# APPLICATION TO PRACTICE MEDICINE

368

MINNESOTA BOARD OF MEDICAL PRACTICE
2700 UNIVERSITY AVENUE WEST, SUITE 106
ST. PAUL, MINNESOTA 55114-1080
(612) 642-0538

RECEIVED
DEC 26 1994
MN BOARD OF

DATE OF APPLICATION:

| DAY | MONTH | YEAR |
|---|---|---|
| 2 | 3 | 94 |

FOR BOARD USE ONLY

APPLICATION #: 59984
CHECK /RECEIPT #: 051816-3
AMT PAID:
TEMP PERMIT #:
BOARD ACTION:
BOARD DATE: 7-8-15
LICENSE #: 38015

| SOURCE CODE | AMOUNT |
|---|---|
| 100 | 160.00 |
| 200 | 200.00 |
| | |
| | |
| | |

## INSTRUCTIONS TO APPLICANT

1. Answer all questions completely and accurately or the application will be returned.
2. The name you enter must exactly match the name on your medical diploma, or documentation of formal name change must be submitted.
3. All addresses must include zip code, if requested on the application.
4. Account for all time from the beginning of high school, whether spent in school, practice, or otherwise. Dates must include Day, Month, and Year. Attach a separate sheet if necessary.
5. Enter all dates as DAY-MONTH-YEAR. For example, January 1, 1989 should be entered as 01-JAN-89.
6. The application fee is not refundable.
7. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

TO: The Minnesota Board of Medical Practice:

I hereby make application for a license to practice medicine and surgery in the State of Minnesota and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

### YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME: LAST: LEVINE FIRST: MARSHALL MIDDLE: DAVID

STREET ADDRESS: 1311 Ridgecrest Dr. SE.

CITY: Albuquerque STATE OR PROVINCE: NM. ZIP CODE: 87108 COUNTRY: USA

HOME PHONE: 505-260-1704 OTHER PHONE: NA GENDER: ☒ MALE ☐ FEMALE MAIDEN NAME: NA

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER:

### BASIS FOR APPLICATION (CHECK ONE)

- ☐ FLEX EXAMINATION ☐ COMP 1 ☐ COMP 2 ☐ COMP 1&2
- ☐ FLEX, OTHER STATE (FLEXOS)
- ☒ NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINATION (NBME)
- ☐ NATIONAL BOARD OF OSTEOPATHIC EXAMINERS EXAMINATION (NBOE)
- ☐ LICENTIATE OF MEDICAL COUNCIL OF CANADA EXAMINATION (LMCC)
- ☐ STATE BOARD EXAMINATION (STATE)
- ☐ UNITED STATES MEDICAL LICENSING EXAM (USMLE)
- ☐ COMBINATION FLEX, NBME, USMLE

### NATURALIZATION (FOREIGN ONLY)

NAME:

PLACE OF NATURALIZATION:

DATE OF NATURALIZATION:

NUMBER:

NOTE: CITIZENSHIP PAPERS MUST BE SUBMITTED AT TIME OF INTERVIEW.

* NOTE: If FLEX is Marked, Also Check Component 1, Component 2, Or Components 1&2



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**ADDRESS OF NEAREST RELATIVE**

| NAME OF RELATIVE: | | |
|---|---|---|
| Laurie Levine | | |
| STREET ADDRESS: 1311 Ridgecrest Dr. SE. | | |
| CITY: Albuquerque | STATE OR PROVINCE: NM. | |
| ZIP CODE: 87108 | COUNTRY: USA | RELATIONSHIP: Wife |

**YOUR INTENDED ADDRESS**

| STREET ADDRESS: | | |
|---|---|---|
| 1311 Ridgecrest Dr. SE | | |
| CITY: Albuquerque | STATE OR PROVINCE: NM | |
| ZIP CODE: 87108 | COUNTRY: USA | EFFECTIVE DATE: Now |
| PHONE: 505-260-1704 | | |

**RECORD OF BIRTH**

| DATE OF BIRTH: | CITY OF BIRTH: | COUNTY OF BIRTH: | STATE/PROVINCE OF BIRTH: |
|---|---|---|---|
| | [illegible] Ridge | NA | Massachusetts |
| FULL NAME OF FATHER: Carlisle N. Levine | | MOTHER'S MAIDEN NAME: Ruth Lumian | COUNTRY OF BIRTH: USA |

