

# APPLICATION FOR LICENSURE AND/OR EXAMINATION

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

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

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

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

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

RECEIVED  
CASH SECTION

JUN 25 2013

Illinois Department of Professional Regulation

## PART I: Application Category Information

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

1. PROFESSION NAME <i>Visiting Physician Permit</i>	2. PROFESSION CODE <i>1 0 6</i>	3. LICENSURE METHOD <i>Non Examination</i>	4. FEE <i>\$ 100.00</i>
--	------------------------------------	---	----------------------------

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

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

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

1. NAME LAST FIRST MIDDLE <i>Paolo Macchiarini</i>	2. TITLE (e.g., M.D., D.D.S., etc.) <i>MD</i>	3. UNITED STATES SOCIAL SECURITY NO. <i>N/A</i>
4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY <i>[REDACTED] Cabrils</i>	ZIP CODE _____	COUNTY _____
5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY <i>Karolinska Univ Hospital. SE-141 86 Stockholm</i>	ZIP CODE _____	COUNTY _____
6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME	
8. PLACE OF BIRTH CITY STATE/COUNTRY <i>[REDACTED]</i>	9. DATE OF BIRTH Month Day Year <i>[REDACTED]</i>	10. AGE <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male
11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: ( <i>[REDACTED]</i> ) _____ Home: <i>[REDACTED]</i> Fax: ( <i>[REDACTED]</i> ) _____ Fax: ( <i>[REDACTED]</i> ) _____ (Area Code) (Area Code)	12. PREFERRED e-MAIL ADDRESS(ES) [If available] <i>[REDACTED]</i>	

NAME (Last, First, MI):

SS#:

Profession:

**PART III: Education Information**

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

1 2 3 4 5 6 7 8 9 10 11 12      Graduated High School?  Yes  No      Received OR G.E.D.?  Yes  No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED      3. LAST PRELIMINARY SCHOOL LOCATION (City and State)      4. DATE OF GRADUATION

\_\_\_\_\_ / \_\_\_\_\_

Month      Year

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		TYPE OF DEGREE EARNED
		FROM	TO	
University of Pisa	Pisa, Italy	1980	1986	MD
University of Pisa	Pisa, Italy	1986	1991	MCh
Organ and Tissue Transplantation University of Franche-Compte	Beqanson, France	1992	1994	MSc
Organ and Tissue Transplantation University of Franche-Compte,	Beqanson, France	1994	1997	PhD
Paris-Sud University	Paris, France	1998	- 1998	Research Director (HDR)* *Habilitation à diriger les Recherches - Accréditation to full professor (France)
Hannover Medical School	Hannover Germany	2000	2000	PD-Privat Dozent: Accreditation to Full Professor (Germany)

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		Did You Complete Training?
		FROM	TO	
Resident, Service of Thoracic Surgery University of Pisa	Pisa, Italy	11/80	11/89	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Fellow, Dept of Thoracic Surgery Univ. of Alabama @ Birmingham	Birmingham, Alabama USA	1/90	12/91	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Fellow, Dept of Thoracic & Vascular Surgery and Heart Lung Transplantation Hôpital Marie-Lannelongue	Paris, France	1/92	12/95	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paris-Sud University, Le Plessis Robinson (F)				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

NAME (Last, First, MI):

SS#:

Profession:

**PART IV: Record of Licensure Information**

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				
Italian Board of Gen Surgery			1991	
French Board of Thoracic Surgery			1997	
French Board of Cardiac and Vascular surgery			1999	
German Board of Thoracic Surgery			2000	
European Board of Thoracic and Cardiovascular Surgery			2000	
Spanish Board of General Surgery			2005	
Spanish Board of Thoracic Surgery			2005	
General Medical Council (UK)			2010	

(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)
No - None			

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

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 been convicted of a felony?			X
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.			X
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.			X
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.			X
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.			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:

**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.

\_\_\_\_\_  
Signature of Applicant

24/06/13  
\_\_\_\_\_  
Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.

