12/17/02 a

FORM 1
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
Cultural Education Center
Albany, NY 12230

DEPARTMENT USE ONLY

060093 60

735 ER

APPLICATION FOR LICENSE AND FIRST REGISTRATION

DB cleared 4/22/03 gw

1 SOCIAL SECURITY NUMBER: [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: 04 19 68 (mo. day yr.)

3 PRINT FULL NAME AS YOU WISH IT TO APPEAR ON YOUR LICENSE:

Last: Cleveland
First: Byrd
Middle:

NYS License Number 228166 4/23/03 gw

4 MAILING ADDRESS CHECK ONE: ☑ HOME ADDRESS ☐ WORK ADDRESS

Care of:
Street: 110 Dove St
City: Albany
State: NY Zip Code: 12210 1704
Province/Country If not U.S.:

5 TELEPHONE

HOME
Area Code Number

WORK
Area Code Number

E-Mail Address

The above address is: ☑ permanent address of record ☐ temporary mailing address

IMPORTANT: The applicant is responsible for notifying the Department of any name or address changes.

6 Name as it appears on diploma or other credentials (if different from above): _____

7 Citizenship: ☑ United States ☐ Alien lawfully admitted for permanent residence in the United States. (Attach a copy of the front and back of the alien registration card) ☐ Other Immigration _____

8 Mother's Maiden Name *(family name before her marriage)*: Wickert

9 I wish to become licensed on the basis of: ☑ acceptable examination scores *(see page 3 of this form)* ☐ endorsement of another license *(See Pg. 11.)*

I am using FCVS to collect my credentials: ☐ YES ☑ NO

10 Have you previously applied for a New York State license or a limited permit to practice medicine? ☐ YES ☑ NO

11 Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? ☐ YES ☑ NO *See note*

12 Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal? ☐ YES ☑ NO *See note*

13 Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☐ YES ☑ NO *See note*

14 Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? ☐ YES ☑ NO *See note*

15 Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures ? ☐ YES ☑ NO *See note*

NOTE: If any answer to any question 11-15 is "Yes," submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

26 **STUDENT LOAN DISCLOSURE:**

(a) Do you have any outstanding loans made or guaranteed by the New York State Higher Education Services Corporation? ☑ Yes ☐ No

(b) If you have such a loan(s), is any part in default? ☐ Yes ☑ No

NOTE: Education Law (Section 6501-a) requires the State Education Department to ask the questions above and forward any "yes" responses to question (b) to the New York State Higher Education Services Corporation. **Your license application is not complete without this information.**

27 **GENDER AND ETHNICITY: (This item is optional. See note below.)**

NOTE: Information on gender and ethnicity is sought solely to allow the Education Department to collect and analyze data concerning representation in the licensed professions. The ethnic and gender data you provide will be used only for statistical, research, and program evaluation purposes. It will not be released to the public. This information has absolutely no bearing on your qualification for licensure.

ETHNICITY: ☑ White (not Hispanic) ☐ Black (not Hispanic) ☐ Asian ☐ Hispanic ☐ Native American

GENDER: ☐ Male ☑ Female

28 **CHILD ABUSE IDENTIFICATION AND REPORTING: (check only one of the following.)**

☑ I graduated from a New York State medicine program after September 1, 1990.

☐ I completed the child abuse coursework and have enclosed a certificate of completion from an approved provider.

☐ I am filing for an exemption to the requirement and have enclosed the exemption form.

29 **PHOTOGRAPH REQUIREMENT:** ⟶

I give permission to the New York State Education Department to release my examination results to my professional school for the confidential purposes of program review and institution research and planning. I may rescind this authority at any time by notifying, in writing, the Division of Professional Licensing Services.

☑ Yes ☐ No Please initial: BE

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure.

Signature of applicant: Byrd Cleveland *Date:* 11/24/02

Date of photo: 11/23/02

(see next page)

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Fee Section, Division of Professional Licensing Services, Cultural Education Center, Albany, NY 12230. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.

Education Record Form

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000
www.op.nysed.gov

Education Record

INSTRUCTIONS: Please complete this form, have it notarized by a Notary Public and return it to the Office of the Professions at the address at the end of this form.

1 **Social Security Number**
(Leave this blank if you do not have a U.S. Social Security Number) [redacted]

2 **Birth Date** Month [redacted]

3 **Print Name Exactly As You Wish It To Appear On Your License**

Last: Cleveland
First: Byrd
Middle:

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Apt./Bldg.: 110 Pover St
Street: Pover St
City: Albany
State: NY Zip Code: 12210-1704
Province/Country If not U.S.:

5 **Profession:** Physician (Medical Doctor) 60

6 **AFFIDAVIT WITH ACKNOWLEDGMENT** (Notarization required.)