**IDENTIFYING CHARACTERISTICS**

| HEIGHT (ft./in.): | WEIGHT (lbs): | COLOR HAIR: | COLOR EYES: |
|---|---|---|---|
| 5-11 | 17A | Brown | Brown |
| IDENTIFYING MARKS: None | | | |

**PRELIMINARY EDUCATION**

| NAME OF HIGH SCHOOL: | CITY: | STATE OR PROVINCE: | | FROM DATE: | TO DATE: |
|---|---|---|---|---|---|
| Newton | Newton | Mass | | 1957 | 1959 |
| NAME OF COLLEGE: | CITY: | STATE OR PROVINCE: | DEGREE | FROM DATE: (DD-MMM-YY) | TO DATE: (DD-MMM-YY) |
| Harvard | Cambridge | Mass | BA | 01Sep59 | 20Jun63 |
| NAME OF COLLEGE: | CITY: | STATE OR PROVINCE: | DEGREE: | FROM DATE: (DD-MMM-YY) | TO DATE: (DD-MMM-YY) |
| | | | | | |

**MEDICAL EDUCATION (MEDICAL COLLEGES MUST BE RECOGNIZED BY THE BOARD)**

| INSTITUTION | CITY | STATE | ZIP CODE | FROM DATE (DD-MMM-YY) | TO DATE (DD-MMM-YY) |
|---|---|---|---|---|---|
| Tufts | Boston | Mass | 0211 | 01Sep63 | 01Jun67 |
| | | | | | |
| | | | | | |
| | | | | | |

**ACCOUNTING OF TIME NOT NOTED ELSEWHERE ON THIS APPLICATION**

| ACTIVITY (ATTACH SEPARATE SHEET, IF NECESSARY) | FROM DATE (DD-MMM-YY) | TO DATE (DD-MMM-YY) |
|---|---|---|
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## MEDICAL DIPLOMAS

| | NAME OF SCHOOL: | CITY: | STATE OR PROVINCE | ZIP: | COUNTRY: | DATE DD-MMM-YY |
|---|---|---|---|---|---|---|
| BACHELOR OF: ☑ MEDICINE ☐ OSTEOPATHY | | | | | | |
| DOCTOR OF: ☑ MEDICINE ☐ OSTEOPATHY | TUFTS | BOSTON | MASS | | USA | 060663 |

## ACCREDITED GRADUATE CLINICAL MEDICAL TRAINING

| NAME OF HOSPITAL: | | | FROM DATE (DD-MMM-YY) | TO DATE (DD-MMM-YY) |
|---|---|---|---|---|
| DUKE U. HOSPITAL | | | 01 JUL 67 | 30 JUN 68 |
| STREET ADDRESS: Trent Drive, Duke South | CITY: DURHAM | STATE OR PROVINCE: NC. | COUNTRY: USA | ZIP CODE: 27710 |
| TYPE OF TRAINING: (BE SPECIFIC) PEDIATRIC INTERNSHIP | | | | |
| NAME OF HOSPITAL: BETH ISRAEL HOSPITAL | | | 01 JUL 68 | 30 JUN 71 |
| STREET ADDRESS: BROOKLINE AVENUE | CITY: BOSTON | STATE OR PROVINCE: MASS | COUNTRY: USA | ZIP CODE: |
| TYPE OF TRAINING: (BE SPECIFIC) OB-GYN RESIDENCY | | | | |
| NAME OF HOSPITAL: HARBOR GENERAL HOSPITAL | | | 01 JUL 73 | 30 JUN 75 |
| STREET ADDRESS: | CITY: TORRANCE | STATE OR PROVINCE: CALIFORNIA | COUNTRY: USA | ZIP CODE: |
| TYPE OF TRAINING: (BE SPECIFIC) MEDICAL GENETICS FELLOWSHIP | | | | |

## POST GRADUATE NON-CLINICAL MEDICAL EDUCATION/TRAINING

| FACILITY NAME: | | | FROM DATE (DD-MMM-YY) | TO DATE (DD-MMM-YY) |
|---|---|---|---|---|
| STREET ADDRESS: | CITY: | STATE OR PROVINCE: | COUNTRY: | ZIP CODE: |
| FACILITY NAME: | | | FROM DATE (DD-MMM-YY) | TO DATE (DD-MMM-YY) |
| STREET ADDRESS: | CITY: | STATE OR PROVINCE: | COUNTRY: | ZIP CODE: |

