THE NEW MEXICO MEDICAL SOCIETY

New Mexico Hospital Association

The New Mexico Statewide Application for Physician/Practitioner Appointment©

Physician (MD) Application

Brenda Pereda MD

Other Names Used: _____

☐ Will you be applying by endorsement? Applying using: FCVS

Are you requesting to be credentialed as a PCP if Family Practice, Internal Medicine, or Pediatrics? ☑ Yes

Gender: F Citizenship: USA Place of Birth: Mexico

Immigration Status: Certification #:

Social Security Number: [redacted] Date of Birth: [redacted]/1974

State Tax ID#: ☐ Pending Fed. Tax ID#: ☐ Pending

Medicare #: ☐ Pending Medicaid #: ☐ Pending

Unique Physician Identification Number (UPIN): ☐ Pending

National Provider Identifier Number (NPI): 1255519435 ☐ Applied

What are your immediate or future Practice Plans in New Mexico?

Family Planning Fellowship- 2 year program at the University of New Mexico, School of Medicine, Department of Obstetrics and Gynecology.

Current Mailing Address

[redacted]

Home address

[redacted]

Pager:

Foreign Languages (spoken fluently by practititioner)

Spanish

Portuguese

Other Practice Locations

Practice Name: Universoty of New Mexico Health Science Center

Dept of OB/GYN, 1 University of New Mexico

MSC 10 5580

Albuquerque NM 87131-0001

United States

Telephone Number: 505-272-4155 Facsimile: 505-272-3918

TEverling@salud.unm.edu

Answering Service: Effective Date: 07/01/2011

Office Manager or Contact Person: Theresa Everling

Manager's Phone Number: 505-272-4155

Practice Limited to: (Clinical Specialty):

Billing Address:

Dept of OB/GYN, 1 University of New Mexico

MSC 10 5580 NM 87131-0001

United States

Telephone Number: 505-272-4155 Facsimile: 505-272-3918

Contact Person:

Practice Associates:

_____ Call Coverage: _____

_____ Call Coverage: _____

_____ Call Coverage: _____

What are the office hours for your Practice or Group Practice? (Provide days/hours):

What provisions have been made for after hours?:

EDUCATION

Graduate Education

College or University: MI State Univ College of Human Medicine (note)

Department: Attn: Gina Brooks Degree: Doctor of Medicine

Address: A-254 Life Science

City: East Lansing State/Province: MI Zip Code: 48824

Telephone Number: 517 353-7140 Facsimile: 517 432-1051 Country: United States

Contact Person: Shelly Nyquist Title:

Email Address: Specialty:

Dates Attended From: 08/02 To: 05/07 Graduation Date: 2007

Post-Graduate Education

College or University: Wayne State University/Detroit Med Ctr - GME*Chrg

Department: GME/Attn: Rachel Degree: Internship/Residency

Address: 4201 St Antoine Room 9C

City: Detroit State/Province: MI Zip Code: 48201

Telephone Number: 313 745-3430 Facsimile: 313 745-4052 Country: United States

Contact Person: Nina Title:

Email Address: Specialty:

Dates Attended From: 07/07 To: Present Graduation Date: 2011

WORK HISTORY

Please list all previous practice experience for the previous 15 years, including military or government service, listing the most recent first. If military service, state type of discharge and rank achieved and attach copy of discharge or separation documents. Please provide written explanation for any gaps in work history of 6 months or more.

Location: Sinai-Grace Hospital/Wayne State University From: 07/01/2010 To:

Department: Department of Obstetrics and Gynecology

Street: 6071 W Outer Dr Phone Number: 313-966-3246

City: Detriot State/Province: MI Zip Code: 48235

Contact Person: Jane A. Stephens Country: United States

Explanation of gap: Title: Obstetrics Traige Lead Coordinator

HOSPITAL AND HEALTHCARE AFFILIATIONS

☑ Are you a PCP? ☑ Do you deliver babies? ☑ Are you an MD, DO, or DPM?

If you answered yes to any question above, you must:

(a) Have admitting privileges at a hospital (list the affiliation in this section) OR
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients along with a signed letter from that physician confirming the arrangements, and the name of the facility which your patients will be admitted.

Please list all hospital staff membership and/or healthcare organization affiliations in the past (5) years, and the status (active, courtesy, consulting, etc.). If an institution is no longer in existence, please provide an alternative source of verification. Use a separate page if necessary.