APPLICANT

I, being duly sworn, declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

Signature of the applicant: Byrd Cleveland

NOTARY

State of New York County of Albany

On the 30 day of Dec. in the year 2002 before me, the undersigned, personally appeared Byrd Cleveland, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature [signature]

Notary ID number [illegible] PELTON
Notary Public in the State of New York
Qualified in Rensselaer County No. PE4984154
My Commission Expires [illegible]

Expiration date _____ Month _____ Day _____ Year

F

FORM 2
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

RECEIVED
DEC 3 2002
REGISTRAR'S OFFICE

12/30/02 DD

CERTIFICATION OF PROFESSIONAL AND PREPROFESSIONAL EDUCATION

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your New York State Licensure Application (Form 1).
2. Send this form to the professional school you attended to complete Section II. Be sure to include any fee required. If you graduated from a medical school that was not registered by New York State or accredited by LCME/AOA, notify the school that a transcript must accompany this form.
3. If you attended a medical school that has been closed, send this form to the official repository of the records for that school (e.g., CONES).
4. This form must be signed by the Registrar, Dean, Rector, or Principal of the medical school and sent back directly to the Office of the Professions by that school official in an official school envelope. Forms sent back by the applicant or other parties will not be accepted.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER [redacted]
(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE [redacted] *Month Day Year*

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR LICENSURE APPLICATION (FORM 1)

Last: CLEVELAND
First: BYRD
Middle:
Maiden or Previous name:

4 MAILING ADDRESS:
Apt./Bldg: 110 Dove Sh
Street: Dove Sh
City: Albany
State: NY Zip Code: 12210
Province/Country If not U.S.:

(check only one) ☑ permanent address of record ☐ temporary mailing address until: ___/___/___ *mo. day. yr.*

5 TELEPHONE: WORK 518-262-7190 *Area Code Number* HOME [redacted] *Area Code Number*

6 Print name under which your degree or diploma was awarded *(if different from above)*: _____

7 Preprofessional School Attended: Brandeis University, University of Texas, University of Pittsburgh

8 Professional School Attended: New York Medical College
Address: Valhalla NY 10595

9 Name of Degree/Diploma: Doctor of Medicine Date awarded: 5/19/00 - May 19, 2000

Mg 12/12/02 — mailed file

FORM 2PGT
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

Certification of completion of approved postgraduate training will be accepted only if it is signed no more than one month prior to the completion date of the training period in which credit is sought.

2003 DEC -2 AM 9:50

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

(To be used only for U.S. and Canadian approved postgraduate training programs)

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your Licensure Application (Form 1).
2. Please send this form to the director of medical education of the hospital(s) in which you completed postgraduate training. One form must be submitted to verify each residency. If you have completed more than one residency, you may photocopy this form.
3. This form must be sent directly to the Department by the hospital in which you did your residency. If the hospital in which you did your residency does not have a director of medical education, the forms may be completed by the department chair. If the Department cannot determine that this verification came directly from the hospital, the postgraduate hospital training will not be credited.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER: [redacted]

(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted] *Month Day Year*

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION (FORM 1):

Last: CLEVELAND
First: BYRD
Middle:

Lyttle ok mg 12/12/02

4 MAILING ADDRESS:

Apt./Bldg.: 110
Street: DOVE ST
City: ALBANY
State: NY Zip Code: 12210
Province/Country If not U.S.:

5 Print name under which postgraduate training was completed: Byrd Cleveland

6 Hospital in which postgraduate training was completed: Albany Medical Center
Address: 43 NewScotland Ave Albany NY 12208

file already on

FORM 2PGT
MEDICINE

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

2002 DEC 17 AM

Certification of completion of approved postgraduate training will be accepted only if it is signed no more than one month prior to the completion date of the training period in which credit is sought.

MG 11/3/03

CERTIFICATION OF APPROVED POSTGRADUATE TRAINING

(To be used only for U.S. and Canadian approved postgraduate training programs)

APPLICANT INSTRUCTIONS

1. Complete Section 1. Enter your name as it appears on your Licensure Application (Form 1).
2. Please send this form to the director of medical education of the hospital(s) in which you completed postgraduate training. One form must be submitted to verify each residency. If you have completed more than one residency, you may photocopy this form.
3. This form must be sent directly to the Department by the hospital in which you did your residency. If the hospital in which you did your residency does not have a director of medical education, the forms may be completed by the department chair. If the Department cannot determine that this verification came directly from the hospital, the postgraduate hospital training will not be credited.