## MILITARY SERVICE

| BRANCH OF SERVICE: | DATE OF ENTRY: | DATE OF RELEASE: | RANK AT DISCHARGE: | TYPE OF DISCHARGE: |
|---|---|---|---|---|
| USNR | 1971 | 1975 | LCDR | HONORABLE |
| DUTY ASSIGNMENT: OB-GYN | | | LOCATION: Quonset Pt., RI / New London, Conn. | |

## STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE BEEN LICENSED

| STATE/PROVINCE/COUNTRY | LICENSE NUMBER | DATE ISSUED | HOW OBTAINED (*) |
|---|---|---|---|
| CA | G-20901 | 1970 | NBME |
| NM | 75-197 | 1975 | NBME |
| MICHIGAN | 4301062685 | 1993 | NBME |
| MASSACHUSETTS | 32027 | 1968 | NBME |
| RI. | 4355 | 1971 | NBME |
| NY | 148894 | 8/1982 | NBME |

(*) NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) STATE BOARD EXAM (STATE) NATIONAL BOARD OF OSTEOPATHIC EXAMINERS (NBOE) LICENTIATE OF MEDICAL COUNCIL OF CANADA (LMCC) FLEX EXAMINATION (FLEX) UNITED STATES MEDICAL LICENSING EXAM (USMLE) COMBINATION FLEX, NBME, USMLE

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## PRACTICE REFERENCES

STATE BELOW WHERE YOU HAVE PRACTICED OUTSIDE OF A TRAINING PROGRAM, AND PROVIDE TWO REFERENCES FROM EACH FACILITY

| NAME OF FACILITY: | FROM DATE: (DD-MMM-YY) | TO DATE: (DD-MMM-YY) | | | |
|---|---|---|---|---|---|
| Dept OB-GYN Univ School of Medicine | 01 Jul 85 | Present | | | |
| **NAME OF REFERENCE:** | **STREET ADDRESS:** | | **CITY:** | **STATE/CNTRY** | **ZIP CODE:** |
| Gloria Sarto, M.D. | 2211 Lomas Blvd. NE | | Albuquerque | NM. | 87131 |
| Randolph Seligman, MD. | 2211 Lomas Blvd., NE | | Albuquerque | NM. | 87131 |
| **NAME OF FACILITY:** | **FROM DATE:** | **TO DATE:** | | | |
| Presbyterian Hospital | 01 Jun 80 | Present | | | |
| James R. Hutchison, MD | 1101 Medical Arts Ave NE | | Albuquerque | NM. | 87106 |
| Samuel Smith, M.D. | 8200 Constitution Pl. NE | | Albuquerque | NM. | 87110 |
| **NAME OF FACILITY:** | **FROM DATE:** | **TO DATE:** | | | |
| St. Joseph Hospital | 01 Jun 80 | Present | | | |
| Michael Flax, MD. | 8200 Constitution Pl NE | | Albuquerque | NM. | 87110 |
| Elizabeth Hyme, MD. | 1101 Medical Arts Ave NE | | Albuquerque | NM | 87106 |
| **NAME OF FACILITY:** | **FROM DATE:** | **TO DATE:** | Kalamazoo, MI Locum Tenens | | |
| Bronson Methodist Hospital | 06 93 | 20 DEC 93 | | | |
| | | | | | |
| | | | | | |
| **NAME OF FACILITY:** | **FROM DATE:** | **TO DATE:** | Alamogordo, NM Locum Tenens | | |
| Gerald Champion Hospital | 10/1/93 | 10/8/93 | | | |
| | | | | | |
| | | | | | |

~~Central Suffolk Hospital - Riverhead, NY Locum tenens 2/94~~

## PROPOSED PRACTICE PLANS IN MINNESOTA (IF ANY)

Locum Tenens

## MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

| NAME OF ORGANIZATION | FROM DATE | TO DATE |
|---|---|---|
| ACOG | 1973 | Present |
| ACMG | 1993 | Present |

Are You Currently Certified By An ABMS Specialty Board? ☑ YES ☐ NO
Specialty: ABOG ABMG

List date(s) on which you were (re)certified: ABOG 9/93

Have you taken the SPEX exam within the last 10 years? ☐ YES ☑ NO
If so when?