Facility Name

Name: Hutzel Hospital

Department:

Street: 4707 Saint Antoine St

City: Detriot State: MI Zip Code: 48201-1498

Province: Country: United States

Phone Number: Facsimile:

Appointment Dates From: 07/07 To: Present

Type of Appointment: Resident Physician

☑ Check here if you have restrictions at this facility, and provide a written explanation below:

I am a PGY-4 completing residency on 6/11

Privileges Assigned:

Check all that apply:

☐ If you have courtesy or consulting privileges at this facility.

☐ If these courtesy or consulting privileges allow you to admit patients.

If your courtesy or consulting privileges do not allow you to admit patients, please provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted. The signed letter should be forwarded to HSC along with your signature pages and other accompanying documents.

PROFESSIONAL REFERENCES

Please list three (3) professional peers familiar with your professional performance in the past five (5) years, (not including current or impending partners or associates in practice).

Name: Renee Page MD Specialty: Obstetrics and Gynecology

Address1: 3990 John R Rd.

Address2: Hutzel Women's Hospital, 7 Brush North

City: Detroit State/Province: MI Zip Code: 48201

Email: rpage@med.wayne.edu Country: United States

Phone Number: 313-993-4032 Facsimile: 313-993-4089

Name: Jay Berman MD Specialty: Obstetrics and Gynecology

Address1: Box1 Jhon R Rd. Wayne State University

Address2: Hutzel Women's Hospital, 7 Brush North

City: Detroit State/Province: MI Zip Code: 48021

Email: jberman@med.wayne.edu Country: United States

Phone Number: 313-993-4047 Facsimile: 313-993-7089

Name: Theodore Jones MD Specialty: Obstetrics and Gynecology

Address1: 3990 Jhon R Rd

Address2: Hutzel Women's Hospital 7 Brush North

City: Detroit State/Province: MI Zip Code: 48201

Email: thjones@med.wayne.edu Country: United States

Phone Number: 313-993-1388 Facsimile: 313-993-4100

Military Service

Branch: ☐ Current

Dates: From: To:

Rank: Type of Discharge:

Immigration

Status: Certification Number:

CLIA

Number (if applicable): Approval Level: Expiration Date:

Certifications

ACLS Certified? No Expires:

ATLS Certified? No Expires:

PALS Certified? No Expires:

ECFMG (Educational Commission for Foreign Medical Graduates)

Number (if applicable): Date Issued:

STATE PROFESSIONAL LICENSE/CERTIFICATION NUMBERS

State: MI Number: 4301090675 Issue Date: 09/23/2009 Expiration Date: 01/31/2013 ☐ Pending

FEDERAL DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION

Number: Expiration: ☐ Pending

STATE CONTROLLED SUBSTANCE REGISTRATION (CSR)

Number: [redacted] State: MI Expiration: 01/31/2013 ☐ Pending

BOARD/SUBSPECIALTY BOARD CERTIFICATIONS

Are you Board Certified? ☐ **Yes** ☐ **No** ☐ **N/A**

Certified/Recertified by the Board/Subspecialty Board of: Obstetrics

Date Certified: 06/27/2011 Date Last Recertified: Expiration Date:

Certification Number:

☑ Accepted for Examination?

☐ If not accepted, have you made application?

If no, provide an explanation:

If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

Certified/Recertified by the Board/Subspecialty Board of: Gynecology

Date Certified: 06/11/2011 Date Last Recertified: Expiration Date:

Certification Number:

☑ Accepted for Examination?

☐ If not accepted, have you made application?

If no, provide an explanation:

If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation. Explain any gaps or delays in achieving Board certification by the recognized Board in your specialty area.

PROFESSIONAL MEDICAL MALPRACTICE INSURANCE

☐ Do you have current medical malpractice insurance?

(Please list medical malpractice insurance carriers for the past 5 years.)

Current Carrier

Name: Detroit Medical Center

Department: Risk Management

Street: 4201 St Antoine 2B UHC

City: Detroit State: MI Zip Code: 48201

Province: Country: United States

Policy #: in training status Limits Per-claim: $ 0 Aggregate: $ 0

Dates Insured From: 07/01/2007 To: 06/17/2011

LICENSING EXAM: Please check all that apply:

☐ State Board Exam Which State? _____ Date(s) passed? _____

☐ **FLEX**

Date Passed: /

☐ **LMCC**

Date Passed: _____

☐ **National Board (NMBE)**

Part/Step 1 Date Passed _____

Part/Step 2 Date Passed _____

Part/Step 3 Date Passed _____

☑ **USMLE**

Part/Step 1 Date Passed 07/05

Part/Step 2 Date Passed 02/07

Part/Step 3 Date Passed 07/08

PROFESSIONAL PRACTICE QUESTIONS

Please answer the following Yes or No questions. If you answer Yes to any question, you must give details including name, address, and telephone number of significant parties. You must respond to each question.