SECTION I: APPLICANT INFORMATION

1 SOCIAL SECURITY NUMBER: [redacted]

(Leave this blank if you have no U.S. Social Security Number)

2 BIRTH DATE: [redacted] *Month Day Year*

3 PRINT FULL NAME EXACTLY AS IT APPEARS ON YOUR APPLICATION (FORM 1):

Last: CLEVELAND
First: BYRD
Middle:

lyc HT ok MG 11/3/03

4 MAILING ADDRESS:

Apt./Bldg.: 110
Street: OLIVE ST
City: ALBANY
State: NY Zip Code: 12210
Province/Country If not U.S.:

5 Print name under which postgraduate training was completed: Byrd Cleveland

6 Hospital in which postgraduate training was completed: MetroWest Medical Center

Address: 115 Lincoln St. Framingham MA 01701-9167

1. Do you wish to register for the period indicated?	✓ Yes	No
2. Since your last registration application,		
a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?		✓ No
b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?		✓ No
c. Are criminal charges pending against you in any court?		✓ No
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?		✓ No
e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?		✓ No
3. a. Are you under an obligation to pay child support?		✓ No
b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?	Yes	No
4. Are you a U.S. citizen or a qualified alien as defined below?	✓ Yes	No

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature BClaudet Business phone (518) 262 4043 Date 9/22/03

228166CLE60031500060105

REGISTRATION RENEWAL DOCUMENT

THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

11/01/04
LIC: 228166
NME: CLE6
YR: 05
OFF: 1
EIN:

CLEVELAND BYRD
1444 VIA DEL MAR
SCHENECTADY NY 12307-4320

PROFESSION: 60 MEDICINE
PERIOD: 04/01/05 - 03/31/06

Complete and sign reverse side of this application

Cat 21 - 03/22/04

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 315
AMOUNT DUE

1. Do you wish to register for the period indicated? ..... ✓ Yes ___ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ..... ___ Yes ✓ No

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? ..... ___ Yes ✓ No

c. Are criminal charges pending against you in any court? ..... ___ Yes ✓ No

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ..... ___ Yes ✓ No

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ..... ___ Yes ✓ No

3. a. Are you under an obligation to pay child support? ..... ___ Yes ___ No

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ..... ___ Yes ___ No

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? ..... ✓ Yes ___ No

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature B Cleveland Daytime phone (516) 393 3819 Date 1/5/05

Cal21B 03/22/04

Do you wish to register for the period indicated?	✓ Yes	___ No
Since your last registration application,		
a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	[redacted]	✓ No
b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	[redacted]	✓ No
c. Are criminal charges pending against you in any court?	[redacted]	✓ No
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]	✓ No
e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	[redacted]	✓ No
a. Are you under an obligation to pay child support?	___ Yes	✓ No
b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?	___ Yes	___ No
Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.?	✓ Yes	___ No

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution** and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone (518) 393 3819 Date 11/5/05

CRC 7.03/02.04

228166CLE6006000060106

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

11/01/05
LIC: 228166
NME: CLE6
YR: 06
OFF: 1
EIN:

CLEVELAND BYRD
1444 VIA DEL MAR
SCHENECTADY NY 12307-4320

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 600
AMOUNT DUE

PROFESSION: 60 MEDICINE
PERIOD: 04/01/06 - 03/31/08

Complete and sign reverse side of this application

Cat 21P-032XM

1. Do you wish to register for the period indicated?	✓ Yes	No
2. Since your last registration application,		
a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?		✓ No
b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?		✓ No
c. Are criminal charges pending against you in any court?		✓ No
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?		✓ No
e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?		✓ No
3. a. Are you under an obligation to pay child support?	Yes	✓ No
b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?	Yes	No
4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.?	✓ Yes	No

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone (518) 262 4042 Date 2/23/06

1. Do you wish to register for the period indicated? ..... ✓ Yes ___ No

2. Since your last registration application,
   a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ... ___ Yes ✓ No
   b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you ... ___ Yes ✓ No
   c. Are criminal charges pending against you in any court? ..... ___ Yes ✓ No
   d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ..... [redacted] ___ No
   e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ..... [redacted] ___ No

3. a. Are you under an obligation to pay child support? ..... ___ Yes ✓ No
   b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ..... ___ Yes ___ No

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? ..... ✓ Yes ___ No

[redacted]

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I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone (518) 262 4046 Date 2/22/06

1. Do you wish to register for the period indicated?	✓ Yes	No
2. Since your last registration application,		
a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?		✓ No
b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?		✓ No
c. Are criminal charges pending against you in any court?		✓ No
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?		✓ No
e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?		✓ No
3. a. Are you under an obligation to pay child support?	Yes	✓ No
b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?	Yes	No
4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.?	✓ Yes	No

