03000005901

PAGE ONE

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

APPLICATION FOR LICENSURE AND/OR EXAMINATION

0 0 0 1 0 4 6 0 0 0 2

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.

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

A. Type or print legibly with black ink only.

B. The licensure and application fee are NOT refundable.

C. Disclosure of Social Security number and gender information is not mandatory. It is used only to ensure identification, accuracy and to expedite processing of your application.

D. 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.

PART I: Application Category Information

022040 67

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
PHYSICIAN	0 3 6	ENDORSEMENT	$ 300.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [x] This is the first time I have made application for this profession in Illinois.
- [ ] I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- [ ] Other: _____
- [ ] My application for this profession has 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.

RECEIVED STATE OF ILLINOIS NOV 10 1997 DEPARTMENT OF PROFESSIONAL REGULATION

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

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g. M.D. D.D.S. etc.)	3. SOCIAL SECURITY NUMBER
LEVINE	MARSHALL	DAVID	M.D.	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

[redacted]

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

1311 RIDGECREST DR. SE, ALBUQUERQUE, NM 87108

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED (SEE D ABOVE)

NA

7. PLACE OF BIRTH CITY STATE/COUNTRY	8. DATE OF BIRTH	9. AGE
[redacted]		

10. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work (505) 256-0826 (Area Code) Home: ([redacted]

IL486-1019 10/95 (LT)

XACT # 1136

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
Newton High School	Newton, Massachusetts	06/59 (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 FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
Harvard	Cambridge, Massachusetts	9/59	6/63	BA
Tufts	Boston, Massachusetts	9/63	6/67	MD.

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
Duke (Internship)	Durham, NC	7/67	6/68	☑ Yes ☐ No
Beth Israel (Residency: OB-GYN)	Boston, Mass	7/68	6/71	☑ Yes ☐ No
UCLA - Harbor General (Genetics)	Torrance, Ca	7/73	6/75	☑ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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IL STATE TREASURER
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FNB CENTRAL IL
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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: MASS	M.D.	32027	1968	LAPSED
State of Current Licensure where you most recently have been practicing: NM	M.D.	75-197	1975	Active
Other States of Licensure				
California	M.D.	G-20901	1970	LAPSED
Rhode Island	M.D.	4355	1971	LAPSED
N.Y.	M.D.	194894	1994	Active
Michigan	M.D.	A301002685	1993	Active
Wisconsin	M.D.	39498	1995	Active

(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)
NATIONAL BOARDS		7/68	PASSED

(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.*		✓
2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		✓
3. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		✓
4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		✓

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.

TEST CODES

b) CHART III - Select the examination site you desire and enter Test Center Code.

TEST CENTER CODE

c) CHART IV - Find your School of Graduation and enter school code.

SCHOOL CODE

d) Record the number of times you have taken this exam in Illinois or any other state.

EXAM ATTEMPTS

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

PART VIII: Certifying Statement

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

[redacted]

Signature of Applicant

9/30 /97

Date

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

PART IV 0 0 0 1 0 4 6 0 0 0 2

MINNESOTA M.D. 38015 1995 Active

IMPORTANT NOTICE. Completion of this form is necessary for consideration for licensure under 225 Illinois Compiled Statutes and 5 Illinois Compiled Statutes 100/10-65(c). Disclosure of this information is MANDATORY. Failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

ADDENDUM TO THE APPLICATION FOR LICENSURE AND/OR EXAMINATION

0 0 0 1 0 4 6 0 0 0 2

Public Act 90-0018 became effective July 1, 1997, and requires the following information be provided by all licensure/registration applicants. Before your application can be given further consideration, you must complete this form and return it to: Department of Professional Regulation
320 W. Washington St., 3rd Floor
Springfield, IL 62786

PART I: Application Category Information (Record information as shown on your application.)