1.	Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	No
2.	Have you ever been denied professional liability insurance coverage? If yes, explain below.	No
3.	Has your professional liability carrier ever excluded any specific procedures from your coverage? If yes, explain below.	No
4.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization? If yes, explain below.	No
5.	Have you ever had any sanctions imposed by Medicare and/or Medicaid?	No
6.	Have you ever been arrested? If so, explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	No
7.	Have you ever been named as a defendant in any criminal proceedings?	No
8.	Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	No
9.	Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings)? If yes, explain below.	No
10.	Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	No

	b.) Have you ever agreed not to exercise your clinical privileges while under investigation?	No
11.	Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	No
12.	a.) Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	No
	b.) Are any currently held licenses pending investigation or being challenged?	No
13.	Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature? If yes, explain below.	No
14.	Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	No
15.	Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery that led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	No
16.	Have you ever been reported to the National Practitioner Data Bank?	No
17.	Are you now, or were you in the past, addicted to, abusive of, or in treatments for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	■
18.	In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which either has affected or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.	■
19.	Have you ever, for any reason:	
	a) Resigned from a medical school or postgraduate training (PGT) program?	No
	b) Withdrawn from a medical school or postgraduate training program?	No
	c) Been suspended, dismissed, or expelled from a medical school or PGT program?	No
	d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?	No
	e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any reason, personal or professional (include illness, pregnancy, academic, etc)?	Yes

Explanations:

As a PGY-2, I was on bed rest for pregnancy complications, with an interruption in my training of 12 weeks including post partum recovery.

Brenda Pereda, MD

Licensed Physician #MD2011-0600

Issue Date	Expiration Date
07/29/2011	07/01/2012

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency.

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Brenda Pereda, MD

License Number: MD2011-0600

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 07/29/2011 Date Expires: 07/01/2012*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

New Mexico Medical Board
2055 S. Pacheco Street
Building 400
Santa Fe, NM 87505
505-476-7220 505-476-7233 fax

Authorization to Release Information

I, BRENDA Pereda have contracted with
Name of Applicant
Federal Credentialing Verification Service to assist with the New
Name of Service
Mexico Medical Board's licensure process. The following employees of
University of New Mexico Health Science Center shall be designated
Name of Service
to obtain information regarding the licensure status of my application:

Theresa M. Everling (505) 272-4155
University of New Mexico
Health Science Center, School of Medicine
MSC 10 5580, Albuquerque NM 87131-0001

I certify that I have thoroughly read and understand the application instructions and Guidelines for Applicants and Representatives.

BRENDA Pereda
Printed Name

Signature

1/23/11
Date

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 7/6/2011

State Queried For: New Mexico Medical Board

Physician Name: Brenda Pereda

Date of Birth:

Year of Graduation:

Social Security Number:

ABMSU ID:

The data provided to FCVS by the ABMS does not include Specialty Certification information on file for this physician. This does not mean that the physician is not certified by one or more of the Member Boards of the American Board of Medical Specialties, as the data provided by ABMS does not include some physicians for which they have incomplete data.

All information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

Section II

Identity

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

X _____

Applicant's Signature (must be signed in the presence of a notary)

PEREDA

Applicant's Printed Last Name

BRENDA .

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

1/24/11 [redacted] 1974

Date of [redacted] Birth

Applic[redacted]

NOTARY

Your seal or stamp must be partly upon the photograph.

K. ANN McGOWAN
NOTARY PUBLIC – MICHIGAN
MACOMB COUNTY
MY COMMISSION EXPIRES SEPT. 30, 2012

State of MI County of OAKLAND

SUBSCRIBED AND SWORN TO before me this 24TH day of JANUARY, 20 11

ACTING IN OAKLAND COUNTY

My commission expires: 9-30-2012

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: K Ann McGowan

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

1/29/11

Section III

Medical Education

Federation of STATE MEDICAL BOARDS

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS to the address at the bottom of page 2.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: Michigan State University

Complete Address: A234 Life Sciences Building

Street Address: _____

City: East Lansing **State:** MI **ZIP Code (Postal Code):** 48824

If name of institution was different when this individual attended, please note this name below:

_____

Premedical Education:

Years of education required for admission to your medical school: 4-year degree

Credential/degree presented by the applicant for admission to your medical school: 4-year degree