NAME (Last, First, MI)

SS#

Profession



**Illinois Department of Financial and Professional Regulation**  
**Division of Professional Regulation**

**PAT QUINN**  
Governor

**MANUEL FLORES**  
Acting Secretary

**JAY STEWART**  
Director  
Division of Professional Regulation

**VARIANCE**

Pursuant to the authority granted to me in the provisions of 68 Illinois Administrative Code 1285.140, I hereby grant a Variance on behalf of Paolo Macchiarini, M.D. (the "Applicant"), to the provision of 68 Illinois Administrative Code 1285.101(g), which states, in regard to a visiting physician permit, that "[o]nly one Visiting Physician Permit shall be issued to an applicant. If, at the conclusion of the term of the appointment for which the permit was issued, the holder of the permit desires to remain in the State and practice or teach his/her profession, he/she must apply for and receive a license to practice medicine in all of its branches or as a chiropractic physician." This Variance is granted based upon review of the evidence for the following reasons:


1. The surgery that the applicant performed in Illinois, a tracheal implant on a 2 ½ year old girl, was the first of its kind in the United States, and has only been performed by the applicant.
2. I believe that a Variance is not unreasonable in this case because: a) the patient is experiencing complications from the surgery; and b) the applicant is the one of the only physicians qualified to continue treating the patient.

The purpose of this Variance is to vary 68 Illinois Administrative Code 1285.60(g) in order to allow the applicant to be issued another Visiting Physician Permit.

This Variance is to be narrowly construed and in no event shall this Variance be construed as qualifying the Applicant for licensure until all other requirements for licensure have been met.

I have determined that the provision from which this Variance is granted is not statutorily mandated; no party will be injured by the granting of this Variance; and the rules from which this Variance is granted would, in this particular case, be unreasonable.

*Manuel Flores, Acting Secretary*  
Department of Financial and Professional Regulation

By:   
Jay Stewart, Director  
Division of Professional Regulation

Date: 6/26/13

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 INVITATION/APPOINTMENT FOR VISITING PHYSICIAN 180-DAY PERMIT**

SUPPORTING DOCUMENT

**MD-VPH**

**NOTE:** An applicant shall not commence the appointment before the program receives written notification of approval from the Department of Financial and Professional Regulation.

A Visiting Physician Permit issued pursuant to Section 18(B) of the Medical Practice Act, shall be valid for 180 days from the date of issuance or until the time the medical, osteopathic, chiropractic, or clinical studies or techniques are completed, whichever occurs first. The applicant may be required to appear before the Board for an interview prior to, and as a requirement for, the issuance of such visiting physician permit.

**APPLICANT:** Complete the applicant section of this form. Forward the form to the dean or program director of the school or hospital at which the invitation/appointment has been established. Return the completed form with the Application for Licensure/Examination at least 60 days prior to the beginning date of the invitation/appointment.

1. NAME LAST FIRST MIDDLE <i>Macchiarini Paolo</i>	2. DATE OF BIRTH [REDACTED]	3. SOCIAL SECURITY NUMBER <i>N/A</i>
4. ADDRESS STREET CITY STATE, ZIP CODE <i>E-08348 Cabrils</i>	5. MAIDEN OR GIVEN SURNAME  <b>Visiting Physician Permit</b> <b>1 0 6</b> Profession Name      Profession Code	

**DEAN OR PROGRAM DIRECTOR OF SCHOOL OR HOSPITAL:** Complete the remainder of this form, then return the form to the applicant.

A. NAME OF MEDICAL, OSTEOPATHIC, CHIROPRACTIC SCHOOL OR HOSPITAL <i>OSF Saint Francis Medical Center</i>	B. THE TERM OF CONTRACT NOT TO EXCEED 180 DAYS From <i>06/24/2013</i> To <i>1/1/1</i> Month Day Year      Month Day Year
C. NAME OF DEPARTMENT OF SCHOOL OR HOSPITAL <i>Surgery</i>	D. TELEPHONE NUMBER (Include Area Code) <i>309-655-2244</i>
E. LOCATION OF SCHOOL OR HOSPITAL (Street, City, State, Zip Code) <i>530 NE Glen Oak Ave Peoria IL 61603</i>	F. FAX NUMBER (Include Area Code) <i>309-655-2347</i>
G. DESCRIBE IN DETAIL THE NATURE OF CLINICAL SUBJECT OR TECHNIQUE THAT APPLICANT HAS BEEN INVITED/APPOINTED TO STUDY, DEMONSTRATE, OR PERFORM. <i>Tracheal transplant post operative and ongoing care</i>	

I do hereby declare that the above-named applicant has been invited/appointed to study, demonstrate or perform a specific clinical subject or technique as a visiting physician for 180 days or until such time as the clinical studies or techniques have been completed, whichever occurs first.

