / 16 (Day) / 2015 (Year) and will graduate on 05 (Month) / 16 (Day) / 2015 (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 true and correct according to the official records of this institution.

[redacted]

SCHOOL SEAL

Meagan Cross — Print Name of School Official

Associate Registrar — Title

4-16-2015 — 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.

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME — LAST: Valliere — FIRST: Sarah — MIDDLE: Marie

[redacted]

[redacted]

[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. Also list any breaks of six (6) months or longer in medical practice since graduation from medical school.

A. NAME OF PRACTICE / WORK LOCATION: Center for Network Neuroscience @ University of North Texas

ADDRESS STREET, CITY, STATE, ZIP CODE: 1155 Union Circle, Denton, TX 76203

DATE OF EMPLOYMENT/ATTENDANCE
From 05 / __ / 2008 (Month / Day / Year)
To 06 / __ / 2011 (Month / Day / Year)

HOURS WORKED PER WEEK: 30

TYPE OF EMPLOYMENT: ☐ Full-time ☑ Part-time

TOTAL TIME WORKED (Year/Month)

JOB TITLE: Chief Cell Culture Technician

DESCRIPTION OF DUTIES PERFORMED:
- research - toxicology, harvesting cell culture - neuronal mice cells
- lab manager - inventory, ordering, scheduling, hiring

B. NAME OF PRACTICE / WORK LOCATION: University of North Texas Student Health Clinic

ADDRESS STREET, CITY, STATE, ZIP CODE: 1500 Chestnut Street Denton, TX 76201

DATE OF EMPLOYMENT/ATTENDANCE
From 02 / __ / 2009 (Month / Day / Year)
To 05 / __ / 2011 (Month / Day / Year)

HOURS WORKED PER WEEK: 30

TYPE OF EMPLOYMENT: ☐ Full-time ☑ Part-time

TOTAL TIME WORKED (Year/Month)

JOB TITLE: Phlebotomist

DESCRIPTION OF DUTIES PERFORMED:
- phlebotomy
- paperwork

NAME (Last, First, MI):

SS#:

Profession:

C. NAME OF PRACTICE / WORK LOCATION
Nanny Manager for Stefani Family

JOB TITLE
Nanny Manager

ADDRESS STREET, CITY, STATE, ZIP CODE
private home address Richardson, TX 75080

DESCRIPTION OF DUTIES PERFORMED
- household care
- transportation
- nanny for 2 girls

DATE OF EMPLOYMENT/ATTENDANCE
From 03 / __ / 2004 (Month / Day / Year)
To 08 / __ / 2007 (Month / Day / Year)

HOURS WORKED PER WEEK
25

TYPE OF EMPLOYMENT
☐ Full-time ☑ Part-time

TOTAL TIME WORKED (Year/Month)

D. NAME OF PRACTICE / WORK LOCATION

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 PRACTICE / WORK LOCATION

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 PRACTICE / WORK LOCATION

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)

APPLICATION CHECK-LIST

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

APPLICATION FINDINGS

✓ Application Complete

✓ PH Form ✓ CCA Form

_____ Name Change

_____ Release on File _____

POSITIVE PERSONAL HISTORY

Yes # OK ITD _____ MLB _____

VE-PC from graduation to present is required Documentation:

LICENSE INFORMATION

✓ CA-MED – Hospital McGaw

Start 6.23.15 *End 6.22.18

*cannot exceed three (3) years

ACGME or AOA accredited program & length:

Family Med - 3

Non-Accredited program & length:

_____

Outline – see worksheet _____

Interview Required _____

MLB approved in past 3 yrs _____

EDUCATION DOCUMENTATION

✓ Premedical Transcripts

_____ Translations

✓ Medical Transcripts* Univ of North Texas

_____ Translations

Degree Date 5/16/15

Copy of Diploma if applicable _____

***CURRENT YEAR GRADUATES MAY SUBMIT**

✓ ED-MED w/transcript certified not more than **30** days prior to graduation

EDUCATION - continued

_____ 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

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

_____ Active practice or enrolled in med school or clinical training within past five (5) years

_____ No breaks over 6 months

CME Required if more than 5 years since last active practice/medical school/clinical training.