Enrollment and Participation: Our records indicate that Bereda, Brenda
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 146 weeks of medical education on the following dates (mm/dd/yy):

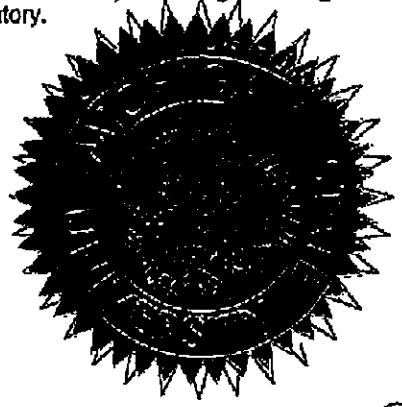
From 8 / 26 / 2002 (Month / Date / Year) **To** 8 / 16 / 2007 (Month / Date / Year)

This individual:

Was awarded the degree of Doctor of Medicine on 8 / 16 / 2007 (Month / Date / Year)

was NOT awarded a degree because: _____
(please explain – attach additional pages if necessary)

Certification: By my signature, I Gina L. Brooks, certify that the above
(type/print name)
information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge. The signature line must contain the original signature, or the electronic typed signature, of the authorized signatory.



Signature: Gina L. Brooks

Title: College Records Officer

Date of Signature: 5 / 23 / 2007

Phone: (517)3583140 **Fax:** (517) 432-1051

Email: brooksgi@msu.edu

PID 129194 RID 23222178 Analyst CAC MSM Code 023010

SEAL VERIFIED

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☒ NO ☐

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family	8/2002	5/2005	☒	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☒

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
   Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Please complete both pages of this form, sign, date and seal on the front page then return to:
Federation Credentials Verification Service/ 400 Fuller Wiser Road, Suite 300/ Euless, TX 76039
or e-mail to: fcvsforms@fsmb.org

Medical Education

School	023010 - Michigan State University College of Human Medicine		
Address	A-110 East Fee Hall East Lansing, MI 48824 USA		
Phone			
Dates	08/2002 - 05/2007	**Grad Date**	05/15/2007
Degree	DM - Doctor of Medicine		
Program 5+ years:	N		
Completed clinical clerkship in a country other than where my medical school was located:	N		
Clinical Training			
Unusual Circumstances			
Leaves/Extensions	Y	I extended prior to starting the program secondary to a preexisting family illness.	
Probation	N		
Disciplined	N		
Negative Reports	N		
Limitations	N		

MICHIGAN STATE UNIVERSITY

OFFICIAL ACADEMIC TRANSCRIPT

PRINTED: 06/03/11

PEREDA, BRENDA

STUDENT ID: A34119427

HUMAN MEDICINE CREDIT

COURSE INFORMATION

COURSE	TITLE	CRS	GRADE	S/R	H
FALL SEMESTER 2002 08/26/02 - 12/13/02					
ANTR 551	MEDICAL GROSS ANATOMY				6
HM 531	CLINICAL SKILLS I				2
HM 537	REPRODUCTIVE HEALTH				1
HM 571	INTEGRATIVE CLIN CORREL I				2
HM 581	MENTOR PROGRAM				1
PSL 534	CELL BIOLOGY AND PHYSIOLOGY I				3
CUM CREDITS : 115.0	CUM GPA : N/A				
SPRING SEMESTER 2003 01/06/03 - 05/02/03					
EPI 546	IM/EPI BIOSTAT				1
HM 532	CLINICAL SKILLS II				2
HM 572	INTEGRATIVE CLIN CORREL II				1
HM 581	MENTOR PROGRAM				1
HM 591	SPEC PROB IN HUMAN MEDICINE				1
NDP 552	MEDICAL NEUROSCIENCE				4
PSL 535	CELL BIOLOGY AND PHYSIOLOGY II				4
CUM CREDITS : 29.0	CUM GPA : N/A				
SUMMER SEMESTER 2003 05/12/03 - 06/27/03					
HM 533	CLINICAL SKILLS III				1
HM 581	MENTOR PROGRAM				1
RADIT 553	INTRODUCTION TO RADIOLOGY				
SUMMER SEMESTER 2003 05/12/03 - 08/14/03					
HM 543	HUMAN DEV & BEHAVIOR SOCIETY				5
HM 591	SPEC PROB IN HUMAN MEDICINE				2
HM 591	SPEC PROB IN HUMAN MEDICINE				2
CUM CREDITS : 41.0	CUM GPA : N/A				
FALL SEMESTER 2003 08/25/03 - 12/12/03					
BMB 514	MEDICAL BIOCHEMISTRY				3
BMB 526	GENETICS				2
EPI 547	IM/EPIBIOSTAT II				1
HM 534	CLINICAL SKILLS IV				2
HM 546	SOC CONTEXT CLIN DECIS				1
IM 618	CLINICAL TROPICAL MEDICINE				2
PRT 320	ADVANCED PORTUGUESE				3
CUM CREDITS : 52.0	CUM GPA : N/A				
SPRING SEMESTER 2004 01/12/04 - 05/07/04					
FMP 580	SPEC TOPICS IN FAMILY PRACTICE				1
HM 547	SOC CON CLIN DECISIONS II				2
HM 548	MEDICAL HUMANITIES SEMINAR				2
HM 591	SPEC PROB IN HUMAN MEDICINE				
MMG 522	MEDICAL MICROBIO & IMMUNOLOGY				5
PTH 542	BASIC PRINCIPLES OF PATHOLOGY				2
CUM CREDITS : 65.0	CUM GPA : N/A				
SUMMER SEMESTER 2004 05/17/04 - 07/02/04					
PHM 563	MEDICAL PHARMACOLOGY				3
SUMMER SEMESTER 2004 05/17/04 - 08/19/04					
HM 573	INTEGRATIVE CLIN CORREL III				1
HM 591	SPEC PROB IN HUMAN MEDICINE				6
HM 591	SPEC PROB IN HUMAN MEDICINE				1
HM 591	SPEC PROB IN HUMAN MEDICINE				1
CUM CREDITS : 77.0	CUM GPA : N/A				