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD
PHYSICIAN	0 3 6	LICENSURE BY ENDORSEMENT

PART II: Application Category Information

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH Month Day Year	3. SOCIAL SECURITY NUMBER
LEVINE, MARSHALL DAVID	[redacted]	[redacted]
4. ADDRESS STREET CITY STATE ZIP CODE [redacted]	6. MAIDEN OR GIVEN SURNAME NA	

PART III: Child Support Information

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.**

You **MUST** check one of the following:

- ☐ I am not more than 30 days delinquent in complying with a child support order.
- ☐ I am more than 30 days delinquent in complying with a child support order.
- ☑ I am not currently under any child support order.

PART IV: Certifying Statement

Under penalties of perjury, I declare that I have examined this document and certify that the above information is true and correct.

[redacted] — Signature of Applicant

11/25/97 — Date

IL486-1019 Addendum 08/97 (LT)

DEC 05 1997

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statues (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

WORK HISTORY

0 0 0 1 0 4 6 0 0 0 2

SUPPORTING DOCUMENT

WH

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

1. NAME LAST FIRST MIDDLE: LEVINE, MARSHALL DAVID

2. DATE OF BIRTH: [redacted]

3. SOCIAL SECURITY NUMBER: [redacted]

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

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application: PHYSICIAN (Profession Name) 0 3 6 (Profession Code)

6. MAIDEN OR GIVEN SURNAME: NA

7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED: ☐

8. DATE FORM COMPLETED: 9/30/97

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

A. NAME OF BUSINESS / INSTITUTION: UNM School of Medicine

JOB TITLE: Associate Professor

ADDRESS STREET CITY STATE ZIP CODE: 2211 Lomas Blvd NE. Albuquerque, N.M. 87131

SUPERVISOR NAME: Gloria Santo, MD.

DATE OF EMPLOYMENT/ATTENDANCE: From 01/03/94 (Month Day Year) To PRESENT (Month Day Year)

HOURS WORKED PER WEEK: >40

TYPE OF EMPLOYMENT: ☐ Full-time ☑ Part-time

TOTAL TIME WORKED (Year/Month):

DESCRIPTION OF DUTIES PERFORMED: Teaching OB Stanics and Gynecology and patient care

B. NAME OF BUSINESS / INSTITUTION: Como Health

JOB TITLE: Locum Tenens Physician

ADDRESS STREET CITY STATE ZIP CODE: 4021 South 700 East Salt Lake City, Utah 84107

SUPERVISOR NAME: —

DATE OF EMPLOYMENT/ATTENDANCE: From 10/01/93 (Month Day Year) To PRESENT (Month Day Year)

HOURS WORKED PER WEEK: Varied

TYPE OF EMPLOYMENT: ☐ Full-time ☑ Part-time

TOTAL TIME WORKED (Year/Month):

DESCRIPTION OF DUTIES PERFORMED: Substitute for OB-Gyn physician

IL486-1071-6/93 (LT-Front)

COMPLETE THE REVERSE SIDE OF THIS FORM

C. NAME OF BUSINESS / INSTITUTION	JOB TITLE
Rio Grande OB-GYN, PA.	Physician / President
ADDRESS STREET, CITY, STATE, ZIP CODE Presbyterian Professional Bldg. Albuquerque, N.M. 87106	DESCRIPTION OF DUTIES PERFORMED OB GYN Generalist Medical Genetics Consultant Corporate President
SUPERVISOR NAME None	
DATE OF EMPLOYMENT/ATTENDANCE From 07,01,80 (Month, Day, Year) To 09,30,93 (Month, Day, Year)	HOURS WORKED PER WEEK >60 TYPE OF EMPLOYMENT ☑ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month) 13 years, 2 months	

D. NAME OF BUSINESS / INSTITUTION	JOB TITLE
UNM School of Medicine	Assistant Professor
ADDRESS STREET, CITY, STATE, ZIP CODE 2211 Lomas Blvd. NE Albuquerque, N.M. 87131	DESCRIPTION OF DUTIES PERFORMED Teaching Residents and Medical Students about OB-Gyn and Medical Genetics
SUPERVISOR NAME Robert Messer, M.D.	
DATE OF EMPLOYMENT/ATTENDANCE From 07,01,75 (Month, Day, Year) To 06,30,80 (Month, Day, Year)	HOURS WORKED PER WEEK >40 TYPE OF EMPLOYMENT ☑ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month) 5 years	

