

48989

DO NOT WRITE ON THIS FOLD

No. 48989

Application for Registration as
PHYSICIAN AND SURGEON

YOGENDRA A. SHAH, M.D.
[Redacted]

\$75.00 Application Fee received 19

Preliminary Education approved 19

Diploma verified 12-4 1973

Diploma returned 12-4 1973

By Registered Mail

Second Examination Fee (\$50) received 19

Third Examination Fee (\$50) received 19

Certificate issued Feb. 20 74

Certificate forwarded 19

Application declined 19

Decl. of Int. No. 19

Issued at A.

on day of 19

Entered U. S.

DO NOT WRITE ON THIS FOLD

EXAMINATION RECORD

SUBJECT	FIRST EXAMINATION	SECOND EXAMINATION	THIRD EXAMINATION
Biochemistry			
Physiology			
Anatomy			
Pharmacology			
Pathology			
Bacteriology			
Medicine			
Public Health and Prev. Medicine			
Obstetrics and Gynecology			
Surgery			
Pediatrics			
Psychiatry			
Total			
General Average			

Date of 1st examination 19

Date of 2nd examination 19

Date of 3rd examination 19

PERSONAL INFORMATION

Applicant Must Fill Following Blanks

Name YOGENDRA AMBAJAL SHAH
(Write plainly)

[Redacted]

Is this your first application for a license in Illinois?
yes

Number years of medical study 4 1/2 yes

Terms of medical lectures attended -

Name of College issuing diploma M.S. University

Located at Buraha India

Date of Graduation 25-3- 1971

School of Practice -

Total Years of Practice as follows: Two

State Illinois Years 2

[Redacted]

98984

INSTRUCTIONS TO GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES

1. The fee to be filed with an application for examination is \$75.00. Remittance should be made by bank draft, express or postal money order, payable to the Department of Registration and Education, Springfield, Ill.

2. The applicant must present to the Department of Registration and Education for verification, at its office in Springfield or on the first day of the examination, the original diploma of a legally chartered medical institution in good standing. Photostatic copies are not acceptable. If the diploma is sent to Springfield by express, charges should be prepaid; if by mail, letter postage should be affixed to the package. If the applicant wishes the diploma returned by mail the necessary postage should be furnished.

3. A transcript of the applicant's medical and premedical records should be forwarded to the Department by the Registrar of the medical college.

4. Graduates after July 1, 1923, are required to furnish proof of having completed one year's rotating internship in an approved general hospital in the United States. If the intern service is not rotating, an applicant must furnish proof of satisfactory completion of residency training or proof that he has been accepted for residency training in a hospital training program approved by this Department.

5. The application must be accompanied by letters of recommendation with regard to the moral and professional character of the applicant from two reputable, licensed physicians in Illinois, or, if from non-resident physicians such letters must be endorsed by Illinois physicians.

6. An applicant who is not a native-born citizen of the United States must submit with his application his certificate of naturalization, or his declaration of intention, or, if eligible to file a petition for naturalization, evidence that this petition has been filed within thirty (30) days after he became eligible to do so.

7. The filing of an application or the taking of an examination does not entitle the applicant to practice in the State of Illinois.

INSTRUCTIONS TO GRADUATES OF FOREIGN MEDICAL SCHOOLS

1. The examination fee is \$75.00, and remittance should be made by bank draft, express or postal money order, or postal note, payable to the Department of Registration and Education, Springfield, Illinois.

2. An applicant must furnish documentary proof of his preliminary and professional education (Study books or transcripts of studies), and his original medical diploma. Photostatic copies of diplomas are not acceptable. If the diploma is sent to Springfield by express, charges should be prepaid; if by mail, letter postage should be affixed to the package. If the applicant wishes the diploma returned by mail, the necessary postage should be furnished. Foreign credentials must be accompanied by certified translations. The original documents must be verified in the Springfield office. Foreign credentials may not be presented for review at an examination.

3. Graduates after July 1, 1923, are required to furnish proof of having completed one year's internship in an approved general hospital in the United States. If the intern service is not rotating, an applicant must furnish proof of satisfactory completion of residency training or proof that he has been accepted for residency training in a hospital training program approved by this Department.

4. After approval of applications, original credentials are returned to the applicant but translations are held on file as a part of the Department records.