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I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone (518) 262 4043 449 0100 Date 7/20/06

C0543978

228166CLE6006000060108

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

11/01/07
LIC: 228166
NME: CLE6
YR: 08
OFF: 1
EIN:

CLEVELAND BYRD
1444 VIA DEL MAR
SCHENECTADY NY 12307-4320

PIN: QV03828

PROFESSION: 60 MEDICINE
PERIOD: 04/01/08 - 03/31/10

Cat 21:080406

Address change
Complete only if change has occurred

Street

City

State/Zip

$ 600
AMOUNT DUE

Complete and sign reverse side of this application

1. Do you wish to register for the period indicated?	✓ Yes	No
2. Since your last registration application,		
a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	[redacted]	✓ No
b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	[redacted]	✓ No
c. Are criminal charges pending against you in any court?	[redacted]	✓ No
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]	✓ No
e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	[redacted]	✓ No
3. a. Are you under an obligation to pay child support?	Yes	✓ No
b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?	Yes	No
4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.?	✓ Yes	No

[redacted]

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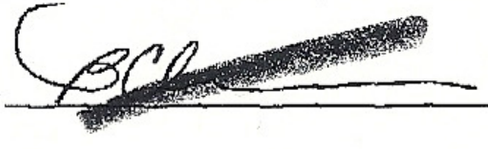
I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature  Daytime phone (818) 496-6938 Date 11/27/07

228166CLE6006000060110

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

11/02/09
LIC: 228166
NME: CLE6
YR: 10
OFF: 1
EIN:

CLEVELAND BYRD
1444 VIA DEL MAR
SCHENECTADY NY 12307-4320

PIN: AB65404

PROFESSION: 60 MEDICINE
PERIOD: 04/01/10 - 03/31/12

Complete and sign reverse side of this application

Address change
Complete only if change has occurred

Street

City

State/Zip

$ 600
AMOUNT DUE

1. Do you wish to register for the period indicated?	✓ Yes	No
2. Since your last registration application,		
a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?		✓ No
b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?		✓ No
c. Are criminal charges pending against you in any court?		✓ No
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?		✓ No
e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?		✓ No
3. a. Are you under an obligation to pay child support?	Yes	✓ No
b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?	Yes	No
4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.?	✓ Yes	No

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct and, further, I attest that I have updated my physician profile within the six months prior to the expiration date of my registration period as a condition of registration renewal in compliance with section 2995-a(4) of the Public Health Law. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature _____ Daytime phone (518) 4966938 Date 12/2/09

Cert21B:122208rd

1. Do you wish to register for the period indicated? ..... ☑ Yes ☐ No

2. Since your last registration application,

a. Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? ..... ☐ Yes ☑ No

b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you? ..... ☐ Yes ☑ No

c. Are criminal charges pending against you in any court? ..... ☐ Yes ☑ No

d. Are charges pending against you in any jurisdiction for any sort of professional misconduct? ..... ☐ Yes ☑ No

e. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence? ..... ☐ Yes ☑ No

3. a. Are you under an obligation to pay child support? ..... ☐ Yes ☑ No

b. If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below? ..... ☐ Yes ☐ No

4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.? ..... ☑ Yes ☐ No

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct and, further, I attest that I have updated my physician profile within the six months prior to the expiration date of my registration period as a condition of registration renewal in compliance with section 2995-a(4) of the Public Health Law. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone (518) 4345678 Date 4/12/12

OFFICE OF THE PROFESSIONS
NEW YORK STATE EDUCATION DEPARTMENT
89 Washington Avenue
Albany, NY 12234
518-474-3817

Registration Renewal - Transaction Summary

License Number : 228166
Profession : MEDICINE
Renewal Period : 04/01/2012 through 03/31/2014

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

CLEVELAND BYRD
1444 VIA DEL MAR
NISKAYUNA NY 12309 - 4320

Renewal Status : **Paid On-line - Renewal Complete**

Offices Selected for Renewal:

	Address	Fee
1)	1444 VIA DEL MAR, NISKAYUNA, NY, 12309,US	$ 600
2)	ALBANY MEDICAL COLL, DEPT/MEDICINE MC 158, 47 NEW SCOTLAND AVE, ALBANY, NY, 12208,US	$ 10

Response to Questions :

	Question	Response
1)	Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?	No
2)	Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?	No
3)	Are criminal charges pending against you in any court?	No
4)	Are charges pending against you in any jurisdiction for any sort of professional misconduct?	No
5)	Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?	No
6)	Are you under an obligation to pay child support?	No
7)	Are you a U.S. citizen?	Yes

License Renewal Payment Details:

Receipt No :4267258982
Payment Date :03/26/2012

16 In the space below, give a complete record of your education preparation. Attach additional sheets if necessary.

SCHOOLS ATTENDED AND LOCATION (including country) List schools in original language and translate.	Number of Years Attended	Diploma or Degree Obtained *List diploma or degree titles in original language and translate. Indicate year obtained*	If no diploma or degree, number of credits earned
High School or Secondary ① Crockett High school Austin Tx USA (see Add. Sheet)	2	no	24 yrs
Postsecondary Preprofessional (Exclusive of Medical School) ① University of Texas Austin Tx USA ② University of Pittsburgh Pittsburgh PA USA (see add. sheet)	2 3	no BS Biological Sciences	63 hrs
Medical Education (Professional) (List all medical schools attended) ① New York Medical College Valhalla NY USA	4	MD	

17 If you completed clinical clerkships in a country other than where your medical school is located, give the dates and location of these clerkships. Attach additional sheets if necessary.

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility And Address	Medical School with which Clerkship Affiliated and Address
N/A			

18 Provide a chronological list of all activities since graduation from professional school to the present. Include vacation periods and periods of employment. Attach additional sheets if necessary.

DATE (mm/dd/yy) From	DATE (mm/dd/yy) (or) To	Type of Activity, Beginning with Date of Graduation from Professional School. Include Name and Address of Employers.
5/19/00	6/24/00	Vacation
6/24/00	6/23/01	Transitional Residency, MetroWest Medical Center Framingham MA 115 Lincoln St 01701-9167
7/1/01	present	Family Practice Residency Albany Medical Center Albany NY 12208

19 **Complete item 19 only if you are a graduate of a program not registered by New York State or LCME or AOA accredited.**

Have you completed all portions of the examination requirements for ECFMG certification? ☐ Yes ☐ No

Do you currently hold a valid ECFMG certificate? ☐ Yes ☐ No

Please complete and forward the ECFMG form enclosed with this application packet.

20 Are you applying for licensure on the basis of a Fifth Pathway program? ☐ Yes ☑ No

If Yes, list name and location of medical school or hospital and the inclusive dates of attendance.

Name and Location of Medical School or Hospital	Inclusive Dates of Attendance

21 List in English, all specialty qualifications you have earned. (i.e., Board Specialty Certification or Diplomate Certificate)

Name of Qualifications	Name and location of organization issuing credential

22 ☑ I will be applying for USMLE Step 3

OR

☐ I have successfully completed the examination combination indicated below:

EXAMINATION COMBINATIONS

- ☐ USMLE Steps 1, 2, and 3
- ☐ FLEX Parts I, II, and III
- ☐ FLEX Components I and II
- ☐ NBME Parts I, II, and III
- ☐ NBME Parts I and II and USMLE Step 3
- ☐ NBME Part I, USMLE Step 2 and NBME Part III
- ☐ NBME Part I, and USMLE Steps 2 and 3
- ☐ USMLE Step 1, and NBME Parts II and III
- ☐ USMLE Step 1, NBME Part II, and USMLE Step 3
- ☐ USMLE Steps 1 and 2 and NBME Part III
- ☐ USMLE Step 1, NBME Part II, and FLEX Component II
- ☐ NBME Part I, USMLE Step 2, and FLEX Component II
- ☐ USMLE Steps 1 and 2 and FLEX Component II
- ☐ NBME Parts I and II and FLEX Component II
- ☐ FLEX Component I and USMLE Step 3
- ☐ NBOME Parts I, II, and III
- ☐ Other: _____

Date examination sequence was completed _____

23 Are you licensed or have you ever been licensed as a physician in any other state or country? ☑ Yes ☐ No

If yes, list each jurisdiction. In addition, you must have a Form 3A or 3B, as appropriate, submitted. See pages 14 - 15.

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date passed)	Endorsement	Other	
Commonwealth of Massachusetts	6/24/2001	207151			✓	Limited Registration To serve as intern with authorization to practice only in metrowest medical center affiliates 1yr limited license

24 If you hold a New York State license in another profession, indicate the profession, your license number and date of licensure below.

Profession	License Number	Date of Initial Licensure (mm/dd/yy)
		___/___/___
		___/___/___
		___/___/___
		___/___/___

25 **CHILD SUPPORT OBLIGATION:**

New York State General Obligations Law, section 3-503, requires every applicant for a professional license, permit, or registration, or any renewal there of, to file a written statement that, as of the date of the filing, he or she is, or is not, under an obligation to pay child support. **Individuals who are four months or more in arrears in child support may be subject to suspension of their business, professional and/or drivers licenses.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable pursuant to section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are under an obligation to pay child support but are not in compliance with the General Obligations Law can be issued a credential for no more than six months to discharge child support obligations consistent with that law.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A ☑ I **am not** under an obligation to pay child support:

OR

B ☐ I **am** under an obligation to pay child support *and* (please check only one of the following)

- ☐ I am current and **am not** four months or more in arrears in the payment of child support: or,
- ☐ I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- ☐ The child support obligation is the subject of a pending court proceeding; or,
- ☐ I am receiving public assistance or supplemental security income; or,
- ☐ None of the above four statements apply.