___ 150 Cat 1 CME hours - prepare memo and route to Manager for review/approval

LICENSURE DOCUMENTATION

_____ CT - Original Jurisdiction of Licensure

State & Number _____

No discipline _____

_____ CT - Current Jurisdiction of Practice

State & Number _____

No Discipline _____

_____ 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: 4/21/2015

Initials: TM

License No: 125

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:

SARAH MARIE VALLIERE DO
McGaw Med Ctr-Northwestern
Dept of GME
240 E Huron Ste 1-203
Chicago, IL 60611-2909

RETURN THIS FORM AND APPLICATION WITH REMITTANCE, IF APPLICABLE

Deficiency Checklist

Submit official transcript(s) verifying medical education with school seal/signature to the attention of the Medical Unit or submit official medical transcripts verifying education completed to date along with completed ED-MED form certified not more than 30 days prior to graduation.

The medical transcripts from University of North Texas Health Science Center were generated more than 30 days prior to graduation and cannot be accepted.

RECEIVED
APR 29 2015
IDFPR - MEDICAL UNIT

RECEIVED
CASH SECTION
APR 28 2015
IDFPR
Div. of Professional Regulation

RETURN INFORMATION WITH A COPY OF THIS NOTICE.

UNT HEALTH SCIENCE CENTER

Division of Student Affairs

April 16, 2015

Re: Sara Marie Vailiere
Applicant for Temporary Physician License

To whom it may Concern:

In regards to your request for the dates Student Doctor Sara Marie Vailiere attended basic science courses, we felt a letter of explanation was in order. Our students do not take most of the basic sciences as stand-alone courses, but rather they are taught as a part of the systems courses. Therefor our students take Anatomy from August through June their first year of medical school. Physiology, Preventative Medicine, Pharmacology/Therapeutics, and Pathology are taught with each systems course throughout the first and second year of the program. Immunology and Biochemistry (shown as Cell Science on our transcript) are taught as individual courses. This accounts for the long periods of time between the "from" and "to" dates of the Basic Science Courses section of the form. Please contact our office if you need any additional information.

Sincerely,

[redacted]

A.J. Randolph
Executive Director of Enrollment Services & Registrar
UNT Health Science Center
3500 Camp Bowie Blvd.
Fort Worth TX, 76107
817-735-2201

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 EDUCATION NON-LCME ACCREDITED MEDICAL COLLEGE

SUPPORTING DOCUMENT

ED- NON

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form. You are authorized to photocopy this form as necessary.

1. NAME — LAST: Valliere — FIRST: Sarah — MIDDLE: Marie — [redacted]

4. SOCIAL SECURITY NUMBER [redacted] OR CONTACT ID NUMBER FROM IDFPR ACKNOWLEDGEMENT LETTER _____

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

- ☐ Permanent Physician 036
- ☑ Temporary Physician 125

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 information requested below.

3/24/15
Date

[redacted]

APPLICANT: DO NOT COMPLETE ANY PORTION BELOW THE LINE.

DEAN OF MEDICAL SCHOOL: Complete the bottom portion of this page and the reverse side, then return to the applicant. If this part is partially or totally completed by the applicant or altered, the form will not be accepted. Complete dates in form of month/day/year are required where indicated.

A. NAME OF MEDICAL SCHOOL: UNT Health Science Center Texas College of Osteopathic Medicine
ADDRESS: 3500 Camp Bowie Blvd
CITY, STATE: Fort Worth TX
COUNTRY/PROVIDENCE: USA

B. DATES OF ATTENDANCE - **EACH YEAR** MUST BE LISTED SEPARATELY. DO NOT GROUP DATES OF ATTENDANCE.

	From (Month/Day/Year)	To (Month/Day/Year)
1st year	07/25/2011	06/08/2012
2nd year	07/23/2012	05/17/2013
3rd year	06/24/2013	06/20/2014
4th year	07/07/2014	05/16/2015
5th year	__/__/____	__/__/____
6th year	__/__/____	__/__/____
7th year	__/__/____	__/__/____
INTERNSHIP YEAR, IF APPLICABLE	__/__/____	__/__/____