5. Naturalized citizens of the United States must submit Certificates of Naturalization; and non-citizens must submit Declarations of Intention to become citizens (first papers); or receipt showing that petition for Naturalization (second papers) has been filed.

6. The application must be accompanied by letters of recommendation with regard to the good moral and professional character of the applicant from two reputable, licensed physicians in Illinois; or, if from non-resident physicians, such recommendations must be endorsed by Illinois physicians.

7. The filing of an applicant or the taking of an examination does not entitle the applicant to practice.

112069

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
SPRINGFIELD

12-5-73 6030121 75.00 036 3 A

APPLICATION FOR REGISTRATION AS PHYSICIAN AND SURGEON

I hereby make application for examination for a Certificate to practice Medicine and Surgery in all their branches, under the provisions of an Act entitled: The "Medical Practice Act" of Illinois.

Full name: YOGENDRA AMBALAL SHAH LAST FIRST MIDDLE

Permanent address: [Redacted]

[Redacted] (City) [Redacted] (County)

Date of birth: [Redacted] Age: 27 years

HIGH SCHOOL EDUCATION

Name and location of school attended: Pioneer High School Anand, India
1st year: Pioneer High School Anand, India Period of attendance: 11 years - March 1963
2d year: _____
3d year: _____
4th year: _____
I was graduated from the Pioneer High school on the day of March, 1963.

COLLEGE OR UNIVERSITY EDUCATION

Name and location of school attended: Faculty of Science M.S. University
1st year: Faculty of Science M.S. University Period of attendance: June 65 - May 65
2d year: _____
3d year: _____
4th year: _____
I have credit for _____ of college work. I received the degree of Pre-Medical
from Faculty of Science M.S. University on the 20 day of May, 1965

MEDICAL EDUCATION

I attended _____ full courses of medical lectures as follows:
At M.S. University of Baroda India
from the day of June, 1965 to the day of Oct., 1969
At _____
from the _____ day of _____, 19____ to the _____ day of _____, 19____
At _____
from the _____ day of _____, 19____ to the _____ day of _____, 19____
At _____
from the _____ day of _____, 19____ to the _____ day of _____, 19____

I was granted the degree of Doctor of Medicine by M.S. University of Baroda India
located at Baroda, Gujarat, State of Gujarat, India on the 28
day of March, 1971, and the Diploma presented with this application is the genuine Diploma of said institution

3-28-71 dip [Signature]


NO

120011

I ^{will} have served rotating straight internship at Mount Sinai Hospital 2750 W. 15th St. Chicago
(Name and address of hospital) IL-60602
from the 27 day of June, 1971 to the 26 day of June, 1972

Residency training at Methodist Hospital 221 N. E. Grand Ave. Peoria IL-61603
(Name of hospital - address of hospital) IL-61603
from the 1st day of July, 1972 to the 30 day of June, 1973
in the specialty of Pathology

State of Missouri
City of St. Louis

 being
day sworn says that he is the person referred to in this application and
that the statements therein contained are true.

Under
(Signature of Applicant)