END OF COLUMN

COURSE	TITLE	CRS	GRADE	S/R	H
FALL SEMESTER 2004 08/30/04 - 12/17/04					
HM 511	INFECTIOUS DISEASE & IMMUNOLGY				3
HM 512	DISORDERS BEHAVIOR & DEVELOP				3
HM 525	PULMONARY DOMAIN				4
HM 526	URINARY TRACT DOMAIN				3
HM 539	HEMATOPOIETIC/NEOPLASIA				3
CUM CREDITS : 89.0	CUM GPA : N/A				
SPRING SEMESTER 2005 01/10/05 - 05/06/05					
HM 513	NEUROLOG & MUSCULOSKEL DOMAIN				4
HM 514	MAJOR MENTAL DISORDERS				2
HM 515	CARDIOVASCULAR DOMAIN				4
HM 527	DIGESTIVE DOMAIN				3
HM 528	MET & ENDO & REPROD DOMAIN				3
HM 535	CLINICAL SKILLS V				2
CUM CREDITS : 107.0	CUM GPA : N/A				
SUMMER SEMESTER 2005 05/16/05 - 07/03/05					
HM 591	SPEC PROB IN HUMAN MEDICINE				1
SUMMER SEMESTER 2005 07/11/05 - 09/02/05					
FMP 608	FAMILY PRACTICE CLERKSHIP				12
HM 635	CORE COMPETENCIES I				2
CUM CREDITS : 122.0	CUM GPA : N/A				
FALL SEMESTER 2005 08/29/05 - 12/16/05					
HM 525	PULMONARY DOMAIN			R	4
HM 636	CORE COMPETENCIES II				2
MED 608	INTERNAL MEDICINE CLERKSHIP				12
CUM CREDITS : 140.0	CUM GPA : N/A				
SPRING SEMESTER 2006 01/09/06 - 05/05/06					
HM 637	CORE COMPETENCIES III				2
OGR 608	OBSTETRICS & GYNECOLOGY CLKSHP				12
SUR 608	JUNIOR SURGERY CLERKSHIP				12
CUM CREDITS : 166.0	CUM GPA : N/A				
SUMMER SEMESTER 2006 05/15/06 - 08/18/06					
PHD 600	PEDIATRIC SPECIALTY CLERKSHIP				12
PSC 608	PSYCHIATRY & BEHAV SCI CLKSHP				12
CUM CREDITS : 190.0	CUM GPA : N/A				
FALL SEMESTER 2006 08/28/06 - 12/15/06					
MED 623	ADVANCED MEDICINE				6
MED 628	ADVANCED INTERNAL MEDICINE				6
OGR 609	ADV OBSTET & GYNECOLOGY CLKSHP				6
CUM CREDITS : 208.0	CUM GPA : N/A				
SPRING SEMESTER 2007 01/08/07 - 05/04/07					
MED 618	INFECTIOUS DISEASES CLERKSHIP				6
MED 628	ADVANCED INTERNAL MEDICINE				6
OGR 610	PERINATOLOGY CLERKSHIP				6
SUR 620	SENIOR SURGERY CLERKSHIP				6
CUM CREDITS : 232.0	CUM GPA : N/A				