E. NAME OF BUSINESS / INSTITUTION	JOB TITLE
US Navy	LCDR, USNR
ADDRESS STREET, CITY, STATE, ZIP CODE Quonset Point Naval Hospital Quonset Point, R.I.	DESCRIPTION OF DUTIES PERFORMED General OB-Gyn Clinical Care
SUPERVISOR NAME ?	
DATE OF EMPLOYMENT/ATTENDANCE From 07,01,71 (Month, Day, Year) To 06,30,73 (Month, Day, Year)	HOURS WORKED PER WEEK >40 TYPE OF EMPLOYMENT ☑ Full-time ☐ Part-time
TOTAL TIME WORKED (Year/Month) 2 years	

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CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

0 0 0 1 0 4 6 0 0 0 2

SUPPORTING DOCUMENT

TN-MED

(DP

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

1. NAME — LAST: LEVINE, FIRST: MARSHALL, MIDDLE: DAVID
2. DATE OF BIRTH: [redacted]
3. SOCIAL SECURITY NUMBER: [redacted]
4. ADDRESS STREET, CITY, STATE, ZIP CODE: [redacted]
5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
   Profession Name: PHYSICIAN
   Profession Co: 0 3 6
6. MAIDEN OR GIVEN SURNAME: NA
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable): NA
8. ISSUANCE DATE: NA

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 6278

This is to certify that the above-named applicant satisfactorily completed 36 months of postgraduate clinical training in OBSTETRICS AND GYNECOLOGY
(Name of Accredited Postgraduate Clinical Training Program)

from 7/68 to 6/71 at the following hospital:

Hospital: Beth Israel
Number and Street: 330 Brookline Ave
City, State and Zip Code: Boston, Mass 02215

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

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

Name of Postgraduate Clinical Training Program Director: Henry Klapholz

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 10/30/97

SEAL

Telephone No: [redacted]

DEC 09 1997

IL 486-1835 4/08 (MD)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

0 0 0 1 0 4 6 0 0 0 2

SUPPORTING DOCUMENT

TN-MED

(DF

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

1 NAME LAST FIRST MIDDLE: LEVINE, MARSHALL DAVID

2 DATE OF BIRTH: [redacted]

3 SOCIAL SECURITY NUMBER: [redacted]

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

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

PHYSICIAN — Profession Name

0 3 (— Profession Co

6 MAIDEN OR GIVEN SURNAME: NA

7 ILLINOIS TEMPORARY LICENSE NUMBER (If applicable): NA

8 ISSUANCE DATE: NA

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. Return the completed form directly to:
Illinois Department of Professional Regulation, 320 West Washington - MED-1, Springfield, Illinois 6278

This is to certify that the above-named applicant satisfactorily completed 36 months of postgraduate clinical training in OBSTETRICS AND GYNECOLOGY
(Name of Accredited Postgraduate Clinical Training Program)

from 7/68 to 6/71 at the following hospital:

Hospital: Beth Israel

Number and Street: 330 Brookline Ave

City, State and Zip Code: Boston, Mass 02215

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

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

Name of Postgraduate Clinical Training Program Director: Henry Klagholz

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 10/30/87

SEAL

JAN 05

Telephone No: [redacted]

IL 486-1634 4/98 (MD)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes (Chapter 111 of the Illinois Revised Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

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

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

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

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

This is to certify that the above-named applicant satisfactorily completed 36 months of postgraduate clinical training in OBSTETRICS AND GYNECOLOGY
(Name of Accredited Postgraduate Clinical Training Program)

from 7/68 to 6/71 at the following hospital:

Hospital: Beth Israel

Number and Street: 330 Brookline Ave

City, State and Zip Code: Boston, Mass 02215

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

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

Name of Postgraduate Clinical Training Program Director: Henry Klapholz

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: [redacted]

SEAL

Telephone No.: [redacted]

IL486-1535 4/96 (MD)

