0300006921

S 87242

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.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FEB 13 2003

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

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

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

A. Type or print legibly with black ink only.
B. FEES ARE NOT REFUNDABLE.
C. Disclosure of your U.S. social security number, if you have one, is mandatory in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician	036	Acceptance of Examination	$ 300.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

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

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

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.O.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO
Garcia, Anthony, Joseph	M.D.	[redacted]

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

5. BUSINESS ADDRESS STREET CITY	STATE/COUNTRY	ZIP CODE	COUNTY
1926 W. Harrison St. Apt. 600 Chicago, IL		60612-	Cook

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME
N/A	Castor

8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH Month Day Year	10. AGE	
[redacted]	[redacted]	29	[ ] Female [X] Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work ([redacted]) (Area Code) Home: ([redacted]) (Area Code)

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

Additional application forms can be downloaded from the IDPR Web site at www.dpr.state.il.us.

NAME (Last, First, MI): Garcia, Anthony J SSN: [redacted] Profession: Physician

PART III: Education Information

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

1 2 3 4 5 6 7 8 9 10 11 (12) Graduated High School? ☒ Yes ☐ No Received GR GED? ☐ Yes ☒ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION Month / Year
Walnut High School	Walnut, CA	06/1991

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

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

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	DATES OF ATTENDANCE TO Month/Year	TYPE OF DEGREE EARNED
California State University Los Angeles	Los Angeles, CA	06/92	06/94	B.S.
University of Utah	Salt Lake City, UT	08/94	05/99	M.D.

FEB 2 4 05

7 SPECIALIZED TRAINING? (Residency, Professional Training, Vocational Training, Internship 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?
Creighton University	Omaha, NE	7/2000	7/2001	☒ Yes ☐ No
University of Illinois Chicago	Chicago, IL	8/2001	9/2002	☒ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

FEB 2 4 05

NAME (Last, First, MI): Garcia, Anthony U. SS#: Profession: Physician

PART IV: Record of Licensure Information

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
Nebraska	Physician	4214	7/2000	Lapsed
State of Current Licensure where you most recently have been practicing.				
Illinois	Physician	125-043788	09/01/2001	Active
Other States of Licensure				

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

PART V: Record of Examination

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

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
USMLE Step 1	UT	6/97	Failed
USMLE Step 1	CA	10/97	Passed
USMLE Step 2	CA	8/98	Failed
USMLE Step 2	CA	3/99	Passed
USMLE Step 3	CA	2/2000	Passed

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

NAME (Last, First, MI): Garcia, Anthony, J. SS#: [redacted] Profession: Physician

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		X
2. 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.*		X
3. 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*		X
4. 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.*		X

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: [ ][ ]

e) Do you authorize the Department to release your Licensure Examination Scores to the education program from which you graduated? Yes ☐ No ☐

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? Yes ☐ No ☒
   (NOTE: If you are not subject to a child support order, answer "no.")

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

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☒

PART IX: Certifying Statement

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

[redacted] 2-3-2003

Signature of Applicant Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of 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 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.

WORK HISTORY

SUPPORTING DOCUMENT: **WH**

APPLICANT: Complete Work History. If you have never been employed you may stop at box 8. You are authorized to photocopy this form if additional space is required.

1. NAME (LAST, FIRST, MIDDLE): Garcia, Anthony Joseph

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

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
Profession Name: Physician — Profession Code: 036

6. MAIDEN OR GIVEN SURNAME: N/A

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

8. DATE FORM COMPLETED: 2-3-2003

9. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS / INSTITUTION: University of Illinois Chicago
ADDRESS (STREET, CITY, STATE, ZIP CODE): 1819 W. Polk, Room 446 Chicago, IL. 60612
SUPERVISOR NAME: Michele Raible
DATE OF EMPLOYMENT/ATTENDANCE: From 08/01/2001 (Month/Day/Year) To 02/03/2003 (Month/Day/Year)
HOURS WORKED PER WEEK: 80
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month): 1 year 6 months
JOB TITLE: Physician
DESCRIPTION OF DUTIES PERFORMED: Anatomic and clinical Pathology
Study Pathology
Study Medicine
Job seeking