CONTINUED ON PAGE 02

PROVIDED SOLELY FOR: (1)
FEDERAL CREDENTIALS VERIFICATION SE
400 FULLER WISER ROAD, SUITE 3000
EULESS TX 76039

Nicole G Rovig
University Registrar

SEAL VERIFIED

29194 CAC 023010

THE FACE OF THIS TRANSCRIPT IS PRINTED WITH BLACK INK ON PAPER WITH GREEN BACKGROUND

MICHIGAN STATE UNIVERSITY
OFFICIAL ACADEMIC TRANSCRIPT

PEREDA, BRENDA

STUDENT ID: A34119427

COURSE	TITLE	CRS	GRADE	S R	H
HUMAN MEDICINE CREDIT					
DOCTOR OF MEDICINE			GRANTED: 08/16/07		
MAJOR:	HUMAN MEDICINE				
COLLEGE:	HUMAN MEDICINE				
NO ENTRIES BELOW THIS LINE					

SEAL
VERIFIED

PROVIDED SOLELY FOR: (1)
FEDERAL CREDENTIALS VERIFICATION SE
400 FULLER WISER ROAD, SUITE 3000
EULESS TX 76039

Nicole G Rovig
University Registrar

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MICHIGAN STATE UNIVERSITY
KEY TO TRANSCRIPT

Office of the Registrar
East Lansing, MI 48824-0210
Telephone (517) 355-3300

The Family Educational Rights and Privacy Act of 1974 prohibits the release of this record or disclosure of its contents to any third party without the written consent of the student.

AUTHENTICATION OF THE TRANSCRIPT

There are two formats for transcripts. One is for students' records that are in the automated system; the other is for students' records not in the automated system. Both formats are printed with black ink on paper with green background which repeats MICHIGAN STATE UNIVERSITY over the entire page.

A transcript is official when it bears the signature of the Registrar and the University seal in black ink.

COURSE NUMBERING SYSTEM

001-099	Non-Credit and Institute of Agricultural Technology Courses
100-299	Undergraduate and Institute of Agricultural Technology Courses
300-499	Advanced Undergraduate Courses
500-599	Graduate Courses prior to 1960
500-699	Graduate-Professional Courses
800-899	Graduate Courses
900-999	Advanced Graduate Courses

CREDITS

Effective Fall 1992 courses at Michigan State University are given on a semester basis. One credit normally requires three hours of effort a week in class, laboratory, and preparation. To convert to quarter credits, the semester credits should be multiplied by three halves (3/2).

Prior to Fall 1992 courses at Michigan State University were given on a quarter basis.

COURSES REPEATED

A course repeated is indicated differently depending on the transcript format. A transcript created from the automated system has a course repeated indicated by an S (Superseded) in the column headed SR. The course that repeated a superseded course is indicated by an R (Repeat) in the SR column.

In the non-automated system, the course that repeated the previous course is indicated by an R to the left of the course number.

For both formats, term credit and grade-point average (GPA) totals are not adjusted for repeats in the term of the superseded course. The summary totals for the level of the student are adjusted to include only the last entry.

HONORS

An "H" in the Honors column indicates an honors course, honors section of a course, or the student took a non-honors course as honors. The latter indicates additional work was completed beyond normal requirements.

GRADE-POINT AVERAGES

Grade points for each course are determined by multiplying the numerical grade by the number of credits for the course. Credits and grade points for courses in which P,I,N,DF,W,ET,CP,CR,NC,U or V have been received do not affect the grade-point average.

A grade-point average of 2.00 is required for graduation from the University for a bachelor's degree; 3.00 for graduate degrees.

The M.S.U. cumulative grade-point average appears on the automated transcript after each term.

To compute the M.S.U. cumulative grade-point average on the non-automated transcript, divide the total points earned at M.S.U. for all terms by the total credits carried at M.S.U. for all terms. Credit and point totals appearing on non-automated transcripts at the end of each term indicate:

Fall 1956 to present—total credits earned, total credits carried at M.S.U., total credits earned at M.S.U, and total points earned at M.S.U. to date.

Fall 1950 through Summer 1956—total credits carried, credits earned, and points earned to date.

Prior to Fall 1950—total credits and points earned to date.

CURRENT GRADING SYSTEM

THE NUMERICAL SYSTEM:

4.0, 3.5, 3.0, 2.5, 2.0, 1.5, 1.0, 0.0 - Credit is awarded for the following minimum levels—1.0 for undergraduate students and 2.0 for graduate students.