Subscribed and sworn to before me this 25th day of

September, 1973

My Commission Expires Dec. 28, 1973



EXTRACTS FROM THE MEDICAL PRACTICE ACT

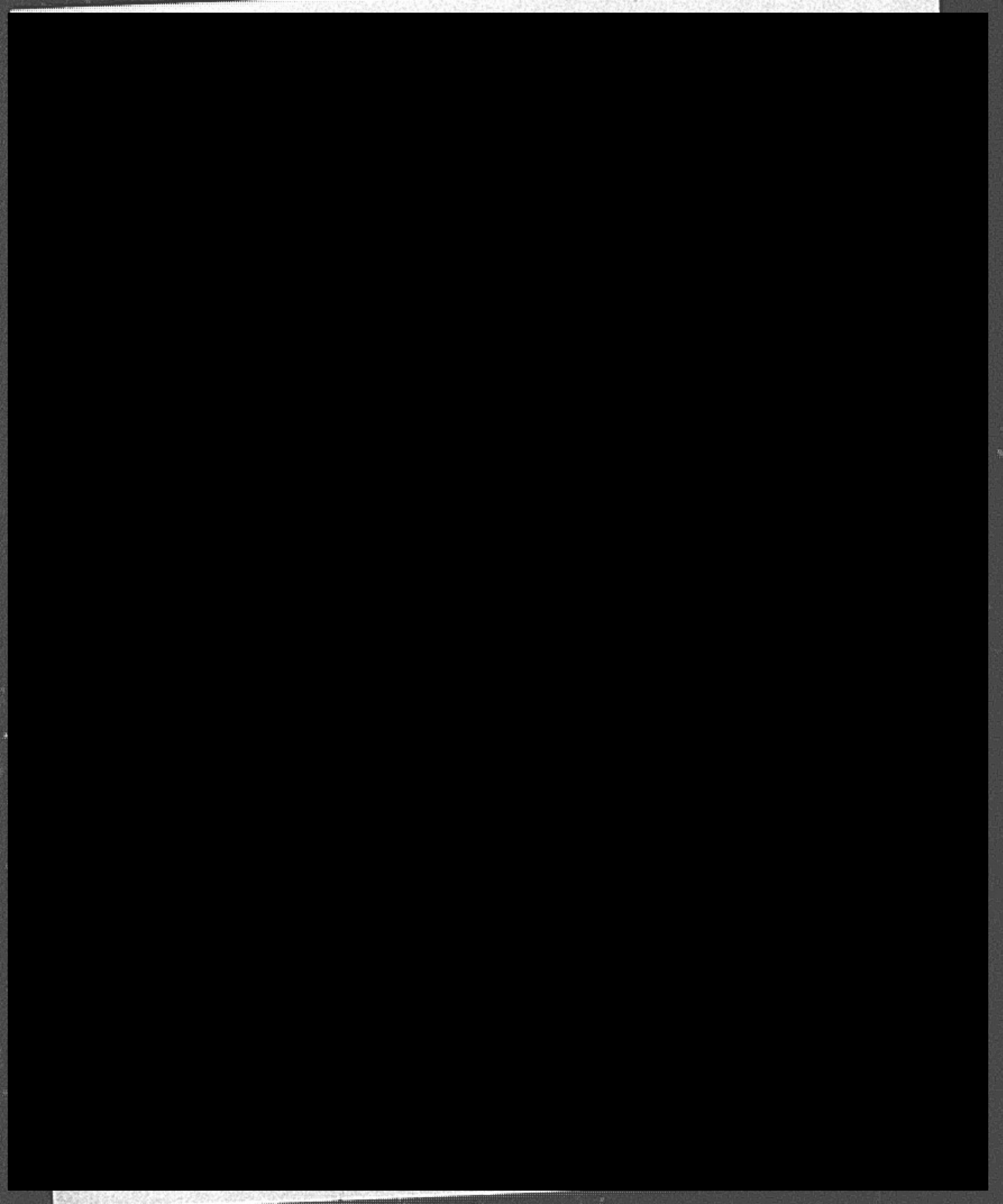
"SECTION 16. The Department may revoke or suspend the license or certificate of any person issued under this Act, or issued under any other Act in this State, to practice medicine, or to practice the treatment of human ailments, in any manner * * *. 7. Employment of fraud, deception or any unlawful means in applying for or securing a license or certificate to practice the treatment of human ailments in any manner, or to practice midwifery, or in passing an examination therefor, or wilful and fraudulent violation of the rules and regulations of the Department governing examinations."

"SECTION 33. Any person who shall employ fraud or deception in applying for or securing a license under this Act, or in passing any examination therefor, shall be guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine of not less than one hundred dollars nor more than five hundred dollars, or by confinement in the county jail not more than one year, or by both such fine and imprisonment, in the discretion of the court."

RULES GOVERNING EXAMINATIONS

1. No applicant will be admitted to an examination without a card of admission issued by the Department of Registration and Education after his application and credentials have been approved. Applications must be filed at least 15 days prior to the examination date.
2. With his card of admission the applicant must present a recent, unmounted photograph, passport size, which is a duplicate of the photograph filed with his application. The signature of the applicant, witnessed by the physicians who signed his recommendations, must appear on the reverse side of the photographs, and a form for that purpose accompanies the application blank.
3. The examination consists of twelve written subjects which are listed on the outer fold of this application. The examination requires four days to complete. To be successful, the applicant must make a general average of 75% with no grade below 60%. In case of failure in the first and second examination, credit will be allowed on the following examination for grades of 75% or more, but in case of failure in the third examination, all subjects must be repeated at all subsequent examinations. An applicant who has failed in five examinations is required to furnish proof of further formal professional study in an accredited institution before admission to subsequent examinations.