C. BASIC SCIENCE COURSES – Please see attached

	From (Month/Day/Year)	To (Month/Day/Year)
Anatomy	08/29/2011	06/08/2012
Physiology	08/29/2011	05/17/2013
Biochemistry	07/25/2011	08/26/2011
Microbiology/Immunology	04/03/2012	04/23/2012
Pathology	07/25/2011	05/17/2013
Pharmacology/Therapeutics	08/29/2011	05/17/2013
Preventative Medicine	07/25/2011	05/17/2013

D. INDICATE LENGTH OF ACADEMIC YEAR 10-12 MONTHS. DATE MEDICAL DEGREE WAS CONFERRED 05/16/2015 (Month/Day/Year)

NAME (Last, First, MI):

SS#:

Profession:

E. CORE CLERKSHIP ROTATIONS.

COMPLETE DATES IN THE FORM OF MONTH/DAY/YEAR ARE REQUIRED. EACH ROTATION MUST BE A MINIMUM OF FOUR (4) WEEKS IN LENGTH AND COMPLETED WHILE ENROLLED IN THE MEDICAL COLLEGE CONFERRING DEGREE. CORE ROTATIONS WILL NOT BE ACCEPTED OR CO-VALIDATED FROM ANOTHER MEDICAL SCHOOL. (MPA Section 11 (A)(2).)

Internal Medicine Rotation
Started: 03 / 03 / 2014 Completed: 4 / 25 / 2014
Total WEEKS spent in clinical training rotation: 8
Facility Name: NorthEast Community Health Clinic
City/State/Country: Bedford, Texas
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☑ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

Pediatrics Rotation
Started: 11 / 04 / 2013 Completed: 12 / 13 / 2013
Total WEEKS spent in clinical training rotation: 6
Facility Name: Driscoll Childrens Hospital
City/State/Country: Corpus Christi, TEXAS
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☑ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

Obstetrics/Gynecology Rotation
Started: 09 / 23 / 2013 Completed: 10 / 21 / 2013
Total WEEKS spent in clinical training rotation: 6
Facility Name: UNTHSC / TCOM
City/State/Country: Ft. Worth, Texas
Check **ONE**:
- ☐ Government owned/operated facility
- ☑ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

Surgery Rotation
Started: 4 / 28 / 2014 Completed: 6 / 20 / 2014
Total WEEKS spent in clinical training rotation: 8
Facility Name: John Peter Smith Hospital
City/State/Country: Ft. Worth, TEXAS
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☑ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

Psychiatry Rotation**
Started: 07 / 01 / 2013 Completed: 7 / 26 / 2013
Total WEEKS spent in clinical training rotation: 4
Facility Name: John Peter Smith Hospital
City/State/Country: Fort Worth, Texas
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☑ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

** The 4 week psychiatry core clerkship rotation may be completed as follows: 2 weeks must be completed formally and distinctly in psychiatry as verified by the medical school on this form. The other 2 weeks may be completed in other clinical rotations as verified by the applicant's affidavit. Contact the Division for the *Affidavit of Psychiatry Core Clerkship Rotations* form.

I hereby certify that the information above is true and accurate to the records of this medical college and in accordance with Section 11 (A)(2) of the Medical Practice Act and Section 1285.20 of the Administrative Rules. I further certify that the applicant received a medical degree from and was enrolled in this college at the time the core rotations were completed; that the core clinical clerkship rotations were conducted in the clinical teaching facilities either **owned or operated by this medical college**; **government owned or operated**; OR **formally affiliated or contracted**; OR **held a verbal affiliation agreement** with this medical college. In the case of a written agreement, it is certified that all affiliation agreements were in full effect at the time of the applicant's rotation and evaluations verifying passage of each core clerkship rotation were submitted by the supervising physician.

SEAL OF COLLEGE

[redacted]
Signature of Dean of Medical College

A.J. Randolph, Executive Director of Enrollment Services & Registrar
Print Name of Dean of Medical College

4-16-2015
Date Completed

UNT Health Science Center Texas College of Osteopathic Medicine
Printed Name of Medical College

RETURN THIS FORM TO APPLICANT