THE CREDIT-NO CREDIT SYSTEM:

CR-CREDIT-Undergraduates must perform at or above the 2.0 level. Graduates must perform at or above the 3.0 level.

NC-NO CREDIT - Performance was below 2.0 level for undergraduates and below 3.0 level for graduates.

THE PASS-NO GRADE SYSTEM:

P-PASS - Credit was granted and the student achieved a level of performance judged to be satisfactory by the instructor.

N-NO GRADE - No credit was granted and the student did not achieve a level of performance judged satisfactory by the instructor.

OTHER SYMBOLS USED:

W-WITHDREW	DF-DEFERRED
V-VISITOR	ET-EXTENSION
U-UNFINISHED	NGR-NO GRADE REPORTED
I-INCOMPLETE	CP-CONDITIONAL PASS

A transcript may temporarily reflect "LDR" as a grade for a course which was dropped late and to which a final grade has not yet been assigned.

PAST GRADING SYSTEMS

Prior to Fall 1988: N-NO GRADE indicated the student officially dropped the course after the middle of the term and was doing passing work, or there was no basis for a grade, or the student did not pass a course approved for grading on a P-N basis.

Fall 1968 to Winter 1972: The grades of 4.5 and 0.5 were included in the numerical system of grading. The 4.5 was awarded only for exceptionally high performance.

Prior to Fall 1969: X-Condition - Until removed and a grade reported, the course was considered to be a deficiency and was included in grade-point averages as a grade of 0.0 under the numerical system. The X-Condition had no affect on the grade-point average if enrollment was on the CR-NC system.

Prior to Fall 1968: A-excellent, B-good, C-fair, D-poor, F-failure, P-pass-given only in credit courses which were approved for grading on pass-fail basis.

PAST GRADE-POINT SYSTEMS

Fall 1968 to Winter 1972: Grades of 4.5 were included in computing grade-point averages only up to a point where the term or cumulative grade-point averages reached 4.00. Thus, the term grade-point average and the cumulative grade-point average was limited to 4.00.

Fall 1950 to Fall 1968: Four points for each credit graded A; 3 for B; 2 for C; 1 for D; 0 for F and X. No points were given for grades P,I,N,V, and DF.

Prior to Fall 1950: Three points for each credit graded A; 2 for B; 1 for C; 0 for D; and -1 for F and X.

I hereby certify that this is a true copy of the diploma for the Physician named below. Gina L. Brooks

Gina L. Brooks, M.A., College Records Officer

Michigan State University

College of Human Medicine

Upon the Nomination of the Faculty and the Dean has conferred upon

Brenda Pereda

the Degree of

Doctor of Medicine

Given under the Seal of the University at East Lansing in the State of Michigan on this sixteenth day of August in the year Two Thousand and Seven.

SEAL VERIFIED

Section IV

Graduate Medical Education Training

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O.Box 619850, Dallas, TX 75261-9850

Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: Detroit Medical Center / Hutzel Womens Hospital
Attention: **Program Director**

Address: OBSTETRICS/GYNECOLOGY
Detroit, MI 48201

Verification For: Name: Pereda, Brenda
DOB: [redacted]1974

Individual's Name on Record (if different from above):,

Packet ID:129194 Request ID:23222178 IFM CODE:10925

PGY: 1-4
Program: Internship/Residency
Specialty/Subspecialty: Obstetrics and Gynecology
From: 7/1/2007 **To:** 6/30/2011
Complete?: Y
Accreditation: ACGME

Unusual Circumstances:

1. Did this individual ever take a leave of absence or break from his/her training? **Y**

   Dr. Pereda was off on maternity leave in 2008.

2. Was this individual ever placed on probation? **N**

3. Was this individual ever disciplined or placed under investigation? **N**

4. Were any negative reports for behavioral reasons ever filed by instructors? **N**

5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reasons? **N**

[redacted]

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: Theodore Jones, MD
Title: Program Director
Email: epuschec@med.wayne.edu

Signature: *Theodore Jones, MD*
Date of Signature: 3/20/2011

Graduate Medical Education

Hospital	Hutzel Women's Hospital
Affiliated School	Wayne State University
	3990 John R Rd
	7 Brush North
	Detroit, MI 48201

PROVIDED BY APPLICANT

Year(s)	4	**Program Type**	Residency
Complete?	In progress	**Specialty/Subspecialty**	Obstetrics and Gynecology
Dates	07/2007 - 06/2011		