B. NAME OF BUSINESS / INSTITUTION: Creighton University
ADDRESS (STREET, CITY, STATE, ZIP CODE): 601 N. 30th St. Omaha, NE 68131
SUPERVISOR NAME: William Hunter
DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/2000 (Month/Day/Year) To 07/31/2001 (Month/Day/Year)
HOURS WORKED PER WEEK: 80
TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month): 1 year
JOB TITLE: Physician
DESCRIPTION OF DUTIES PERFORMED: Anatomic and clinical Pathology
Study Pathology
Study Medicine
Job seeking

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

APPLICANT: *Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.*

1. NAME LAST · FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Garcia Anthony Joseph	[redacted]	[redacted]

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

6. MAIDEN OR GIVEN SURNAME: N/A

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

Physician (Profession Name) — 036 (Profession Code)

7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable): 125-043788

8. ISSUANCE DATE: 09/01/2001

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 62786

This is to certify that the above-named applicant satisfactorily completed 19 months of postgraduate clinical training in Anatomic and Clinical Pathology
(Name of Accredited Postgraduate Clinical Training Program)

from 8/2001 to 3/2003 at the following hospital:

Hospital: University of Illinois at Chicago

Number and Street: 820 S. Wood St.

City, State and Zip Code: Chicago, IL 60612

I further certify that at the time of such training the program was accredited by:

- ☒ the Accreditation Council for Graduate Medical Education;
- ☐ the Accreditation Council on Canadian Graduate Medical Education; or
- ☐ the American Osteopathic Association

Name of Postgraduate Clinical Training Program Director: Michelle Raible, M.D.

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 4/8/03

Telephone No: [redacted]

SEAL

RECEIVED
MAY 2 2003
IDPR-MEDICAL UNIT

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(OPR)

APPLICANT: *Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.*

1. NAME (LAST, FIRST, MIDDLE): Garcia, Anthony Joseph
2. DATE OF BIRTH (Month, Day, Year): [redacted]
3. SOCIAL SECURITY NUMBER: [redacted]
4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted]
5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
   Profession Name: Physician
   Profession Code: 036
6. MAIDEN OR GIVEN SURNAME: N/A
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable):
8. ISSUANCE DATE:

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 62786

This is to certify that the above-named applicant satisfactorily completed 12 months of postgraduate clinical training in Anatomic and Clinical Pathology
(Name of Accredited Postgraduate Clinical Training Program)

from 07/01/2000 to 06/30/2001 at the following hospital:

Hospital: Creighton University St. Joseph's Hospital

Number and Street: 601 N. 30th St.

City, State and Zip Code: Omaha, NE. 68131

RECEIVED
MAR 03 2003
IDPR-MEDICAL UNIT

I further certify that at the time of such training the program was accredited by:

- [x] the Accreditation Council for Graduate Medical Education;
- [ ] the Accreditation Council on Canadian Graduate Medical Education; or
- [ ] the American Osteopathic Association

Name of Postgraduate Clinical Training Program Director: W. J. Hunter MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

SEAL

Date of this Certification: 15 Feb 2003

Telephone No: [redacted]

CALIFORNIA STATE UNIVERSITY, LOS ANGELES
5151 STATE UNIVERSITY DRIVE, LOS ANGELES, CA 90032

Anthony J. Garcia

Student ID: [redacted] Birthdate: [redacted]

Official Baccalaureate Academic Record

Secondary Schools:
High School Graduation Date — Graduated Jun 1991

Higher Education Institutions:

UC Davis	Sep 1983 - Dec 1993
CSU Los Angeles	Jun 1992 - Sep 1993
Mt San Antonio College	Jun 1988 - Jun 1992
CSU Cal Poly Pomona	Jan 1991 - Jun 1992
Prelim Last 90	

Degrees Awarded:
Bachelor of Science — Jun 11, 1994
School of Natural & Social Sciences
Major: Biology