Returned copy rec'd w/ seal, needs original signature

TUFTS UNIVERSITY
SCHOOL OF MEDICINE
BOSTON, MASSACHUSETTS

0 0 0 1 0 4 6 0 0 0 2

Record of LEVINE, MARSHALL DAVID — Degree A.B. (cum Laude)

Matriculated Sept. 16, 1963 from Harvard University

FIRST YEAR, registered 9/16/63		
Gross Anatomy	[redacted]	
~~Microscopic Anatomy~~ Histology		
Biochemistry		
Physiology		
Psychiatry		
2nd 3rd Average (weighted)		

THIRD YEAR, registered 9/10/65		
Medicine	[redacted]	
Obstetrics & Gynecology		
Pediatrics		
Surgery*		
Dermatology		
Ophthalmology*		
Psychiatry		
3rd 3rd Average (weighted)		

SECOND YEAR, registered 9/15/64		
Bacteriology Microbiology	[redacted]	
Medicine: Lab. Diag.		
Medicine: Phys. Diag.		
Medicine: Prev. and Occ.		
Pathology (incl. 12)		
Pharmacology		
Psychiatry		
~~Parasitology~~		
2nd 3rd Average (weighted)		

FOURTH YEAR, registered 6/9/66		
Medicine	[redacted]	
Surgery		
Obstetrics & Gynecology		
Pediatrics		
Psychiatry		
Preventive Medicine		
1st 3rd Average (weighted)		

No copy of record is valid without signature and seal

Passing grade: [redacted] 4 year average: [redacted]

Faculty action

Carol E. Vivado
Carol E. Vivado
Registrar
OCT 24 1997

Date of Diploma June 3, 1967 M. D. Degree awarded June 4, 1967

THE NATIONAL BOARD EXAMINATIONS

PART I date		
Anatomy	[redacted]	
Physiology		
Biochemistry		
Pathology		
Bacteriology		
Pharmacology		
Average		

PART II date		
Medicine	[redacted]	
Surgery		
Obstetrics and Gynecology		
Public Health & Prev. Med.		
Pediatrics		
Psychiatry		
Total Grade ~~Average~~		

Internship Hospital Duke Hospital, Durham, N.C. - P Dates 7/1/67 - 7/1/68

Quincy House
HARVARD COLLEGE
CAMBRIDGE 38, MASSACHUSETTS

RECORD OF Levine, Marshall David CLASS 1963

RECEIVED A. B. DEGREE cum Laude ON June 13 19 63

ADMITTED IN 5-59 FROM Newton High School
Newtonville, Massachusetts

FINAL CREDIT FOR WORK DONE ELSEWHERE — COURSES WITH C OR HIGHER IN

MAY NOT COUNT:

STUDENTS ARE NOT GIVEN AN EXACT RANK IN CLASS

SEE EXPLANATION OF RANK LIST ON REVERSE SIDE OF TRANSCRIPT

STATUS

X GOOD STANDING
___ ALLOWED TO WITHDRAW
___ PROBATION
___ CONNECTION SEVERED
___ PROBATION CLOSED
___ REQUIRED TO WITHDRAW
___ A/C RECORD
___ A/C DISCIPLINE
___ FOR SECOND AND FINAL TIME

EXPLANATION OF GRADING SYSTEM ON REVERSE SIDE OF TRANSCRIPT.

DATE OF ISSUE OCT 31 1997

[redacted]

THE TRANSCRIPT IS NOT VALID UNLESS SIGNED AND SEALED.
FOR DESCRIPTION OF COURSES PLEASE SEE THE CATALOGUE.