[16] continued

High school	yrs	Degree/Diploma
② SF Austin High School Austin TX USA	1½	yes

Post secondary school
pre-professional

③ Brandeis University	2½	MS Neuroscience

BCleveland

7 In the spaces below, give an accurate record of your educational preparation. **Be sure to complete items A-E for each school.** Please print. Attach additional sheets if necessary.

A. Name of Schools Attended and Locations	B. Number of Years Attended	C. Attendance: Entrance Date	C. Attendance: Leaving Date	D. Title of Diploma Or Degree Obtained*	E. If no diploma or degree, number of credits earned
Elementary or Primary School School Name: please see attached list City: ____ State/Country: ____		___/___ mo/yr	___/___ mo/yr		
High School or Secondary School School Name: Crockett High School City: Austin TX State/Country: Texas	2yrs	5/81 mo/yr	9/83 mo/yr		2yrs
School Name: St. Austin High School City: Austin TX State/Country: Texas	1½	5/83 mo/yr	1/85 mo/yr	High School Diploma	~~Hwy~~
Postsecondary School(s) School Name: University of Texas City: Austin State/Country: Texas	2	9/85 mo/yr	5/87 mo/yr	—	63 credits
School Name: University of Pittsburgh City: Pittsburgh State/Country: Pennsylvania	3	9/87 mo/yr	5/90 mo/yr	BS Biological sciences	
School Name: Brandeis University City: Waltham State/Country: MA	2½	9/91 mo/yr	2/94 mo/yr	MS Neuroscience	
School Name: New York Medical College City: Valhalla State/Country: NY	4	9/96 mo/yr	5/2000 mo/yr	MD	
School Name: ____ City: ____ State/Country: ____		___/___ mo/yr	___/___ mo/yr		

*Note: If your professional school was located outside the U.S., and you have a copy of your degree/diploma in the original language, attach a copy to this form.

Return this form to: New York State Education Department, Office of the Professions, Medical Admission (60) Unit,
Division of Professional Licensing Services, 89 Washington Avenue, Albany, NY 12234-1000.

Byrd Cleveland
[redacted]
Profession 60.

Education Record Addendum- Elementary/Primary School

Name and Location	Years	Dates	Diploma	Credits
Dill Elementary School, Austin TX	2	9/74 –5/76	no	1st, 2nd grade
Matthews Elementary School, Austin TX	~1/2	9/76- ?12/76	no	part 3rd grade
Rosedale Elementary School, Austin TX	~1 1/2	?1/77-5/78	no	rest 3rd grade 4th grade
Odom Elementary School, Austin TX	1/2	9/78- 12/78	no	part 5th grade
Perry Elementary School, Perry KS	1/2	1/79- 5/79	no	rest 5th grade
Joslin Sixth Grade Center, Austin TX	1	9/79- 5/80	no	6 th grade
Bedicheck Junior High School, Austin TX	1	9/80- 5/81	Junior High Diploma	

No. 476601

STATE OF TEXAS

200th

IN RE Laura Elizabeth Cleveland, AN ADULT

DECREE CHANGING NAME OF ADULT

DATE. This case was tried on the 22 day of March, 1989.

APPEARANCES. Petitioner, Laura Elizabeth Cleveland, appeared in person and by attorney and announced ready for trial.

FINDINGS. The Court examined the pleadings and heard the evidence and argument of counsel. The court finds that all necessary residence qualifications and prerequisites of law have been legally satisfied, that this Court has jurisdiction of all parties and subject matter of this cause. All persons entitled to citation were properly cited.

The Court finds that there is good cause for the change of name of the Petitioner and that the change of name is in the interest or to the benefit of the Petitioner.

NAME CHANGE ORDERED. IT IS ORDERED that the name of the Petitioner, Laura Elizabeth Cleveland, be changed.

NEW NAME. IT IS ORDERED that the new name of the Petitioner be and is Byrd Elizabeth Cleveland.

COSTS. All costs of court in this case are adjudged against Petitioner.

RELIEF DENIED. All relief prayed for and not granted in this order is denied.

SIGNED this 24 day of March, 1989.