Unusual Circumstances

Leaves/Extensions	Y	As a PGY-2, I had maternity leave.
Probation	N	
Disciplined	N	
Negative Reports	N	
Limits	N	

Section V

Examination History/Score Transcripts

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

USMLE
United States Medical Licensing Examination

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date: 04/20/2011

Recipient:
Federation Credentials Verification Service
ATTN: FCVS
Euless, TX 76039

Packet ID: 129194

Examinee: Pereda, Brenda
Also Name(s):

Examinee ID#: 5-133-205-4
Date of Birth: [redacted]/1974

Results for 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. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
06/29/2005	Pass	183	182	75	75	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
01/25/2007	Pass	207	182	84	75	

Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
01/30/2007	Pass					

USMLE STEP 3

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
MICHIGAN 07/05/2008	Pass	202	187	83	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

CAC

TouchSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

Pereda, Brenda MD2011-0600

QUESTION ID	QUESTION TEXT	ANSWER	CREATE DATE	UPDATE DATE
1.	Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	N	5/29/2012	
2.	Since your last renewal have you been denied professional liability insurance coverage?	N	5/29/2012	
3.	Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	5/29/2012	
4.	Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	5/29/2012	
5.	Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	5/29/2012	
6.	Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	5/29/2012	
7.	Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	5/29/2012	
8.	Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective c	N	5/29/2012	
9.	Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either forma	N	5/29/2012	
10. a.	Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical rec	N	5/29/2012	
10. b.	Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	5/29/2012	
11.	Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	5/29/2012	
12. a.	Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	5/29/2012	
12. b.	Are any currently held licenses pending investigation or being challenged?	N	5/29/2012	
13.	Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	5/29/2012	
14.	Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there cu	N	5/29/2012	
15.	Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the follow	N	5/29/2012	
16.	Since your last renewal have you been reported to the National Practitioner Data Bank?	N	5/29/2012	
17.	Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	[redacted]	5/29/2012	
18.	In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected	[redacted]	5/29/2012	
19.	I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	5/29/2012	
20.	Are you ABMS (American Board of Medical Specialties) Board Certified?	Y	5/29/2012	
21.	If yes do you hold Lifetime Certification?	N	5/29/2012	
22 .	If yes do you hold Time Limited Certification?	Y	5/29/2012	

Pereda, Brenda **Medical Doctor** **MD2011-0600**

1. Since your last renewal has your professional liability coverage been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians ?	N	05/20/2015
2. Since your last renewal have you been denied professional liability insurance coverage?	N	05/20/2015
3. Since your last renewal has your professional liability carrier excluded any specific procedures from your coverage?	N	05/20/2015
4. Since your last renewal have you been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	N	05/20/2015
5. Since your last renewal have you been excluded from or sanctioned by Medicare and/or Medicaid?	N	05/20/2015
6. Since your last renewal, have you been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	N	05/20/2015
7. Since your last renewal, have you been named as a defendant in any criminal proceedings?	N	05/20/2015
8. Since your last renewal, have you been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	N	05/20/2015
9. Since your last renewal have you been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	N	05/20/2015
10. a. Since your last renewal have your privileges at any healthcare entity been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	N	05/20/2015
10. b. Since your last renewal have you agreed not to exercise your clinical privileges while under investigation?	N	05/20/2015
11. Since your last renewal have you resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	N	05/20/2015
12. a. Since your last renewal has your application for licensure or license to practice in any jurisdiction been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	N	05/20/2015
12. b. Are any currently held licenses pending investigation or being challenged?	N	05/20/2015
13. Since your last renewal have you been notified to appear before any licensing agency for a hearing or complaint of any nature?	N	05/20/2015
14. Since your last renewal has your federal or state narcotics registration certificate in any jurisdiction been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	N	05/20/2015
15. Since your last renewal have you been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? If yes, please provide the following information for each claim or suit. Please type on a separate sheet	N	05/20/2015
16. Since your last renewal have you been reported to the National Practitioner Data Bank?	N	05/20/2015
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	[redacted]	05/20/2015
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on -going ability to practice medicine safely and	[redacted]	05/20/2015
19. I certify that I have completed a minimum of 75 AMA Category I hours of Continuing Medical Education as required by 16.10.4 NMAC?	Y	05/20/2015
19a. I certify that 5 hours of the required 75 hours of CME are in Pain Management, as required by 16.10.14. 11 NMAC OR I certify that I do NOT hold a NM Controlled Substance Registration.	Y	05/20/2015
20. I attest that I will limit my practice to areas in which I am competent to practice.	Y	05/20/2015