Transfer Credit:
HIGHER EDUCATION CREDIT: 136.00

Summer Quarter 1992

BIOL-418	EVOLUTION		
BIOL-499	UNDRGRD DIR STUDY		
	Credit/No Credit		

	AHRS	EHRS	QHRS
Current	8.00	8.00	4.00
Cumulative	144.00	144.00	4.00

Fall Quarter 1992

BIOL-360	GENERAL ECOLOGY		
BIOL-398	COOP EDUC		
	Credit/No Credit		
CHEM-201	QUANT ANALYSIS		
CHEM-301A	ORGANIC CHEMISTRY		
SOC -425	MEDICAL SOCIOLOGY		

	AHRS	EHRS	QHRS
Current	18.00	18.00	16.00
Cumulative	162.00	162.00	20.00

Winter Quarter 1993

BIOL-330	CELL BIOLOGY		
BIOL-352	WRITING FOR BIOL		
BIOL-398	COOP EDUC		
	Credit/No Credit		
BIOL-416	MOLECULAR GENETCS		
CHEM-301B	ORGANIC CHEMISTRY		
CHEM-302A	ORGANIC CHEM LAB		

	AHRS	EHRS	QHRS	QPTS	GPA
Current	18.00	18.00	17.00	42.00	
Cumulative	180.00	180.00	37.00	105.00	

001195868

NO ENTRY BELOW THIS LINE

Transfer Credit Applied to Spring Quarter 1993
SUPPLEMENTAL HIGHER ED CREDIT 12.00

Spring Quarter 1993

BIOL-422	VERTEBRATE STRUCT+FUNCT	
BIOL-424	GEN EMBRYOLOGY	
BIOL-440	TAXON ANGIOSPERMS	
CHEM-301C	ORGANIC CHEMISTRY	
CHEM-302B	ORGANIC CHEM LAB	
MATH-206	CALCULUS I	
	Advanced Placement	

	AHRS	EHRS	QHRS	QPTS	
Current	22.00	22.00	18.00	37.00	
Cumulative	214.00	214.00	55.00	142.00	

Spring Quarter 1994

NTRS-300	PHYSIO+NUTR BASES OF FITNESS	
RELS-345	HLTH+WELLNESS WORLD RELIGIONS	

	AHRS	EHRS	QHRS	QPTS	
Current	8.00	8.00	8.00	32.00	
Cumulative	222.00	222.00	63.00	174.00	

Requirements completed for Bachelor of Science.
End of Baccalaureate Academic Record

Anthony Joseph Garcia
[redacted]

UNIVERSITY OF UTAH
SALT LAKE CITY, UTAH 84112

Official Transcript

Name: GARCIA, ANTHONY JOSEPH
Student ID: [redacted]
SSN:
Birthdate:

UNIVERSITY OF UTAH DEGREES
Doctor of Medicine
Major in Medicine
Confer Date: May 22, 1999

DEGREES AWARDED BY OTHER INSTITUTIONS
CALIFORNIA STATE UNIVERSITY LOS ANGELES
LOS ANGELES, CA
Bachelor of Science
June 11, 1994

[redacted] BEGINNING OF MEDICINE QUARTER-CAREER

Course	Description	Attempted Units	Earned Units	Grade
	Autumn 1994			
ANAT 601	Gross Anatomy Human			
ANAT 603	Histology			
ANAT 605	Embryology			
BIO C 609	Medical Biochemistry			
Term GPA: 0.000				
	Winter 1995			
BIO C 609	Medical Biochemistry			
FP MD 634	Medicine & Society			
PHYSL 603	Medical Physiology			
PSYCT 601	Basic Sci Foundation			
Term GPA: 0.000				
	Spring 1995			
BIO C 610	Medical Biochemistry			
[redacted] BEN 610	Genetics In Medicine			
PHYSL 604	Endocrinology			
Term GPA: 0.000				

Continued Next Column

Course	Description	Attempted Units	Earned Units	Grade
	Autumn 1995			
PATH 600	Medical Immunology			
PATH 604	Medical Microbiology			
Term GPA: 0.000				
	Spring 1996			
ANAT 605	Neuroanatomy			
INTMD 701	Intro To Medicine			
Term GPA: 0.000				
	Autumn 1996			
INTMD 702	Intro TO Medicine			
PATH 601	General Pathology			
PH TX 601	Pharmacology Therapy			
Term GPA: 0.000				
	Winter 1997			
MD ID 602	Organ Systems			
PATH 602	Systemic Pathology			
PH TX 604	Pharmacology			
Term GPA: 0.000				
	Spring 1997			
INTMD 704	Foundations Geriatrics			
MD ID 603	Organ Systems			
PATH 603	Systemic Pathology			
PSYCT 610	Intro Clinicl Psychiatr			
Term GPA: 0.000				
	Autumn 1997			
OBST 701	Clerkship Ob Gyn Clinic			
PED 701	Pediatric Clerkship			
Term GPA: 0.000				