Judge Presiding

I, JOHN DICKSON, District Clerk, Travis County, Texas, do hereby certify that this is a true and correct copy as same appears of record in my office. Witness my hand and seal of office on Dec. 22, 1989

JOHN DICKSON, DISTRICT CLERK
By Deputy: Lena Dodd

Byro Cleveland, M.D.

SECTION II : CERTIFICATION OF PROFESSIONAL

INSTRUCTION TO SCHOOL: Please complete this section, sign certifying statement, attach the information in Item 5 and send directly to the Office of the Professions at the address shown below. **This form will not be accepted if returned by the applicant or any other party.**

1 Applicant's Entrance date: 8 / 5 / 96 Completion/Withdrawal Date: 5 / 19 / 00

2 Degree/diploma conferred: Doctor of Medicine Date of conferral: 5 / 19 / 00

3 Did the applicant receive advanced standing based on prior academic work? ☐ YES ☒ NO
If Yes, indicate when the prior work was completed below.

Name of Institution: _____ Dates of attendance: _____ to _____

Submit with this form: (1) An official transcript of studies at your institution, and
(2) Copies of documentation in your file to support the granting of transfer credit.

4 ***For Applicants from N.Y.S. Registered or LCME/AOA Accredited Medical Schools:***

Applicant met LCME/AOA requirements for admission to medical/osteopathic school? ☒ YES ☐ NO

If No, number of preprofessional postsecondary credit hours completed by applicant prior to admission to medical school _____ semester hours or _____ quarter hours.

5 ***For All Other Applicants:***

Years of education required for admission into your medical school: _____

Preprofessional credential/degree submitted by applicant for admission into your medical school: _____

Was Social Service required? ☐ YES ☐ NO If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: _____ Dates: _____ to _____

Was a pre-graduation internship required? ☐ YES ☐ NO If Yes, give inclusive dates and name of institution in which requirement was met.

Institution: _____ Dates: _____ to _____

Submit with this form:

A. An official transcript (course record, index, or marksheets) showing courses taken at your institution and accepted from other institutions for transfer of credit of convalidation.
The transcript must bear the original signature of the dean, principal, rector, or registrar and original seal of the school.

B. A copy of documentation from your files to support the granting of transfer credit or convalidated course and clerkships.

C. List of clinical clerkship completed outside jurisdiction where medical school is located, including (for each): area or specialty, starting and ending dates of clerkship, and name and address of hospital where clerkship was performed.

FOR ATTENDEES OF CIFAS, CETEC, AND UTESA, this list must include all clerkships completed, both inside and outside the jurisdiction where the medical school is/was located.

I certify that to the best of my knowledge and belief the foregoing is a true statement of the record of the individual named on this form.

Signature: _____ 451500

Type or Print Name: Judith A. Ehren

Title: University Registrar

Medical School: New York Medical College (SEAL)

Address: Sunshine Cottage
Valhalla, NY 10595

Telephone: 914-594-4495 *E-mail address:* _____

Date: 12 / 9 / 02

CERTIFICATION IS NOT ACCEPTABLE UNLESS DATED AFTER GRADUATION.

Return this Form and material requested above to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000.

SECTION II : CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying statement, and return the form ***directly*** to the Division of Professional Licensing Services at the address shown below. **This form will not be accepted if returned by the applicant.**

This is to certify that Byrd Cleveland
(Physician's Name)

a graduate of New York Medical College
(Medical school)

was enrolled in a postgraduate training program(s) approved by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or Royal College of Physicians and Surgeons of Canada at Albany Medical Center Albany NY 12208
(Name and location of Hospital)

Level of Training (example PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
PGY 2	Verified w/ hosp.	7/01/01 to 9/30/02	☑ YES ☐ NO ☐ In progress; satisfactory to date
PGY 3	Family Practice	10/1/02 to 9/30/03	☐ YES ☐ NO ☑ In progress; satisfactory to date
	Mg 12/12/02	___/___/___ to ___/___/___	☐ YES ☐ NO ☐ In progress; satisfactory to date
		___/___/___ to ___/___/___	☐ YES ☐ NO ☐ In progress; satisfactory to date
		___/___/___ to ___/___/___	☐ YES ☐ NO ☐ In progress; satisfactory to date

If this physician did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

☐ Explanation is attached

I am the director of medical education or department chair of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: Catherine Eckart

Type or Print Name of Director/Chair. Catherine Eckart

Title or Official position: Director GME

Institution: Albany Medical Center

Address: 43 New Scotland Avenue, MC50
Albany, NY 12208

(SEAL)

Telephone: 518-262-3095 Date: 11/26/02

E-mail Address: eckartc@mail.amc.edu

Return this Form to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000.