SEAL

*6/24/13*  
Date

[REDACTED SIGNATURE]  
Signature of Dean or Program Director  
*TIM C. MILLER*  
Print or Type Name of Dean or Program Director



# SAINT FRANCIS MEDICAL CENTER

IDPR-MEDICAL UNIT

JUN 25 2013

RECEIVED

Sandy Dunn  
320 W. Washington St.  
3<sup>rd</sup> Floor  
Springfield, IL 62786

Dear Ms. Dunn:

Per instructions of Representative Lietch, please find the enclosed materials in support of Dr. Paolo Macchiarani's application for permanent licensure:

1. Application for licensure
2. \$100 application fee
3. Completed MD-VPH form
4. An updated certification from Italy is NOT included as he has most certainly been practicing here at Saint Francis Medical Center since the visiting permit was issued in January of this year.

I hope the enclosed materials meet all the Departments requirements. Please contact me directly if there are any questions or concerns, and we will address them immediately.

Thank you very much for your help in this matter.

Sincerely,

Edward A. Hirsch, M.D.  
Director of Medical Affairs  
OSF Saint Francis Medical Center  
530 N E Glen Oak Avenue | Peoria, IL | 61637  
309-624-3591 | 309-655-7968 (fax)  
[Edward.Hirsch@OSFHealthcare.org](mailto:Edward.Hirsch@OSFHealthcare.org)



# SAINT FRANCIS MEDICAL CENTER

December 12, 2012

IDFPR  
Division of Professional Regulation  
320 W Washington 3rd Floor  
Springfield, IL 62786

To Whom It May Concern:

Please accept this as notification that Dr. Paolo Macchiarini did not come to or perform patient care at OSF Saint Francis Medical Center for which his initial visiting physician permit was issued. We are anticipating that he will come January 1, 2013. Please issue a corrected 106 Visiting Physician permit, beginning the date noted above.

Sincerely,

Tim C. Miller, MD  
Vice President Medical and Academic Affairs

**RECEIVED**

DEC 14 2012

**IDFPR - 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 INVITATION/APPOINTMENT FOR VISITING PHYSICIAN 180-DAY PERMIT**

SUPPORTING DOCUMENT

**MD-VPH**

**NOTE:** An applicant shall not commence the appointment before the program receives written notification of approval from the Department of Financial and Professional Regulation.

A Visiting Physician Permit issued pursuant to Section 18(B) of the Medical Practice Act, shall be valid for 180 days from the date of issuance or until the time the medical, osteopathic, chiropractic, or clinical studies or techniques are completed, whichever occurs first. The applicant may be required to appear before the Board for an interview prior to, and as a requirement for, the issuance of such visiting physician permit.

**APPLICANT:** Complete the applicant section of this form. Forward the form to the dean or program director of the school or hospital at which the invitation/appointment has been established. Return the completed form with the Application for Licensure/Examination at least 60 days prior to the beginning date of the invitation/appointment.

1. NAME LAST FIRST MIDDLE <i>Macchiarini Paolo</i>	2. DATE OF BIRTH Month Day Year [REDACTED]	3. SOCIAL SECURITY NUMBER <i>N/A</i>
4. ADDRESS STREET, CITY, STATE, ZIP CODE [REDACTED] <i>E-08348 Cabrils</i>	5. MAIDEN OR GIVEN SURNAME  <b>Visiting Physician Permit</b> <b>1 0 6</b> Profession Name      Profession Code	

**DEAN OR PROGRAM DIRECTOR OF SCHOOL OR HOSPITAL:** Complete the remainder of this form, then return the form to the applicant.

A. NAME OF MEDICAL, OSTEOPATHIC, CHIROPRACTIC SCHOOL OR HOSPITAL <i>OSF Saint Francis Medical Center</i>	B. THE TERM OF CONTRACT NOT TO EXCEED 180 DAYS From <i>01/01/2013</i> To <i>06/30/2013</i> Month Day Year      Month Day Year
C. NAME OF DEPARTMENT OF SCHOOL OR HOSPITAL <i>Surgery</i>	D. TELEPHONE NUMBER (Include Area Code) <i>309-655-2244</i>
E. LOCATION OF SCHOOL OR HOSPITAL (Street, City, State, Zip Code) <i>530 NE Glen Oak Ave Peoria, IL 61637</i>	F. FAX NUMBER (Include Area Code) <i>309-655-2347</i>
G. DESCRIBE IN DETAIL THE NATURE OF CLINICAL SUBJECT OR TECHNIQUE THAT APPLICANT HAS BEEN INVITED/APPOINTED TO STUDY, DEMONSTRATE, OR PERFORM.  <i>Tracheal transplant</i>	

I do hereby declare that the above-named applicant has been invited/appointed to study, demonstrate or perform a specific clinical subject or technique as a visiting physician for 180 days or until such time as the clinical studies or techniques have been completed, whichever occurs first.