[redacted]

Continued Page 2

AN OFFICIAL SIGNATURE IS WHITE WITH A GRAY BACKGROUND — REJECT DOCUMENT IF SIGNATURE BELOW IS DISTORTED

DEPARTMENT OF PROFESSIONAL REGULATION
STATE OF ILLINOIS
320 WEST WASHINGTON ST MED1
SPRINGFIELD IL 62786

Ralph O. Boren
University Registrar

This officially sealed and signed transcript is printed on grey SCRIP-SAFE® security paper with the name of the universi printed in small type across the face of the document. A raised seal is not required. When photocopied the word COP should appear. A BLACK ON WHITE OR A COLOR COPY SHOULD NOT BE ACCEPTED!

COPY OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE

UNIVERSITY OF UTAH
SALT LAKE CITY, UTAH 84112

Official Transcript

Name: GARCIA, ANTHONY JOSEPH
Student ID: [redacted]
SSN:
Birthdate:

Course	Description	Attempted Units	Earned Units	Grade
	Winter 1998			
INTMD 7200	Clinical Clerkship			
MD ID 7140	Topics In Medicine			
PSYCT 7200	Psychiatric Clin Clkshp			
Term GPA: 0.000				
	Spring 1998			
FP MD 7180	Family Practice Clkshp			
[redacted] ID 7150	Topics In Medicine			
SURG 7020	Junior Clinical Clkshp			
Term GPA: 0.000				

CAREER SUMMARY

Cumulative GPA:	0.000
Cumulative GPA Units:	0.000
Units Attempted:	226.000
U of U Units Earned:	226.000
Total Transfer Units:	0.000
Total Test Credit:	0.000
Total Other Credit:	0.000
Cumulative Units	226.000

END OF MEDICINE QUARTER CAREER

BEGINNING OF MEDICINE SEMESTER CAREER
Quarter to Semester Cum Stats
GPA: 0.000 150.670 150.670

Course	Description	Attempted Units	Earned Units	Grade
	Fall 1998			
[redacted]TH 6070	Med Student Research			
PATH 7020	Clinical Pathology			
PATH 7050	Anatomical Pathology			
Term GPA: 0.000				

Continued Next Column

Course	Description	Attempted Units	Earned Units	Gra
	Spring 1999			
FP MD 7210	Fam Pract Subinternship			
INTMD 7560	Medical Ethics			
NEURO 7910	Clin Clerkship - V.A.			
PATH 6070	Med Student Research			
Term GPA: 0.000				

CAREER SUMMARY

Cumulative GPA:	0.000
Cumulative GPA Units:	0.000
Units Attempted:	186.670
U of U Units Earned:	186.670
Total Transfer Units:	0.000
Total Test Credit:	0.000
Total Other Credit:	0.000
Cumulative Units	186.670

END OF MEDICINE SEMESTER CAREER

BEGINNING OF NON-CREDIT QUARTER CAREER
Autumn 1995

H EDU 47	Cpr Recertification	0.00	0.00	

END OF NON-CREDIT QUARTER CAREER
End of Transcript

USMLE
United States Medical Licensing Examination™

Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 09/11/2001

549-95-5489

Illinois Department of Professional Regulation
ATTN: Alicia Purchase, Section Manager
320 W. Washington St.
3rd Floor, Unit IV
Springfield, IL 62786

Examinee: Garcia, Anthony Joseph
USMLE ID#: [redacted]
DOB:
Alt Name(s):

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	10/14/1997	PASS	[redacted]				Test Accommodations:
	6/10/1997	FAIL					

STEP2	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	3/2/1999	PASS	[redacted]				Test Accommodations
	8/25/1998	FAIL					

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
NEVADA	2/22/2000	PASS	[redacted]				Test Accommodations

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

Patent 5656874

CALIFORNIA STATE UNIVERSITY, LOS ANGELES

Office of the University Registrar

5151 State University Drive
Los Angeles, CA 90032
(323) 343-3840

TRANSCRIPT OF ACADEMIC RECORD

ACCREDITATION

Cal State L.A. is fully accredited as a four-year degree-granting institution by the Western Association of Schools and Colleges.