ISSUED TO STUDENT

CONCENTRATION History

GENERAL EXAMS Passed in History May, 1963

DIVISIONAL RECOMM. Not recommended for Honors

REC. BY FACULTY FOR A.B. DEGREE with THE CLASS OF 19 63 cum Laude (General Studies)

SENIOR YEAR SEMESTER | COURSES 2 | CONCENTRATION 2

LANGUAGE REQUIREMENT CEEB French [redacted]

1959-60	GRADES Courses	GRADES Half Courses
GENERAL EDUCATION AHF	[redacted]	[redacted]
Chemistry 2[1]		
Mathematics 20b[1]		
French 20		
Humanities 8		
Chemistry 40a[2]		
Government 180[2]		
1960 Summer School		
Chemistry S-20 (full course)		

1960-61	GRADES Courses	GRADES Half Courses
Government 188[1]	[redacted]	[redacted]
Physics 1a[1]		
Natural Sciences 5		
Social Sciences 1		
Mineralogy 112[2]		
Physics 1b[2]		

1961-62	GRADES Courses	GRADES Half Courses
History 132a[1]	[redacted]	[redacted]
History 98		
History 119		
Social Sciences 111		
History 132b[2]		

1962-63	GRADES Courses	GRADES Half Courses
Biology 140[1]	[redacted]	[redacted]
Chemistry 20		
History 99		
Social Relations 120		
History 146b[1]		

PHYSICAL TRAINING [redacted]
RANK LIST GROUP [redacted]
TOTAL COURSES PASSED
TOTAL SATIS. GRADES
REPORT SENT JUL 16 1960

RANK LIST GROUP [redacted]
TOTAL COURSES PASSED
TOTAL SATIS. GRADES
REPORT SENT

RANK LIST GROUP [redacted]
TOTAL COURSES PASSED
TOTAL SATIS. GRADES
REPORT SENT

TOTAL COURSES PASSED [redacted]
TOTAL SATIS. GRADES
TOTAL COURSES REQUIRED
TOTAL SATIS. GRADES REQUIRED

Senatus Universitatis Tuftensis Academicus

in Republica Massachusettensi

Omnibus ad quos hae litterae pervenerint salutem

Praeses Universitatis Tuftensis

perfunctis Scholae probantibus eius quae medicinae scientiam colit,

Charlotte Otero
Notary Republic
My Commission expires
August 19, 1996

Marshall David Levine

ad gradum **Medicinae Doctoris** admisit eique

0001046002

fruenda dedit et concessit omnia iura, honores, insignia, privilegia ad hunc gradum pertinentia. In cuius rei testimonium, litteris hisce Sigillo Academico munitis a. d. III Non. Jun. anno Salutis MCMLXVII

nos Praeses Universitatis et Decanus Scholae atque Secretarius Curatorum, auctoritate nobis commissa nomina subscripsimus.

[redacted]

[redacted]

NATIONAL BOARD OF MEDICAL EXAMINERS®

Record of Scores and Endorsement of Certification

This document was prepared by
National Board of Medical Examiners (NBME)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

0 0 0 1 0 4 6 0 0 0 2

Recipient: Illinois Dept Prof Reg
320 W Washington Street
3rd Floor
Springfield, IL 62786

Date: 10/30/1997

Examinee: Marshall David Levine

Examinee ID: [redacted]
Date of Birth:

NBME Certification Date: 07/01/1968

Certificate#:

This record shows only NBME passing scores for each NBME examination reported on this document unless a complete NBME examination history has been requested by the examinee. If applicable, also results for USMLE Steps taken by this examinee (and for which scores have been reported to date) are shown.

This examinee has successfully completed the examination, education and training requirements for NBME certification.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores Anat	Phys	Bioc	Path	Micr	Phar
06/1965	Pass	Three-Digit								
		Two-Digit	[redacted]							

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores Med	Surg	ObGyn	PM/PH	Peds	Psych
04/1967	Pass	Three-Digit								
		Two-Digit	[redacted]							

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/1968	Pass	Three-Digit		
		Two-Digit	[redacted]	

* * * END OF DOCUMENT * * *

See reverse side for explanation of information reported above.