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**IN ANSWERING THE FOLLOWING QUESTIONS, PLEASE CHECK THE APPROPRIATE BOX NEXT TO EACH QUESTION. IF NECESSARY, ATTACH ADDITIONAL SHEETS TO PROVIDE SUFFICIENT DETAIL. YOU MUST ANSWER ALL QUESTIONS WITH 'YES' OR 'NO'.**

| YES | NO | | |
|---|---|---|---|
| ☑ | ☐ | 1. | Are you presently in good physical and mental health? If not, give particulars. |
| ☐ | ☑ | 2. | Have you ever been voluntarily or involuntarily committed to a public or private mental health facility, detoxification center, or chemical dependency treatment facility, or been disabled by accident or physical or mental illness. If so, give particulars and provide medical records. |
| ☐ | ☑ | 3. | Do you now, or have you ever, personally used or administered to yourself any controlled substances, or have you ever been treated for drug or alcohol abuse? If so, give particulars as well as the attending physician's statement. |
| ☐ | ☑ | 4. | Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars. |
| ☐ | ☑ | 5. | Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars. |
| ☐ | ☑ | 6. | Have you ever been denied a license by, or the privilege of taking an examination before any State Medical Examining Board, or has a conditioned license ever been issued to you by any state medical board. If so, give particulars. |
| ☐ | ☑ | 7. | Has your license to practice medicine in any state or country ever been voluntarily or involuntarily (i.e. by Medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board? If so, give particulars. |
| ☐ | ☑ | 8. | Have you ever been notified of any investigations by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you ever been reprimanded or censured by any medical society or licensing board? If so, give particulars. |
| | | | Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents). |
| ☐ | ☑ | 10. | Have your hospital privileges ever been restricted or revoked? If so, give particulars. |
| ☐ | ☑ | 11. | Have there ever been any criminal charges filed against you? If so, give particulars. |
| ☐ | ☑ | 12. | Have you ever applied for licensure in Minnesota before? If so, give particulars; eg. license #, issue date. |

#59981

## CERTIFICATE OF ETHICAL AND MORAL CHARACTER

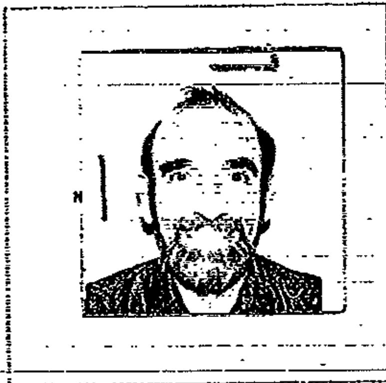
THIS CERTIFICATE MUST BE SIGNED BY TWO LICENSED PHYSICIANS WHO ARE PERSONALLY ACQUAINTED WITH THE APPLICANT.

I certify that the photograph attached is a recent one and likeness of Dr. Levine

and that s/he is a person of good ethical and moral character.

| [signature] | 1/31/94 | 92-317 | NM |
|---|---|---|---|
| SIGNATURE | DATE | LICENSE NUMBER | STATE OF ISSUE |

BOBBY G. NEVILS
PRINT OR TYPE FULL NAME



I certify that the photograph attached is a recent one and likeness of Dr. Levine

and that s/he is a person of good ethical and moral character.

| [signature] | 1/31/94 | 39409 | VA |
|---|---|---|---|
| SIGNATURE | DATE | LICENSE NUMBER | STATE OF ISSUE |

RALPH L KRAMER
PRINT OR TYPE FULL NAME



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**AFFIDAVIT OF APPLICANT:**

**STATE OF:** N.M.

**COUNTY OF:** Bernalillo

I, Marshall D. Levine, swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota: that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this 31st day of January, 1994

Kristine L. Krayer
Signature Of Notary Public

My Commission Expires: 12/20/95

Marshall D. Levine
Signature Of Applicant

**RIGHTS OF SUBJECTS OF DATA**

Under Minnesota Statutes §13.41, subdivision 2 (1984), information you provide in this application, except for your name and address is classified as private, that is, accessible only to you, the staff and members of the Board, the Board's counsel, and persons you designate, while you remain an applicant. When you become licensed, the information in your file related to your license is classified as public under Minnesota Statutes §13.41, subdivision 4 (1984).

The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. You are not legally required to provide this information, but you cannot be licensed without doing so.