SEAL

*11/24/12*  
Date

[REDACTED]  
Signature of Dean or Program Director  
*TIM MILLER M.D.*  
Print or Type Name of Dean or Program Director

JUN 21 2012

FOR OFFICIAL USE ONLY

**IDFPR**  
**Professional Regulation**  
**APPLICATION FOR LICENSURE AND/OR EXAMINATION**

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

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

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

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

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

**PART I: Application Category Information**

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

1. PROFESSION NAME <i>Visiting Physician Permit</i>	2. PROFESSION CODE <i>1 0 6</i>	3. LICENSURE METHOD <i>Non Examination</i>	4. FEE <i>\$ 100-</i>
--	------------------------------------	---	--------------------------

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> This is the first time I have made application for this profession in Illinois.  | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements. |
| <input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying. | <input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.               |
| <input type="checkbox"/> Other: _____  |   |

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

1. NAME LAST FIRST MIDDLE <i>Paolo Macchiarini</i>	2. TITLE (e.g., M.D., D.D.S., etc.) <i>MD</i>	3. UNITED STATES SOCIAL SECURITY NO. [REDACTED]
---	--	--

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY [REDACTED] <i>Cabrils</i>	ZIP CODE _____	COUNTY _____
---	-------------------	-----------------

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY <i>Karolinska Univ Hosp. SE-141 86 Stockholm</i>	ZIP CODE _____	COUNTY _____
---	-------------------	-----------------

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

8. PLACE OF BIRTH CITY STATE/COUNTRY <i>Basel Switzerland</i>	9. DATE OF BIRTH [REDACTED] Month Day Year	10. AGE <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male
--	--	--

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: [REDACTED] Home: [REDACTED] Fax: [REDACTED] Fax: [REDACTED] (Area Code) (Area Code)	12. PREFERRED e-MAIL ADDRESS(ES) [If available] [REDACTED]
--	---

NAME (Last, First, MI):

Paolo Macchiarini

SS#:

Profession:

106

**PART III: Education Information**

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

1 2 3 4 5 6 7 8 9 10 11 12      Graduated High School?  Yes  No      Received OR G.E.D.?  Yes  No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED      3. LAST PRELIMINARY SCHOOL LOCATION (City and State)      4. DATE OF GRADUATION

\_\_\_\_\_ / \_\_\_\_\_

Month      Year

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		TYPE OF DEGREE EARNED
		FROM	TO	
University of Pisa	Pisa, Italy	1980	1986	MD
University of Pisa	Pisa, Italy	1986	1991	MCh
Organ and Tissue Transplantation University of Franche-Compte	Beçanson, France	1992	1994	MSc
Organ and Tissue Transplantation University of Franche-Compte,	Beçanson, France	1994	1997	PhD
Paris-Sud University	Paris, France	1998	-1998	Research Director (HOR)* *Habilitation à Diriger la Recherche - Accreditation to full professor (France)
Hannover Medical School	Hannover Germany	2000	2000	PD-Privat Dozent: Accreditation to Full Professor (German)

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		Did You Complete Training?
		FROM	TO	
Resident, Service of Thoracic Surgery University of Pisa	Pisa, Italy	11/86	11/89	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Fellow, Dept of Thoracic Surgery Univ. of Alabama @ Birmingham	Birmingham, Alabama USA	1/90	12/91	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Fellow, Dept of Thoracic & Vascular Surgery and Heart Lung Transplantation Hôpital Marie-Lannelongue	Paris, France	1/92	12/95	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paris-Sud University, Le Plessis Robinson (F)				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

NAME (Last, First, MI):

SS#:

Profession:

**PART IV: Record of Licensure Information**

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				
Italian Board of Gen Surgery			1991	
French Board of Thoracic Surgery			1997	
French Board of Cardiac and Vascular surgery			1999	
German Board of Thoracic Surgery			2000	
European Board of Thoracic and Cardiovascular Surgery			2000	
Spanish Board of General Surgery			2005	
Spanish Board of Thoracic Surgery			2005	
General Medical Council (UK)			2010	

(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)
No - None			

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

NAME (Last, First, MI):

Paolo, Macchiarini

SS#:

Profession:

106

**PART IV: Record of Licensure Information**

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

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				
	Italian Board of Gen. Surgery		1991	
	French Board of Thoracic Surgery		1997	
	French Board of Cardiac and Vascular Surgery		1999	
	German Board of Thoracic Surgery		2000	
	European board of Thoracic and Cardiovascular Surgery		2000	
	Spanish Board of General Surgery		2005	
	Spanish Board of Thoracic Surgery		2005	
	General Medical Council (UK)		2010	

(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
N/A			(Passed, Failed, Absent)

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

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 been convicted of a felony?			X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.			
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.			X
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.			X
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.			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: 

--	--	--	--	--	--

**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 100/10-05(c), applicants 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.")