NOV 3 1997

IL 0294

NM BOARD OF MEDICAL EXAMINERS
LAMY BUILDING - 2ND FLOOR
491 OLD SANTA FE TRAIL
SANTA FE, NM 87501
(505) 827-6784

0 0 0 1 0 4 6 0 0 0 2

CERTIFICATE OF VERIFICATION
(Letter of Good Standing)

The New Mexico Board of Medical Examiners does hereby certify that it's records indicate the following information regarding the physician named below:

This is to certify that:

MARSHALL D LEVINE, M.D.
[redacted]

LICENSE NUMBER: **75-197**

DATE OF BIRTH: [redacted]

ISSUE DATE: **November 17, 1975**

EXPIRATION DATE: **June 30, 2000**

LICENSED BY: **NATIONAL BOARD**

STATUS: **Active**

Our records indicate no derogatory information (Good Standing)

COMMENTS: _____

Details of Disciplinary Action, if any, are enclosed.

[redacted] Date: October 24, 1997
Dee A. Perea
Verification Officer

SEAL

NOV 04 1997

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111
(617)727-3086
Fax: (617)451-9568
An Agency within the Office of Consumer Affairs and Business Regulation

0 0 0 0 2

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR
PENELOPE WELLS
GENERAL COUNSEL

NISHAN J. KECHEJIAN, M.D.
CHAIRMAN
BRUCE A. SINGAL
VICE-CHAIRMAN
RAFIK ATTIA, M.D.
BOARD MEMBER
ARNOLD S. RELMAN, M.D.
BOARD MEMBER
CARL M. SAPERS
BOARD MEMBER
MARY ANNA SULLIVAN, M.D.
BOARD MEMBER
PETER N. MADRAS, M.D.
BOARD MEMBER

VERIFICATION OF LICENSURE

Date: 10-27-97

To Whom It May Concern:

This is to certify that Marshall Revine a graduate of Tufts University in the year 1/9/67 has been duly registered by this Board as provided by the laws of the Commonwealth.

Certificate Number 32027 was issued to Dr. Revine

on 1/15/70

THIS IS TO ADVISE THAT THE ABOVE NAMED PHYSICIAN DID NOT APPLY FOR RELICENSURE. LICENSE REVOKED BY OPERATION OF LAW.

[redacted]

Mary Anna Sullivan, M.D., Secretary

Board Seal

Enforcement Information

The laws of Massachusetts, including the regulations of the Board of Registration in Medicine, mandate the collection of certain information by the Board, and further establish conditions of confidentiality for such information. The law distinguishes between "complaints" against physicians, which may be filed by patients or other members of the public, and "statutory reports," which are reports of incidents or conduct mandated by law to be reported to the Board. While complaint files on a physician (including, with the physicians waiver, open complaint information) are available to requesters, statutory reports are not available for release. Accordingly, the information included in this notice does not include statutory report information unless that information has been used by this agency in a formal disciplinary action or has let to the resignation of the physician.

NOV 04 1997

e Federation of State Medical Boards
of the United States, Inc.
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Telephone: (817) 868-4000
FAX (817) 868-4099

0 0 0 1 0 4 6 0 0 0 2

BOARD ACTION CLEARANCE REPORT

November 18, 1997

Attn: Pat Eubanks
Illinois Dept. of Reg. & Ed.
320 W. Washington Street
Springfield, IL 62786

Re: Board Action Query Dated: November 18, 1997
Your Reference Number:
FSMB Batch Number: [redacted]

The following is a final report of the search results from the Board Action Data Bank as of November 18, 1997 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of November 18, 1997

Item	Name	DOB	SSN	School	Yr/Grad	Request ID
[redacted]						
3	levine, marshall david	[redacted]				

Profession: 036

Date: 11-19-97 Initials: [illegible]

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:

MARSHALL DAVID LEVINE MD 0 0 0 1 0 4 3 0 0 0 2

[redacted]

Return this form with the requested materials to:

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

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

Other Instructions:

The enclosed application addendum must be completed. — ① DONE 12/2/97
② TN-MED form RESENT to Dept 00-64N, Beth Israel Hospital, Boston, Mass. /MOP

DEC 05 1997

Profession: 036 (physician)

Date: 12/15/97 Initials: KB

DEFICIENCY NOTICE FOR TEMPORARY/PERMANENT PHYSICIAN LICENSURE APPLICATION

TO:
Hebry Klapholz, MD
Beth Israel Hospital
Harvard Medical School
330 Brookline Ave
Boston, MA 02215