2-28-19-88-E





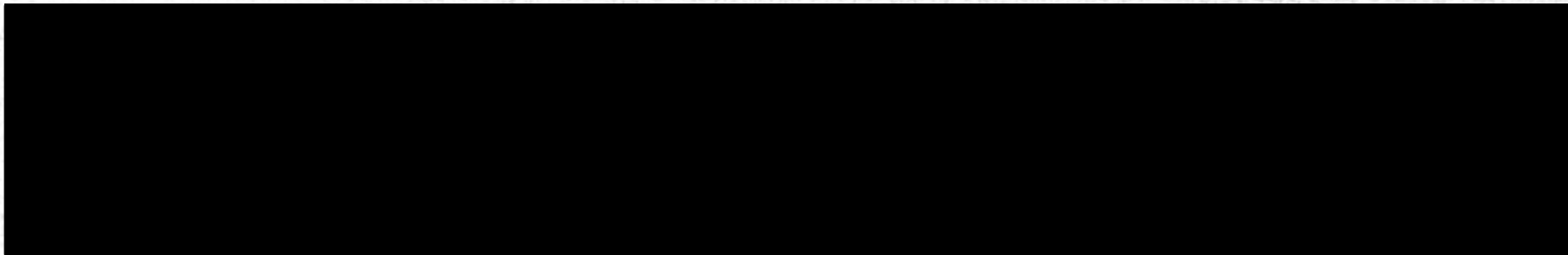
STATE OF ILLINOIS
DEPARTMENT OF
REGISTRATION AND EDUCATION
SPRINGFIELD

DR. DEAN BARRINGER
DIRECTOR

PETER A. KOTSOS
ASSISTANT DIRECTOR

IN REPLY REFER TO:

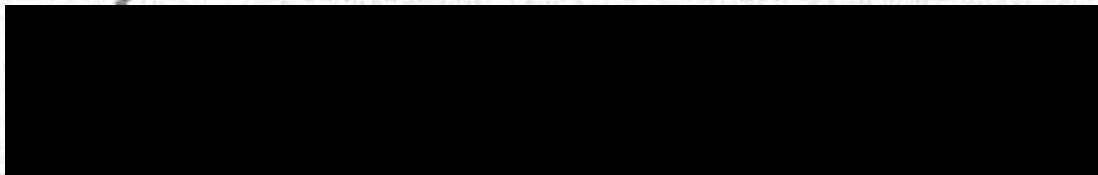
Medical Section



(Signature of Applicant)

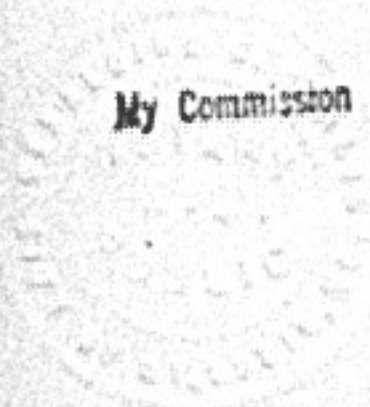
being duly sworn, says that he is the person referred to in this application and that the statements therein contained are true.

Subscribed and sworn to before this 25th day of September, 19 73



(NOTARY PUBLIC)

My Commission Expires Dec. 28, 1973



THE FEDERATION OF STATE MEDICAL BOARDS
OF THE UNITED STATES, INC.
1612 SUMMIT AVENUE, SUITE 304
FORT WORTH, TEXAS 76102

DATE: 9/14/ 19 73

TO: Mrs. Margaret Markum, Medical Section
Illinois Dept. of Registration & Education
Springfield, Illinois 62786

SUBJECT: FLEX Examination Grades for YOGENDRA A. SHAH

This is to certify that the above person took the FLEX Examination in 6/73 19
under Missouri admission number 10970 and obtained
the following grades: FLEX Test Processing number 10970

BASIC SCIENCE:

Anatomy _____
Physiology _____
Biochemistry _____
Pathology _____
Microbiology _____
Pharmacology _____

BASIC SCIENCE AVERAGE: _____

CLINICAL SCIENCE:

Medicine _____
Surgery _____
Obstetrics _____
Public Health _____
Pediatrics _____
Psychiatry _____

CLINICAL SCIENCE AVERAGE: _____

CLINICAL COMPETENCE AVERAGE: _____

FLEX WEIGHTED AVERAGE: _____

Sincerely,


M. H. CRABB, M. D., Secretary

MHC:mf /je

CERTIFICATION OF COLLEGE ATTENDANCE

(Give exact dates.)