COURSE NUMBERING SYSTEM

000-099	Subcollegiate level (no credit allowed toward requirements for academic degrees).
100-299	Lower division courses (freshman and sophomore level).
300-399	Upper division courses (junior and senior level) that do not earn graduate credit
400-499	Upper division courses (junior and senior level) that may earn graduate credit for graduate students.
500-599	Graduate courses for graduate students only.
600-699	Specialized graduate courses for postgraduate students matriculated in the joint Ph.D program in Special Education.
700-749	Courses intended primarily for lower division students. Not acceptable toward degree or credential programs but acceptable for professional advancement credit.
750-799	Courses intended primarily for upper division students. Not acceptable toward degree or credential programs but acceptable for professional advancement credit.
800-899	Highly specialized courses intended primarily for graduate students. Not acceptable toward degree or credential programs but acceptable for professional advancement credit.
900	Non credit courses open to graduate students only.

RECORDS SYSTEM

All credits are offered beginning Summer 1967 in quarter units. The University operates on a four quarter system. All quarters contributing equally to the academic year which runs from Summer through Spring Quarters.

All Baccalaureate higher education work is incorporated in the Earned Hours (EHRS). A maximum of 105 quarter units from community colleges may be applied toward a bachelor's degree.

GRADING SYSTEM AND GPA CALCULATION

(plus-minus added to grading scheme effective Fall 1996)

		Contibutes To Quality Hours	Quality Points Earned	Contributes To Earned Hours	Effective Date
A	Superior	Yes	4.0	Yes	
A-	Outstanding	Yes	3.7	Yes	
B+	Very Good	Yes	3.3	Yes	
B	Good	Yes	3.0	Yes	
B-	Better than Average	Yes	2.7	Yes	
C+	Above Average	Yes	2.3	Yes	
C	Average	Yes	2.0	Yes	
C-	Below Average	Yes	1.7	Yes	
D+	Weak	Yes	1.3	Yes	
D	Poor	Yes	1.0	Yes	
D-	Barely Passing	Yes	0.7	Yes	
F	Non-Attainment	Yes	0.0	No	
U	Unauthorized Incomplete	Yes	0.0	No	Sum 1967 - Sum 2002
WU	Withdrawal Unauthorized	Yes	0.0	No	Fall 2002
IN	Incomplete	No	0.0	No	Sum 1967 - Sum 2002
I	Incomplete Authorized	No	0.0	No	Fall 2002
I	Expired Incomplete	Yes	0.0	No	Sum 1967 - Sum 2002
IC	Incomplete Charged	Yes	0.0	No	Fall 2002
SP	Satisfactory Progress	No	0.0	No	Sum 1967 - Sum 2002
RP	Report in Progress	No	0.0	No	Fall 2002
W	Withdrawn	No	0.0	No	
CR	Credit	No	0.0	Yes	
NC	No Credit	No	0.0	No	
RD	Report Delayed	No	0.0	No	

EHRS (Earned Hours): those hours which earn credit, but may or may not carry grade point value

QHRS (Quality Hours): those hours which carry grade point value

QPTS (Quality Points): points awarded per course multiplied by the point value of the grade.

GPA (Grade Point Average) is determined by dividing Quality Points (QPTS) by Quality Hours (QHRS).

Repeat – Repetition of prior course with lower grade removal from GPA calculation

THE TRANSCRIPT IS PRINTED ON GREEN SAFETY PAPER AND IS OFFICIAL IF IT BEARS THE SEAL OF THE UNIVERSITY AND THE SIGNATURE OF THE UNIVERSITY REGISTRAR.