Yes  No

N/A

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

N/A

**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.

\_\_\_\_\_  
 Signature of Applicant

4-18-12  
 Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.

NAME (Last, First, MI):

Paolo, Machiavini

SSN#

Profession:

106

NAME (Last, First, MI):

SS#:

Profession:

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 been convicted of a felony?			X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.			
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.			X
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.			X
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.			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:

**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 the [redacted] knowledge, they are true, correct, and complete.

\_\_\_\_\_  
Signature of Applicant

9.23.12  
\_\_\_\_\_  
Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.

<p><b>IMPORTANT NOTICE:</b> 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.</p>	<p><b>CERTIFICATION OF INVITATION/APPOINTMENT FOR VISITING PHYSICIAN 180-DAY PERMIT</b></p>	<p>SUPPORTING DOCUMENT</p> <p style="font-size: 24pt;"><b>MD-VPH</b></p>
--	---	--

**NOTE:** An applicant shall not commence the appointment before the program receives written notification of approval from the Department of Financial and Professional Regulation.

A Visiting Physician Permit issued pursuant to Section 18(B) of the Medical Practice Act, shall be valid for 180 days from the date of issuance or until the time the medical, osteopathic, chiropractic, or clinical studies or techniques are completed, whichever occurs first. The applicant may be required to appear before the Board for an interview prior to, and as a requirement for, the issuance of such visiting physician permit.

**APPLICANT:** Complete the applicant section of this form. Forward the form to the dean or program director of the school or hospital at which the invitation/appointment has been established. Return the completed form with the Application for Licensure/Examination at least 60 days prior to the beginning date of the invitation/appointment.

<p>1. NAME LAST FIRST MIDDLE</p> <p style="font-size: 24pt;">Macchiarini, Paolo</p>	<p>2. DATE OF BIRTH</p> <div style="background-color: black; width: 100px; height: 30px;"></div>	<p>3. SOCIAL SECURITY NUMBER</p> <p style="text-align: center;">NA</p> <p style="text-align: center;">-----</p>
<p>4. ADDRESS STREET, CITY, STATE, ZIP CODE</p> <div style="background-color: black; width: 100px; height: 20px;"></div> <p style="font-size: 24pt;">E-08348 Cabrils</p>	<p>5. MAIDEN OR GIVEN SURNAME</p> <p style="text-align: center; font-weight: bold; font-size: 18pt;">Visiting Physician Permit</p> <p style="text-align: center; font-size: 10pt;">Profession Name</p> <p style="text-align: right; font-weight: bold; font-size: 18pt;">1 0 6</p> <p style="text-align: right; font-size: 10pt;">Profession Code</p>	

**DEAN OR PROGRAM DIRECTOR OF SCHOOL OR HOSPITAL:** Complete the remainder of this form, then return the form to the applicant.

<p>A. NAME OF MEDICAL, OSTEOPATHIC, CHIROPRACTIC SCHOOL OR HOSPITAL</p> <p style="font-size: 24pt;">OSF St. Francis Medical Center</p>	<p>B. THE TERM OF CONTRACT NOT TO EXCEED 180 DAYS</p> <p>From <u>06/29/2012</u> To <u>12/28/2012</u></p> <p style="font-size: 8pt; text-align: center;">Month Day Year Month Day Year</p>
<p>C. NAME OF DEPARTMENT OF SCHOOL OR HOSPITAL</p> <p style="font-size: 24pt;">Surgery</p>	<p>D. TELEPHONE NUMBER (Include Area Code)</p> <p style="font-size: 24pt;">309-655-2244</p>
<p>E. LOCATION OF SCHOOL OR HOSPITAL (Street, City, State, Zip Code)</p> <p style="font-size: 24pt;">530 NE Glen Oak Ave Peoria, IL 61637</p>	<p>F. FAX NUMBER (Include Area Code)</p> <p style="font-size: 24pt;">309-655-2347</p>

G. DESCRIBE IN DETAIL THE NATURE OF CLINICAL SUBJECT OR TECHNIQUE THAT APPLICANT HAS BEEN INVITED/APPOINTED TO STUDY, DEMONSTRATE, OR PERFORM.