_____ October 20 _____, 1971

TO THE DEPARTMENT OF REGISTRATION AND EDUCATION, SPRINGFIELD, ILLINOIS:

This is to certify that SHAH YOGENDRA AMBALAL
was in regular attendance at the Medical College M.S. University of Baroda
from the 15th day of JUNE, 1965 to the day of October, 1969
from the _____ day of _____, 19____ to the day of _____, 19____
from the _____ day of _____, 19____ to the day of _____, 19____
from the _____ day of _____, 19____ to the day of _____, 19____
from the _____ day of _____, 19____ to the day of _____, 19____
and was granted a Diploma as Doctor of medicine by N.K. Irtikal, vice chancellor
located at Baroda State of Gujarat, India
on the 28 day of March, 1971, having completed _____ hours.

[Seal of College]

(Dean, Secretary, or Registrar)

**THE METHODIST HOSPITAL OF CENTRAL ILLINOIS
Peoria, Illinois**

This is to Certify that

YOGENDRA AMBALAL SHAH, H.D.

has served and satisfactorily completed

First Year Residency in

ANATOMIC PATHOLOGY

From July 1, 1972 through June 30, 1973


Associate Administrator

GUJARAT SECONDARY SCHOOL CERTIFICATE EXAMINATION BOARD, BARODA.

This is to certify that the withinsigned

SHAH YOGENDRA A.

SHAH YOGENDRA AMBALAL

passed the Secondary School Certificate Examination of March 1963 in the grade shown below & reached the standard (Pass, Credit or Distinction) as shown in the following subjects:

1	Lang. Higher Level	Lang. Lower Level	Social Studies	Gen. Science	E. Maths. or Alg. Geom.	English (20)	Science	Class/Mod. Eurp. Lang.	History	Geog.	Ind. Adm.	Arithmetic	Art	Type-writing	Mod. Ind. Lang. under Gr. II
2	Bk. & Accts.	Elem. of Com.	Home Science	House Craft	Geom. & Machine Drawg.	Mech. Engrg.	Elec. Engrg.	Wks. Tech. Gr. I	Elem. of M. & E. Engrg.	Yill. & Soil.	Cron. and A. Herb.	Hd. Spg. & Ind. Wvg.	Tailor & Cutting	Tailor & Embro	Indian Music
3	Short-hand	Wood work Tech.	Fat Desn. & Est.	Dyeing Tech.	Bldg. & Const.	Radio Engrg.	Radio Service work	Wks. Tech. Gr. II	Surveying	Weaving Power	Typography	Chem. Tech.	Hand Made Paper Mfg.	—	European Music
1															
2															
3															

SEAT No. GRADE TOTAL SUBJECTS SCHOOL No. COMBINATION CODES

[Redacted]

Date of Birth

[Redacted]



Signature of the Head of the School

**The Head Master,
The Pioneer High School, ANAND**

[Redacted]

Secretary.

The Secondary School Certificate is awarded to successful candidates in—
Grade I—to those who obtain at least 60 percent of marks in the aggregate.
Grade II—to those who obtain at least 45 per cent of marks in the aggregate.
Grade III—to all other candidates.

Note—The date of birth shown in this Certificate is the same as that entered in the candidate's application for admission to the Examination.

P = PASS, C = CREDIT, D = DISTINCTION, and SYMBOL '1' = BLANK Not offered or Failed in the subject though offered

BARODA.

1st June 1963

* There are Six Combination Heads under which different Languages/subjects are grouped. A particular Language/subject offered by the candidate under each Head is indicated by Numerical Codes as shown under "Combination Codes" above. Each Numerical Code is explained overleaf.

(P. T. O.)

No change in any entry is to be made except by the authority issuing the certificate. Infringement of the rule will be punished with rustication

LEAVING CERTIFICATE

THE PIONEER HIGH SCHOOL, ANAND.