The University of Utah

upon the recommendation of the Faculty of

The School of Medicine

has conferred upon

Anthony Joseph Garcia

the Degree of

Doctor of Medicine

with all its Rights, Honors and Responsibilities

In Witness Thereof we have caused the Seal of the University to be affixed this

Twenty-second day of May, One Thousand Nine Hundred Ninety-nine.

[redacted]
Commissioner of Higher Education

[redacted]
Chair, Utah State Board of Regents

[redacted]
President of the University

[redacted]
Chair, Board of Trustees

[redacted]
Senior Vice President for Health Sciences
Interim Dean, School of Medicine

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANNS, GOVERNOR

CERTIFICATION OF LICENSE

DEPT OF PROFESSIONAL REGULATION
320 W WASHINGTON L & T-1
SPRINGFIELD IL 62786

PROFESSION NAME: Temporary Educational Permit

Number: 4214
Status: Lapsed
Issuance Date: 07/01/2000
Expiration Date: 07/01/2002

Name: Anthony Joseph Garcia MD
Address: Creighton - Pathology
601 N 30th Street Suite 1609
Omaha NE 68131

Credential Obtained by: Application

Exam Type:

School/Graduation Date: Univ of Utah School of Med - Salt Lake City 05/22/1999

Date of Birth: [redacted]
Place of Birth:

Disciplinary Action:

To expedite the certification process, the Credentialing Division is using the above format. There is no derogatory information in the professional's records if the Disciplinary Action section above is left blank.

[redacted]

Helen L. Meeks, Administrator
Credentialing Division

March 12, 2003

(SEAL)

RECEIVED
MAR 18 2003
IDPR-MEDICAL UNIT

You may verify licenses under the following Internet Web Site Address: http://www.hhs.state.ne.us/lis/lis.asp

APPLICATION TRANSMITTAL - Physician

(This transmittal must accompany the application.)

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
Garcia, Anthony Joseph	[redacted]	[redacted]
4. ADDRESS STREET, CITY, STATE, ZIP CODE [redacted]	5. REFER TO BOXES A-1 AND A-2 IN PART I ON YOUR APPLICATON FOR LICENSURE/EXAMINATION. Physician (Profession Name) — 0 3 6 (Profession Code)	

In the area below, indicate whether you have enclosed the 4-page application and the other items listed below or if you have requested an item to be forwarded directly to the Department by another entity (i.e. exam scores).

Enclosed	Requested	Description
X		4-page Application for Licensure and/or Examination
X		Application Fee
X		Form WH (required for all applicants)
[redacted]		FCVS Physician Profile
	X	TN-MED Form
		ECFMG Certificate (Copy)
X		Medical School Diploma (Copy)
	X	Proof of Pre-Medical and Medical Education (Official transcript of grades issued by medical college or university with school seal affixed) from: California State University Los Angeles / University of Utah
		AF-MED
		ED-NON
		5th Pathway/Social Service
[redacted]		Certification of Licensure (CT) from original and current state of licensure
[redacted]	X	Exam Scores (Sent directly from USMLE, FLEX, National Board, LMCC or State Board)

The above items are those documents most frequently requested. In the area below, list any other documentation you are submitting with your application that may be required for licensure.

Remarks: _____

IL486-1914 05/04 (MD)

Profession: 036

Date: 3/20/2003

Initials: lh

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

To:

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

	1 Submit the required fee of $_____made payable to the Department of Professional Regulation. This fee is not refundable.		21 Complete AF-MED form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s) 1. 2. 3. 4. 5.
	2 Your application is being returned for completion of Part _____		
	3 Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from _____ to _____.		23 Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
	4 All documents in a foreign language must be accompanied by original notarized translations by a person other than yourself who is fluent in both English and the language of the document(s). Original documents will be returned to you.		24 The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
	5 Submit proof that you are a lawfully admitted alien.		25 Submit a list of your work experience from _____ to _____. You must account for entire time period since graduation from medical school (Supporting Document WH). Use complete dates (mm/dd/yy) and ***no gaps over 30 days***.
	6 Have applicable documentation submitted for each positive personal history response. (see attached form)		26 Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
	7 When your application is complete, the Medical Licensing Board will review your qualifications.		27 Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
	8 Your application will be reviewed by the Medical Licensing Board on _____		28 Have your exam scores forwarded directly from _____
	9 Submit completed CA-MED form which indicates beginning and ending program dates.		29 Submit evidence of remedial training.
	10 Submit CA-LTD form.	X	30 Submit TN-MED form signed by program director, with seal of hospital.
	11 Submit ED-MED form (certification of education).	X	31 University/Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on official stationary must be attached verifying no seal exists.
	12 Submit ED-NON form completed in its entirety.		32 Sign Form(s) where indicated
	13 Affidavits, (ED-AFF forms) must be completed in accordance with DPR policy. Copy of policy attached.		33 Submit certification of original/current licensure (Supporting Document CT) from _____
	14 **Verification of Pass/Fail Exam History**--Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.		34 Submit proof that you are board certified in a specialty.
	15 Submit official premedical/medical transcript with school seal affixed.		35 Submit restoration questionnaire (Supporting Document RS).
	16 Submit photocopy of your degree.		36 Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
	17 Submit proof of Titulo or Acta.		37 Returning original documents.
	18 Submit proof of Social Service or Fifth pathway.		38 Submit proof of 150 CME (minimum 60 CAT I and maximum 90 CAT II)
	19 Submit proof of E.C.F.M.G. certification		
	20 Submit copy of evaluation form for each of the following core rotations 1. 4. 2. 5. 3.		

Other Instructions: Need TN-MED form from University of IL/Chicago.

Profession: 036

Date: 3-4-03 Initials: fa

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield, Illinois 62786

1. Submit the required fee of $_____ made payable to the Department of Professional Regulation. This fee is not refundable.	21. Complete **AF-MED** form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s). 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
2. Your application is being returned for completion of Part _____.	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: _____ to _____.	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).	25. Submit a list of your work experience from _____ to _____. You must account for entire time period since graduation from medical school (Supporting Document **WH**).
5. Submit proof that you are a lawfully admitted alien.	26 Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions
6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.	27 Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
7. When your application is complete, the Medical Licensing Board will review your qualifications.	28. Have your _____ scores forwarded directly from _____
8. Your application will be reviewed by the Medical Licensing Board on _____.	29. Submit evidence of remedial training.
9. Submit completed **CA-MED** form which indicates beginning and ending program dates.	X 30. Submit **TN-MED** form signed by program director, with seal of hospital.
10. Submit **CA-LTD** form.	X 31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on offilcal stationary must be attached verifying no seal exists.)
11. Submit **ED-MED** form (certification of education).	32. Sign form(s) where indicated.
12. Submit **ED-NON** form completed in its entirety.	X 33. Submit certification of original/current licensure (Supporting Document **CT**) from NE
13. Affidavits, (**ED-AFF** forms) must be completed in accordance with DPR policy. Copy of policy attached.	34 Submit proof that you are Board-certified in a specialty.
14. **Verification of Pass/Fail Exam History**—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.	35. Submit restoration questionnaire (Supporting Document **RS**).
15. Submit official premedical/medical transcript with school seal affixed.	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
16. Submit photocopy of your degree.	37. Returning original documents.
17. Submit proof of Titulo or Acta.	
18. Submit proof of Social Service or Fifth pathway.	
19. Submit proof of E.C.F.M.G. certification.	
20. Submit copy of evaluation form for each of the following core rotations: 1. _____ 4. _____ 2. _____ 5. _____ 3. _____	

Other Instructions:

#30 - Need TN-MED from Univ of IL / Chicago.

#33 - Need CT from Nebraska.

IL468-1588 5/94 (LT)

Profession: 0336

Date: 3-28-03 Initials: TA

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

Return this form with the requested materials to:

State of Illinois
Department of Professional Regulation
320 West Washington Street
MED 1
Springfield Illinois 62786