Tracheal Transplant



I do hereby declare that the above-named applicant has been invited/appointed to study, demonstrate or perform a specific clinical subject or technique as a visiting physician for 180 days or until such time as the clinical studies or techniques have been completed, whichever occurs first.

<p>SEAL</p> <p style="font-size: 24pt; text-align: center;">6/30/12</p> <p style="text-align: center;">Date</p>	<div style="background-color: black; width: 150px; height: 30px; margin: 0 auto;"></div> <p style="text-align: center; font-size: 10pt;">Signature of Dean or Program Director</p> <p style="font-size: 24pt; text-align: center;">TIM C. MILLER</p> <p style="text-align: center; font-size: 10pt;">Print or Type Name of Dean or Program Director</p>
---	---

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 INVITATION/APPOINTMENT FOR VISITING PHYSICIAN 180-DAY PERMIT**

SUPPORTING DOCUMENT

**MD-VPH**

**NOTE:** An applicant shall not commence the appointment before the program receives written notification of approval from the Department of Financial and Professional Regulation.

A Visiting Physician Permit issued pursuant to Section 18(B) of the Medical Practice Act, shall be valid for 180 days from the date of issuance or until the time the medical, osteopathic, chiropractic, or clinical studies or techniques are completed, whichever occurs first. The applicant may be required to appear before the Board for an interview prior to, and as a requirement for, the issuance of such visiting physician permit.

**APPLICANT:** Complete the applicant section of this form. Forward the form to the dean or program director of the school or hospital at which the invitation/appointment has been established. Return the completed form with the Application for Licensure/Examination at least 60 days prior to the beginning date of the invitation/appointment.

1. NAME LAST FIRST MIDDLE MACCHIARINI, PAOLO	2. DATE OF BIRTH [REDACTED] Month Day Year	3. SOCIAL SECURITY NUMBER NA - - - - -
4. ADDRESS STREET, CITY, STATE, ZIP CODE [REDACTED] E-08348 CABRILS	5. MAIDEN OR GIVEN SURNAME  <b>Visiting Physician Permit</b> <b>1 0 6</b> Profession Name      Profession Code	

**DEAN OR PROGRAM DIRECTOR OF SCHOOL OR HOSPITAL:** Complete the remainder of this form, then return the form to the applicant.

A. NAME OF MEDICAL, OSTEOPATHIC, CHIROPRACTIC SCHOOL OR HOSPITAL OSF SAINT FRANCIS MEDICAL CENTER	B. THE TERM OF CONTRACT NOT TO EXCEED 180 DAYS From ___/___/___ To ___/___/___ Month Day Year      Month Day Year
C. NAME OF DEPARTMENT OF SCHOOL OR HOSPITAL SURGERY	D. TELEPHONE NUMBER (Include Area Code) (309) 655-2244
E. LOCATION OF SCHOOL OR HOSPITAL (Street, City, State, Zip Code) 530 NE GLEN OAK AVENUE PEORIA, IL 61637	F. FAX NUMBER (Include Area Code) (309) 655-2347

G. DESCRIBE IN DETAIL THE NATURE OF CLINICAL SUBJECT OR TECHNIQUE THAT APPLICANT HAS BEEN INVITED/APPOINTED TO STUDY, DEMONSTRATE, OR PERFORM.

TRACHEAL TRANSPLANT

I do hereby declare that the above-named applicant has been invited/appointed to study, demonstrate or perform a specific clinical subject or technique as a visiting physician for 180 days or until such time as the clinical studies or techniques have been completed, whichever occurs first.

RODNEY L L VASQUEZ  
NOTARY PUBLIC - STATE OF ILLINOIS  
MY COMMISSION EXPIRES: 10/17/13

[REDACTED]

Signature of Dean or Program Director

SEAL

4/17/12  
Date

TIM C. MILLER CHIEF MEDICAL OFFICER  
Print or Type Name of Dean or Program Director



# REGISTER OF MEDICAL DOCTORS IN THE PROVINCE OF LUCCA

VIA GUINIGI, 40 - 55100 LUCCA Tel. 0583467276 - Fax 0583490627

Protocol n. 3103

## IS CERTIFIED THAT

**Dr. MACCHIARINI Paolo**

Born in [REDACTED]  
Nationality ITALY codice fiscale [REDACTED]  
Resident in [REDACTED] Cabrils 08348  
Who graduated in MEDICINE AND SURGERY at the University of PISA  
on 16/04/1986 with 110/110  
He passed the qualifying examination for the medicine and surgical practise in 1986 at the University of Pisa (Italy).

