Medical License No.: 036109200 PIN: [redacted]

Fee Before 7/31/2005: $600.00 After 7/31/2005: $700.00

PART B:

Please read the enclosed CME Fact Sheet regarding Continuing Education requirements.

____ I wish to place my license on INACTIVE STATUS.
No FEE IS REQUIRED TO GO INACTIVE PRIOR TO 7/31/2005.
After 7/31/2005, you must submit $700 to go inactive.

PART C: Check appropriate statement below:

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.")

X No ____ Yes

PART D:

APPLICATIONS NOT SIGNED AND/OR INCOMPLETE WILL BE RETURNED.

I understand that if I provide false/fraudulent information I could lose my license, be fined and/or have other penalties assessed. I also understand the FEES ARE NOT REFUNDABLE. Therefore, I declare that I have examined this form and, to the best of my knowledge, all statements are true, correct and complete.

SIGNATURE: [redacted]

SOCIAL SECURITY NUMBER: [redacted]

DAYTIME PHONE NUMBER: ([redacted]

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, but in no event shall such reduction be made in an amount greater than $50.

036109200001000060000V000070000T

Medical License No.: 036109200 PIN: [redacted]

License Renewal Notices for:

LICENSED
PHYSICIAN

CONTROLLED SUBSTANCE LICENSE(S)

Avoid Delays!

Renew Your License the Fast and Easy Way
www.idfpr.com or 1-800-823-6100
(See License Renewal Instruction Sheet)

MasterCard VISA DISCOVER

Department of Financial and Professional Regulation
Division of Professional Regulation
Post Office Box 7086
Springfield, IL 62791-7086

ANTHONY JOSEPH GARCIA MD

License Fee Summary				
License	License #	PIN#	Renewal Fee Before 7/31/2005	Renewal Fee After 7/31/2005
Medical:	036109200	[redacted]	$600.00	$700.00
Controlled Substance:	No CS Licenses			
Total Fees:			$600.00	$700.00

03610920000 00000801 62 06/22/2005 600.00

Name/Address Change

Please follow the instructions below for making Name and Address Changes for your Medical License.

Current Medical License Name and Address: ANTHONY JOSEPH GARCIA MD [redacted]

Name: ____

Address Lines: ____

City: ____

State: ____ Zip Code: ____

County: ____

PART A: LICENSE RENEWAL QUESTIONS: You must respond to ALL of the following questions in order to renew your license. Failure to answer ALL of these question will result in the form(s) being returned to you for proper completion.

___Yes X No Since July 31, 2002, have you been convicted of any criminal offense in any state or federal court (other than minor traffic violations)? If yes, attach a statement of each conviction including date and place of conviction, nature of the offense and, if applicable, the date of discharge from any penalty imposed.

___Yes X No Since July 31, 2002, have you had or do you now have any disease or condition that impairs or impaired 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? If yes, please set forth details on a separate sheet, including dates, names and addresses of treating physicians and/or counselors and nature of treatment.

___Yes X No Since July 31, 2002, 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.

___Yes X No Since July 31, 2002, have your clinical, hospital or practice privileges relating to patient care been involuntarily restricted, suspended or revoked (other than for non-completion of medical records)? If yes, attach a detailed explanation.

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Medical License No.: 036109200 PIN: [redacted]

Fee Before 7/31/2008: $600.00 After 7/31/2008: $700.00

PART B: Check one of the following:

✓ I have fully complied with the Continuing Medical Education (CME) requirement of 150 hours for the renewal of my license. Submit proof of CME ONLY if submitting fee after 07/31/2008. See enclosed CME Fact Sheet for further information.

____ I am requesting a waiver of my Continuing Medical Education requirements. See enclosed CME Fact Sheet for further information.

____ I wish to place my license on INACTIVE STATUS. No FEE IS REQUIRED TO GO INACTIVE PRIOR TO 7/31/2008. After 7/31/2008, you must submit $700 plus proof of CME to go inactive.

PART C: Check appropriate statement below:

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.")

✓ No ____ Yes

PART D:

APPLICATIONS NOT SIGNED AND/OR INCOMPLETE WILL BE RETURNED.

I understand that if I provide false/fraudulent information I could lose my license, be fined and/or have other penalties assessed. I also understand the FEES ARE NOT REFUNDABLE. Therefore, I declare that I have examined this form and, to the best of my knowledge, all statements are true, correct and complete.

SIGNATURE: [redacted]

SOCIAL SECURITY NUMBER: [redacted]

DAYTIME PHONE NUMBER: ([redacted]

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, but in no event shall such reduction be made in an amount greater than $50.

036109200001000060000V000070000T

Medical License No.: 036109200 PIN: 001622068

License Renewal Notices for:

LICENSED
PHYSICIAN

CONTROLLED SUBSTANCE LICENSE(S)

Avoid Delays!

Renew Your License the Fast and Easy Way at www.idfpr.com (See License Renewal Instruction Sheet)

MasterCard VISA DISCOVER

Department of Financial and Professional Regulation
Division of Professional Regulation
Post Office Box 7086
Springfield, IL 62791-7086

ANTHONY JOSEPH GARCIA MD

License Fee Summary				
License	License #	PIN#	Renewal Fee Before 7/31/2008	Renewal Fee After 7/31/2008
Medical:	036109200	[redacted]	$600.00	$700.00
Controlled Substance:	336078158	[redacted]	15.00	15.00
Total Fees:			$615.00	$715.00

03610920000 00000864 8 05/28/2008 600.00

Name/Address Change

Please follow the instructions below for making Name and Address Changes for your Medical License.

Current Medical License Name and Address: ANTHONY JOSEPH GARCIA MD [redacted]

Name: ____________________

Address Lines: ____________________

____

____

City: ____________________

State: ____________ Zip Code: ____________

PART A: LICENSE RENEWAL QUESTIONS: You must respond to ALL of the following questions in order to renew your license. Failure to answer ALL of these question will result in the form(s) being returned to you for proper completion.

✓ Yes ___No I have completed the On-line Physician Profile as required for the renewal of my license.

___Yes ✓ No Since July 31, 2005, have you been convicted of any criminal offense in any state or federal court (other than minor traffic violations)? If yes, attach a statement of each conviction including date and place of conviction, nature of the offense and, if applicable, the date of discharge from any penalty imposed.

___Yes ✓ No Since July 31, 2005, have you had or do you now have any disease or condition that impairs or impaired 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? If yes, please set forth details on a separate sheet, including dates, names and addresses of treating physicians and/or counselors and nature of treatment.

___Yes ✓ No Since July 31, 2005, 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.

___Yes ✓ No Since July 31, 2005, have your clinical, hospital or practice privileges relating to patient care been involuntarily restricted, suspended or revoked (other than for non-completion of medical records)? If yes, attach a detailed explanation.

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Electronic Renewal Record

Exit | Find Another

Field	Value
License Number	036109200
Pin	
Phone	
Authorization	
SSN	
Address Change (IVR only)	Y
Perjury Disclaimer	Y
Transaction Dt	4/16/2011
Renewal Fee	$600.00
Fee Type	R
Service Fee	$10.00

Method | I | Credited:

User Responses

#	Item	Response	#	Item	Response
1	SSN		9	MD2	Y
2	IA1	N	10	MD3	Y
3	PH1	N	11	CS1	N
4	PH2	N	12	CE1	Y
5	PH3	N	13		
6	PH4	N	14		
7	MD1	N	15		
8	MD1A	Y			