G. R. No. of the pupil [REDACTED]

Serial No. [REDACTED]

Name of the pupil [REDACTED]

Caste [REDACTED]

Place of [REDACTED]

Date of Birth according to Christian E [REDACTED]

(in words and figures) [REDACTED]

Last School attended [REDACTED]

Date of Admission [REDACTED]

Progress [REDACTED]

Conduct [REDACTED]

Date of leaving School [REDACTED]

Std in which studying since [REDACTED]

(in words and figures) [REDACTED]

Reason of leaving School [REDACTED]

Attendance in the S. S. C. Class [REDACTED]

Remarks [REDACTED]

Certified that the above information is in accordance with the School-Register.

Date: 6-6-1963

Librarian [REDACTED]

Class Teacher [REDACTED]

Head Master [REDACTED]


The Pioneer High School, Anand.

CHIROTAR PRESS, ANAND.

FACULTY OF SCIENCE
The M. S. University of Baroda

S. J. Science Institute,
Baroda-2, 195 .
20-5-1965.

This is to certify that Shri/S^{mt}. Shah Yogendra Ambalal
has passed the BSc Pre-Medical Examination of 1965
in Second class at the First attempt.


I/c DEAN,
Faculty of Science.



No.S/ 19404

MEDICAL COLLEGE,
BARODA.

Original
12-4-73

Date: 23rd December 70.

TRANSCRIPT

This is to certify that Shri Shah Yogendra Ambalal, who joined this College in June 1965 was declared successful at the Final M.B.B.S. Examination of the M.S. University of Baroda, in October 1969. He has completed satisfactorily Compulsory Rotating Housemanship (Resident Internship) for a period of one year on 14.12.1970.

The subjectwise transcript in clock hours is as stated below:-

	<u>Clock hours</u>		<u>Clock hours</u>
<u>Anatomy</u> Embryology, Histology, Anatomy including Neuro-Anatomy.	981	Preventive & Social Medicine, Hygiene & Sanitation.	630
		<u>Medicine</u>	
<u>Physiology</u> Including Biochemistry, Psycho-Biology.	540	Paediatric, Psychiatry, Neuro- logy, Dermatology, Physical- Medicine, Therapeutics, Tropical Medicine.	1065
<u>Pharmacology</u>	409		
		<u>Surgery</u>	
<u>Pathology</u> Including Bacteriology, Immunology etc.	354	Including Orthopaedic-Surgery Urology, Ophthalmology, Radiolo- gy, Anaesthesia, otolaryngology, & Obstetrics & gynaecology.	1390



Medical College, Baroda.



MEDICAL COLLEGE,
BARODA.

Date: 23rd December 70.

C E R T I F I C A T E

This is to certify that Shri Shah Yo^eandra Ambalal, who joined this College in June 1965 was declared successful at the Final M.B.B.S. Examination of the M.S. University of Baroda, in October 1969. He has completed satisfactorily Compulsory Rotating Housemanship (Resident Internship) for a period of one year on 14.12.1970 as stated below:-

1. Rural Health Training Centre, Padra (Public Health Work). From 1.3. 1970 to 31.5. 1970.
2. Government Hospital, Rajpipla & Shree Sayaji General Hospital, Baroda (Medicine, Surgery and Obstetrics & gynaecology 3 months in each). From 1.12.1969 to 28.2. 1970.
From 1.6. 1970 to 14.12.1970.

Internees can prescribe drugs and treatment under supervision of the teacher.

He is recommended for higher studies.


Dean,
Medical College, Baroda.

*Orig with
12-4-73*

THE METHODIST HOSPITAL OF CENTRAL ILLINOIS
Peoria, Illinois

This is to Certify that

YOGENDRA AMBALAL SILAH, M.D.

has served and satisfactorily completed

First Year Residency in

ANATOMIC PATHOLOGY

From July 1, 1972 through June 30, 1973



Donald K. Larson
Associate Administrator

*had hospital
deal on Orig.*

Orig ret'd
12-4-73


The
Maharaja Sayajirao
University of Baroda

Whereas Shri Yogendra Ambalal Shah
of the Faculty of Medicine has pursued a
course of study prescribed by the University
and passed the requisite Examination

Now Therefore this is to certify that
he has this day been duly admitted by
the Senate to the Degrees of

Bachelor of Medicine
& Bachelor of Surgery

Given under my hand this twenty-eighth
day of March one thousand nine
hundred and seventy-one.