0 0 0 1 0 4 0 3 2

Return this form with the requested materials to:

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

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

Other Instructions: Enclosed is the copy of the certification of Dr. Levine's postgraduate clinical training that you recently forwarded. We previously received the original sans seal. Now we received a copy with a seal, but no original signature. Please sign your name and affix the date on the enclosed and return it. Thank you for your assistance.

cc: Marshall Levine, MD

L486-1508 5/94 (LT)

JAN 05

0005000407

IMPORTANT NOTICE: Completion of this form is required by 720 of the Illinois Compiled Statutes (Chap. 56 1/2, of the Ill. Rev. Stat. 1985). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application. This form has been approved by the Forms Management Center.

RECEIVED
HEALTH SERVICES SECTION
AUG 16 1996
DEPARTMENT OF PROFESSIONAL REGULATION

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

A Controlled Substances license will not be issued until your professional license has been issued.

1. Every person who prescribes or dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Professional Regulation in accordance with the Illinois Controlled Substances Act.
2. A separate controlled substances registration is required for each place of professional practice or business where controlled substances are stored or located.
3. A State Controlled Substances Registration is prerequisite to a Federal Controlled Substances Registration.

A. Type or print legibly with black ink only.

B. The fee is $5 - Make check payable to the Department of Profess [redacted] (Separat [redacted] registratic

C. Submit ap [redacted]

Depar
320 V
Sprin

336059114

CHECK BOX INDICATING THE APPROPRIATE INFORMATION RE
(Do not use this form to renew existing Re

☑ First Time Applicant ☐ Additional Location (separate office where drugs are stored)

PART I: Application Category Information

1. PROFESSIONAL NAME	2. PROFESSIONAL CODE	3. LICENSURE METHOD	4. FEE
Controlled Substances	0 0 3	Registration	$5

PART II: Application Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g. M.D., D.D.S., etc.)	3. SOCIAL SECURITY NUMBER
LEVINE	MARSHALL	DAVID	MD.	[redacted]

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

5. NAME OF BUSINESS AND LOCATION (STREET/CITY/ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED
[redacted]

6. MAIDEN OR GIVEN SURNAME OR ANY NAME(S)
NA

7. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Work (312, 932-0773
Home ([redacted]
Area Code

PART III: Professional Activity

1. CHECK AND COMPLETE ONE OF THE FOLLOWING
Practitioner *(Give Professional License No.)*
☑ Physician 036 - 097170
☐ Dentist 019 -
☐ Podiatrist 016 -
☐ Veterinarian 090 -

2. DRUG SCHEDULES (Circle the schedules for which you are applying)
II IIN III IIIN IV V

FOR OFFICIAL USE ONLY

FEE $5

BNDD Number: Type: Suffix:

Schedule Codes: Additional Function: A Card Code: K

Issuance Date (Month/Day/Year)

Employee Initials and Number

IL486-0500 8/96 (CS)

REVERSE SIDE MUST BE COMPLETED

PART IV: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you ever been charged or convicted of any drug related criminal offense in any state or in federal court? *If yes, attach a statement for each conviction including dates and place of conviction, nature of the offense and if applicable, the date of discharge from any penalty imposed.*		✓
2. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		✓
3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing agency elsewhere? *If yes, attach a detailed explanation.*		✓
4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		✓
5. Has any previous registration held by the applicant under the Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? *If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.*		✓

IDPR
FOR DEPOSIT ONLY
IL STATE TREASURER
237021072A
FNB CENTRAL IL
071100272

PART V: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

IDPR
FOR DEPOSIT ONLY
IL STATE TREASURER
JUL 09 98
237021072B
FNB CENTRAL IL
071100272

Marshall D. Levine
Print Name of Applicant

[redacted]
Signature of Applicant

6/28/98
Date of Application

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

IL486-0500 8/96 (CS)

IDPR
FOR DEPOSIT ONLY
IL STATE TREASURER
237021072B
FNB CENTRAL IL
071100272

Application must be completed in its entirety.

If not completed, it will be returned to the address noted on front of application.