SECTION II : CERTIFICATION OF POSTGRADUATE TRAINING

INSTRUCTION TO HOSPITAL: Please complete this section, sign certifying statement, and return the form ***directly*** to the Division of Professional Licensing Services at the address shown below. **This form will not be accepted if returned by the applicant.**

This is to certify that Byrd Cleveland
(Physician's Name)

a graduate of New York Medical College
(Medical school)

was enrolled in a postgraduate training program(s) approved by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or Royal College of Physicians and Surgeons of Canada at MetroWest Medical Center Framingham MA
(Name and location of Hospital)

Level of Training (example PGY-1)	Clinical Area	Inclusive dates (mm/dd/yy)	Successfully completed
PGY-1	Transitional Residency	6/24/00 to 6/23/01	☑ YES ☐ NO ☐ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date
		__/__/__ to __/__/__	☐ YES ☐ NO ☐ In progress; satisfactory to date

If this physician did not successfully complete the postgraduate training program, please attach a letter of explanation with this form.

☐ Explanation is attached

I am the director of medical education or department chair of the clinical area. I was the program director for the physician named above during the postgraduate training indicated and have carefully read and completed this form and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

Signature of Director/Chair: [signature] MD

Type or Print Name of Director/Chair: Matthias M. Nurnberger, M.D.

Title or Official position: Director, Transitional Year Program

Institution: MetroWest Medical Center-Framingham Union Hospital (SEAL)

Address: 115 Lincoln Street
Framingham MA 01702

Telephone: 508-383-1555 Date: 12/6/02

E-mail Address: _____

Return this Form to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Medicine Licensing Unit, 89 Washington Avenue, Albany, NY 12234-1000.

228166CLE6000100060203

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

09/05/03
LIC: 228166
NME: CLE6
YR: 03
OFF: 2
DOB:
SSN: [redacted]
EIN:

CLEVELAND BYRD
ALBANY MEDICAL COLL
DEPT/MEDICINE MC 158
47 NEW SCOTLAND AVE
ALBANY NY 12208-3479

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

PROFESSION 60 MEDICINE
PERIOD 04/01/03 - 03/31/05

$ 10
AMOUNT DUE

Cat 6 - 1001

Complete and sign reverse side of this application

228166CLE600010006020S

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

11/01/04
LIC: 228166
NME: CLE6
YR: 05
OFF: 2
EIN:

CLEVELAND BYRD
ALBANY MEDICAL COLL
DEPT/MEDICINE MC 158
47 NEW SCOTLAND AVE
ALBANY NY 12208-3479

PROFESSION: 60 MEDICINE
PERIOD: 04/01/05 - 03/31/06

Cat 21 03/22/04

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 10
AMOUNT DUE

228166CLE6000100060206

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

11/01/05
LIC: 228166
NME: CLE6
YR: 06
OFF: 2
EIN:

CLEVELAND BYRD
ALBANY MEDICAL COLL
DEPT/MEDICINE MC 158
47 NEW SCOTLAND AVE
ALBANY NY 12208-3479

PROFESSION: 60 MEDICINE
PERIOD: 04/01/06 - 03/31/08

Complete and sign reverse side of this application

Cat 21P-NWZ08

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 10
AMOUNT DUE

228166CLE600010006030 6

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

07/06/06
LIC: 228166
NME: CLE6
YR: 06
OFF: 3
EIN:

CLEVELAND BYRD
326 SOUTH PEARL ST
ALBANY NY 12202-0000

PROFESSION: 60 MEDICINE
PERIOD: 04/01/06 - 03/31/08

Del 21P:032204

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$ 10
AMOUNT DUE

228166CLE6000100060312

MAR 3 0 2012

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

03/23/12
LIC: 228166
NME: CLE6
YR: 12
OFF: 3
EIN:

CLEVELAND BYRD
UPPER HUDSON PLANNED
PARENTHOOD
855 CENTRAL AVE
ALBANY NY 12208-0000

Address change
Complete only if change has occurred

Street

City

State/Zip

PIN: AI17862

PROFESSION: 60 MEDICINE
PERIOD: 04/01/12 - 03/31/14

$ 10
AMOUNT DUE

Complete and sign reverse side of this application

228166CLE6000100060312

MAR 3 0 2012

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

03/23/12
LIC: 228166
NME: CLE6
YR: 12
OFF: 3
EIN:

CLEVELAND BYRD
UPPER HUDSON PLANNED
PARENTHOOD
855 CENTRAL AVE
ALBANY NY 12206-0000

PIN: AI17862

PROFESSION: 60 MEDICINE
PERIOD: 04/01/12 - 03/31/14

Address change
Complete only if change has occurred

Street

City

State/Zip

$ 10
AMOUNT DUE

Complete and sign reverse side of this application