Vice-Chancellor

Original
12-4-73

International Council for Foreign Medical Graduates

SPONSORED BY
AMERICAN HOSPITAL ASSOCIATION
AMERICAN MEDICAL ASSOCIATION
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION
FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES
CERTIFIES THAT

YOGENDRA AMBALAL SHAH

HAS SATISFIED ALL THE REQUIREMENTS OF THE COUNCIL
HAS SUCCESSFULLY PASSED ITS EXAMINATION
AND HAS BEEN AWARDED CERTIFICATE NO. 121 459 2

SEPTEMBER 16, 1970



President



Executive Director

Original
12-4-73

The Chicago Medical School
and
Mount Sinai Hospital
Medical Center
Chicago, Illinois

Be it known that
Sogendra Gambalal Shah, M.D.
has served in the capacity of

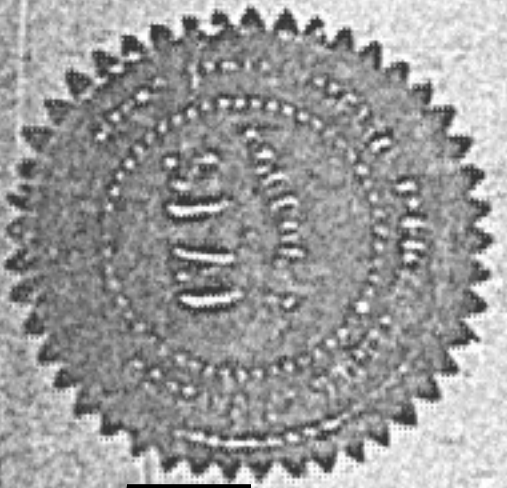
Rotating Intern

for a period of 12 months ending June 26, 1972 and having
satisfactorily performed his duties is granted this

diploma

In Witness Whereof, the undersigned have affixed their signatures
this 26th day of June 1972

By _____
The Symp Board



RECOMMENDATION

Date April 20, 1973

This certifies that I am personally acquainted with

YOGENDRA AMBALAL SHAR, M.D.

that I know him to be of good moral and professional character and entirely worthy of confidence.

I hereby recommend him to the Department of Registration and Education to be licensed to practice

Medicine

in the State of Illinois.

P.

Endorser is a Graduate of

Albany Medical College
(Name of Professional School)

in the year

1951

Illinois License No.

36-36508

Date issued

May 19, 1960

RECOMMENDATION

Date October 20, 1973

This certifies that I am personally acquainted with

YOGENDRA AMBALAL SHAH, M.D.

that I know him to be of good moral and professional character and entirely worthy of confidence.

I hereby recommend him to the Department of Registration and Education to be licensed to practice

MEDICINE

in the State of Illinois.

Endorser is a Graduate of JEFFERSON MED. in the year 1963
(Name of Professional School)

Illinois License No. 36-43220 Date issued June 17 1970



STATE OF ILLINOIS
DEPARTMENT OF
REGISTRATION AND EDUCATION
SPRINGFIELD

DR. DEAN BARRINGER
DIRECTOR

PETER A. KOTSOS
ASSISTANT DIRECTOR

IN REPLY REFER TO: Medical Section

August 11, 1973

M. H. Crabb, M.D., Secretary
Federation of State Medical Boards
1612 Summit Avenue, Suite 304
Fort Worth, Texas 76102

Re: Shah Yogendra A., M.D.

Dear Dr. Crabb:

Please forward a transcript of the grades Dr. A.
received in the month of June 1973
from the Missouri Flex examination.

Sincerely,


Dean Barringer, Ph.D.
DIRECTOR

db

H.M.
js

August 30, 1973

Mr. William H. Robinson
Superintendent of Registration
628 East Adams Street
Springfield, Illinois 62708

RECEIVED

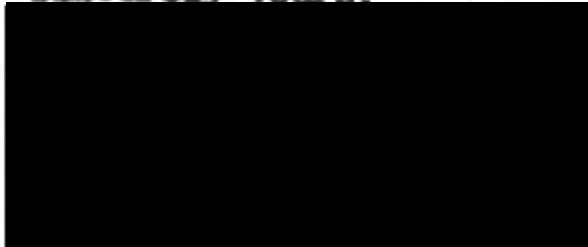
SEP 4 1973

DIRECTOR OF REGISTRATION
AND EDUCATION

Dear sir,

I have passed the Flex Examination from the Missouri State held in June 1973. I wish to apply for reciprocity for the Illinois State. I will very much appreciate if you will send me the necessary information and forms.
Thanking you.