<b>Specializations:</b>	<b>on</b>	<b>at</b>	<b>mark</b>
GENERAL MEDICINE	02/07/1991	Pisa	50/50 cum laude

### Situation concerning the Medical and Dental Register:

First inscription in the Medical Surgical Register of the Association of the province of Lucca on the 10/09/1986 at number 1759 (Medical Surgical Register).

Dr. MACCHIARINI was not disqualified, suspended or prohibited from practising medicine and the regulatory authority is not aware of any matters that call into question his good standing.

LUCCA, 30/10/2012



PRESIDENT  
Dott. Quiriconi Umberto

Issued on unstamped paper for all legal uses. If a revenue stamp is needed, please paste a revenue stamp of appropriate value, otherwise this deed will not be valid.

Issued pursuant to Article 3, Legislative Decree no. 39 dated 12.2.1993, based on data from the electronic database of the Association, as drawn from the documents contained in the personal file of the above-mentioned member.



# ORDINE DEI MEDICI CHIRURGHI E DEGLI ODONTOIATRI DI LUCCA

VIA GUINIGI, 40 - 55100 LUCCA Tel. 0583467276 - Fax 0583490627 - EMail ordmedlucca@virgilio.it

**Protocollo Nr.: 3103**

## SI CERTIFICA

Che il Prof. **MACCHIARINI PAOLO**

Nato a [redacted] il 22/08/1958  
nazione cittadinanza ITALIA codice fiscale [redacted]  
residente a Cabrils in [redacted]  
laureato/a in MEDICINA E CHIRURGIA c/o l'Università di PISA  
il 16/04/1986 con voti 110/110  
Esami di stato a PISA del 1986

**Ha la seguente situazione in relazione al/agli albo/i Professionale/i:**

Prima iscrizione nell'Albo dei Medici Chirurghi di LUCCA il 10/09/1986

E' regolarmente iscritto/a nell'Albo dei Medici Chirurghi di LUCCA dal 10/09/1986 al numero 01759.

Con specializzazione/i in	ottenuta/e il	a	con voto
MEDICINA GENERALE	02/07/1991	PISA	50/50 e lode

Non ha in corso procedimenti disciplinari

LUCCA, martedì 30 ottobre 2012

[redacted]  
IL PRESIDENTE  
Dott. Quiriconi Umberto



Operatore \_\_\_\_\_

Rilasciato in carta libera per gli usi consentiti dalle leggi vigenti. Per gli usi in cui è previsto il bollo, apporre la marca secondo valore vigente, pena la non validità dell'atto.

Rilasciato a norma dell'art. 3 del D. Lgs. n. 39 del 12.2.1993 sulla base degli elementi dell'archivio elettronico dell'Ordine, acquisiti dai documenti desunti dal fascicolo personale dell'iscritto sopra indicato.

Il presente certificato non può essere prodotto agli organi della Pubblica Amministrazione o ai privati gestori di pubblici servizi.



# REGISTER OF MEDICAL DOCTORS IN THE PROVINCE OF LUCCA

VIA GUINIGI, 40 - 55100 LUCCA Tel. 0583467276 - Fax 0583490627

Protocol n. 1259

## Certificate of "Good Standing"

### IS CERTIFIED THAT

**Dr. MACCHIARINI Paolo**

Born in

Nationality

ITALY

codice fiscale

Resident in

Cabrils 08348

Degree in

MEDICINE AND SURGERY at the University of PISA

on

16/04/1986 with 110/110

He passed the qualifying examination for the medicine and surgical practise in 1986 at the University of Pisa (Italy).

**RECEIVED**  
AUG 17 2012  
IDPR-MEDICAL UNIT

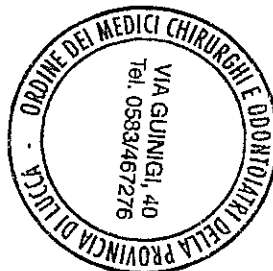
### Situation concerning the Medical and Dental Register:

First inscription in the Medical Surgical Register of the Association of the province of Lucca on the 10/09/1986 at number 1759 (Medical Surgical Register).