1. Submit the required fee of $_____ made payable to the Department of Professional Regulation. This fee is not refundable	21. Complete **AF-MED** form (Certification of Affiliation). Submit along with copies of affiliation agreement(s) from the following hospital(s). 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
2. Your application is being returned for completion of Part _____.	23. Affidavit of verbal affiliation agreement. See attached for specific information that must be submitted.
3. Submit a copy of your marriage certificate, divorce decree, or court order showing change of name from: _____ to _____.	24. The Department is unable to verify completion of 54 months of combined premedical and medical education. Submit proof in the form of official educational documents verifying you meet the minimum education requirements.
4. All documents in a foreign language must be accompanied by original, notarized translations by a person other than yourself who is fluent in both English and the language of the document(s).	25. Submit a list of your work experience from _____ to _____. You must account for entire time period since graduation from medical school (Supporting Document **WH**).
5. Submit proof that you are a lawfully admitted alien.	26 Submit documentation evidencing maintenance of clinical skills since graduation from medical school. See attached instructions.
6. You are referred to Step 1, Question #7 of the enclosed application filing instructions. Have applicable documentation submitted for each positive personal history response.	27. Submit proof of professional capacity. See copy of attached instructions for specific information required to be submitted.
7. When your application is complete, the Medical Licensing Board will review your qualifications.	28. Have your _____ scores forwarded directly from _____.
8. Your application will be reviewed by the Medical Licensing Board on_____.	29. Submit evidence of remedial training.
9. Submit completed **CA-MED** form which indicates beginning and ending program dates.	X 30. Submit **TN-MED** form signed by program director, with seal of hospital.
10. Submit **CA-LTD** form.	X 31. University / Hospital seal must be affixed to form. (If institution does not have a seal, form must be notarized and a letter on offical stationary must be attached verifying no seal exists.)
11. Submit **ED-MED** form (certification of education).	32. Sign form(s) where indicated.
12. Submit **ED-NON** form completed in its entirety.	X 33. Submit certification of original/current licensure (Supporting Document **CT**) from Nebraska
13. Affidavits, (**ED-AFF** forms) must be completed in accordance with DPR policy. Copy of policy attached.	34. Submit proof that you are Board-certified in a specialty.
14. **Verification of Pass/Fail Exam History**—Request appropriate board(s) or council(s) to forward official transcript of your pass/fail exam history (FLEX, National Board, USMLE) directly to this Department. Must include date and results for each exam attempt.	35 Submit restoration questionnaire (Supporting Document **RS**).
15. Submit official premedical/medical transcript with school seal affixed.	36. Submit VE form. If in private practice, submit sworn statement attesting to your active practice.
16. Submit photocopy of your degree.	37. Returning original documents.
17. Submit proof of Titulo or Acta.	
18. Submit proof of Social Service or Fifth pathway.	
19. Submit proof of E.C.F.M.G. certification.	
20. Submit copy of evaluation form for each of the following core rotations: 1. _____ 4. _____ 2. _____ 5. _____ 3. _____	

Other Instructions:

036 APPLICATION CHECKLIST ENDORSEMENT___ ACCEPTANCE_✓

APPLICATION FINDINGS

___Approved Program ✓6-Year
✓Application Complete
✓Personal History Yes#_____

DOMESTIC GRADUATES

✓Premedical Transcripts
✓Medical Transcripts
✓Diploma Date 5-22-99

FOREIGN GRADUATES

___ECFMG/5th Pathway/Social Service
___Premedical Transcripts
___Translations
___Medical Transcripts
___Translations
___Diploma Date_____
___Translation

6-Year Post Secondary Education

___AF-MED Part A
___AF-MED Part B
Evaluations: ___Med ___Ob/Gyn
___Peds ___Psych ___Surgery
Affiliations/Contracts
_____ _____ _____
_____ _____
___ED-NON _____Total Months
Core Rotations: ___Med ___Ob/Gyn
___Peds ____Psych ___Surgery

SUPPORTING DOCUMENTS

✓Work History
Professional Capacity OK✓
3PD ✓Original Jurisdiction of Licensure
License State & Number NE #
No Discipline_____
___Current Jurisdiction of Licensure
License State & Number_____
No Discipline_____
5/2 ✓Clinical Training 12 or 24 months
Seal✓ RPD✓ Accredited✓
✓Acceptable Examination or Combination
___NBME ___NBOME ___FLEX
✓USMLE ___LMCC ___State-constructed
___American Board Certified
___Name Change
✓Federation Check

OTHER INFORMATION/NOTES

~~Updated to mailed~~