Sincerely yours,



Nov. 27, 1973

Dr. Dean Barringer
Director
Department of Registration & Education
Springfield, Illinois 62786

Dear Dr. Barringer

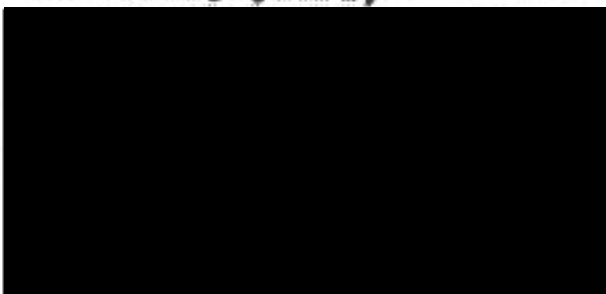
Thank you very much for sending me application forms. I have passed the Flex Examination from Missouri State in June 1973. I am making an application for reciprocity. enclosed please find....

- 1) Completed application form
- 2) Declaration of intension for citizenship
- 3) two recommendation letters from Illinois physicians
- 4) Photograph
- 5) \$75 Cashier's Check
- 6) Nine Original Certificate
 - 1) School leaving Certificate
 - 2) Pre-Medical Certificate
 - 3) Transcript of Medical School
 - 4) Internship Certificate from S.S.C. Hospital, India
 - 5) High School Certificate
 - 6) First year Residency (Pathology) Certificate
 - 7) ECFMG Certificate
 - 8) Rotating Internship Certificate P from Mount Sinai Hospital
 - 9) Medical School Diploma Certificate
- 7) Photostate copies of the Nine M Original Certificate
- 8) Prepaid return Registered letter

Please feel free to write me in any question. Please return the Original Certificates at your earliest convenience.

Thanking you

Sincerely yours,



RECEIVED
CASH SECTION

APPLICATION FOR STATE JUL 05 2017
CONTROLLED SUBSTANCES REGISTRATION
IDFPR

FOR OFFICIAL USE ONLY

Lic#: [REDACTED]
SHAH, YOGENDRA A
[REDACTED] 07/11/2017
By: NON-EXAM

9/8/17

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 Controlled Substances	2. PROFESSION CODE - Check applicable box <input type="checkbox"/> 319 Dentist <input type="checkbox"/> 316 Podiatrist <input checked="" type="checkbox"/> 336 Physician <input type="checkbox"/> 346 Optometrist <input type="checkbox"/> 390 Veterinarian	3. LICENSURE METHOD Registration	4. FEE \$5
---	--	---	-------------------

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE Shah, Yogendra A.	2. TITLE (e.g., M.D., O.D., etc.) MD	3. UNITED STATES SOCIAL SECURITY NO. [REDACTED]
--	---	--

4. PERMANENT MAILING ADDRESS [REDACTED]	CITY [REDACTED]	STATE/COUNTRY [REDACTED]	ZIP CODE [REDACTED]	COUNTY [REDACTED]
--	--------------------	-----------------------------	------------------------	----------------------

7. 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.

8. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)
[REDACTED]

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 - 048989

Podiatrist 016 - _____

Veterinarian 090 - _____

NAME (Last, First, MI):

SSN:

Profession:

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 personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.
2. Have you been convicted of a felony? In general, a felony conviction by itself does not usually result in denial of licensure.
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. Do you 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.

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?
(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 of an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State?

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.

06/28/17
Date of Application

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):

SS#:

Profession:

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 personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.
2. Have you been convicted of a felony? In general, a felony conviction by itself does not usually result in denial of licensure.
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. Do you 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.

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

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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?

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.

06/29/2017
Date of Application

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.**

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 SHAH YOGENDRA A	3. PROFESSIONAL LICENSE NUMBER (if any) 366-0489 036-048989
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.**

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

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? *

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.

Signature [REDACTED]

Date 06/29/2017