Dr. MACCHIARINI was not disqualified, suspended or prohibited from practising medicine and the regulatory authority is not aware of any matters that call into question his good standing.

LUCCA, 03/08/2012

PRESIDENT  
Dott. Quirconi Umberto



Rilasciato in carta libera per gli usi consentiti dalle leggi vigenti. Per gli usi in cui è previsto il bollo, apporre la marca secondo valore vigente, pena la non validità dell'atto.

Rilasciato a norma dell'art. 3 del D. Lgs. n. 39 del 12.2.1993 sulla base degli elementi dell'archivio elettronico dell'Ordine, acquisiti dai documenti desunti dal fascicolo personale dell'iservito sopra indicato.



Protocollo nr. 1259

Certificato di "Good Standing"

**SI CERTIFICA**

Che il Dottore **MACCHIARINI Paolo**

Nato a [redacted] 22/08/1958

nazione cittadinanza ITALIA codice fiscale [redacted]

residente a [redacted] Cabrils 08348

laureato/a in MEDICINA E CHIRURGIA c/o l'Università di PISA  
il 16/04/1986 con voti 110 /110 e Lode

Abilitato all'esercizio della professione: Università di Pisa, anno 1986

Ha la seguente situazione in relazione all'agli albo/i Professionale/i:

Prima iscrizione nell'Albo dei Medici Chirurghi di LUCCA il 10/09/1986 al n. 1759

E' regolarmente iscritto nell'Albo dei Medici Chirurghi di LUCCA dal 10/09/1986 al n. 1759.

**RECEIVED**

AUG 14 2012

**IDPR-MEDICAL UNIT**

Non ha in corso procedimenti disciplinari

LUCCA, venerdì 3 agosto 2012



IL PRESIDENTE  
Dott. Curioni Umberto

**RECEIVED**  
SUBSCRIPTION SERVICES

AUG 13 2012

**IDPR**  
Div. of Professional Regulation

Operatore \_\_\_\_\_

Rilasciato in carta libera per gli usi consentiti dalle leggi vigenti. Per gli usi in cui è previsto il bollo, apporre la marca secondo valore vigente, pena la non validità dell'atto.

Rilasciato a norma dell'art. 3 del D. Lgs. n. 39 del 12.2.1993 sulla base degli elementi dell'archivio elettronico dell'Ordine, acquisiti dai documenti desunti dal fascicolo personale dell'iscritto sopra indicato.

# THE HEART INSTITUTE FOR CHILDREN

Affiliated with Advocate Health Care

GENERAL CARDIOLOGY - PERINATAL CARDIOLOGY - CARDIAC IMAGING - INTERVENTIONAL CATHETERIZATION - CARDIAC ELECTROPHYSIOLOGY  
ADULT CONGENITAL HEART DISEASE- CARDIOVASCULAR SURGERY - MAURICE LEV CONGENITAL HEART AND CONDUCTION SYSTEM CENTER - MOLECULAR CARDIOLOGY

Advocate Hope  
Children's Hospital  
4440 W. 95<sup>th</sup> Street  
Oak Lawn, IL 60453  
(708) 684-5580 Fax : (708) 684-4068

Advocate Lutheran General  
Children's Hospital  
1775 Dempster Street  
Park Ridge, IL 60018  
(847) 723-6465 Fax : (847) 723-2251

University of Illinois at Chicago  
1740 West Taylor Street  
Chicago, IL 60612  
(312) 996-6605 Fax: (312) 413-3373

June 5, 2012

Illinois Dept. of Financial and Professional Regulation  
Division of Professional Regulation  
320 W Washington St./MED UNIT  
Springfield, IL 62786

RE: Macchiarini Paolo, M.D.

To Whom It May Concern:

Enclosed please find application for Visiting Physician Permit (106) for the following doctors:

Each packet includes the following:

1. \$100.00 Application Fee
2. CT form
3. Copy of CV
4. MD-VPH Form.

Kindly fax deficiency notice and/or a copy of Visiting Physician Permit to me at (708) 658-5812.  
If you have any questions please contact me at phone number (708) 684-2635 or by email  
[Diana.Vafina@advocatehealth.com](mailto:Diana.Vafina@advocatehealth.com).  
Thank you!

Sincerely,

*Diana Vafina*

Diana Vafina  
The Heart Institute for Children  
Advocate Hope Children's Hospital  
4440 West 95th Street  
Oak Lawn, IL 60453  
Phone: (708) 684-2635  
Fax: (708) 658-5812