APPLICATION FOR LICENSE TO PRACTICE MEDICINE / OSTEOPATHIC MEDICINE IN INDIANA

State Form 29495 (R9 / 7-96)
Approved by State Board of Accounts, 1994

9901407D

Health Professions Bureau
402 W. Washington St., Room 041
Indianapolis, IN 46204
Telephone number: (317) 232-2960

*** Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

Application fee	50 —
Date fee paid (*month, day, year*)	11-1-99
Receipt number	818.286-110.0%3
Application number	
License number	01052043
License issuance date (*month, day, year*)	1-27-00

Permit fee	
Date fee paid (*month, day, year*)	
Receipt number	
Permit number	4459
Permit issuance date (*month, day, year*)	11-22-99

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)	Check one:	Social Security number *
MARSHALL DAVID LEVINE	☑ MD ☐ DO	[illegible]

Address (*number and street or Rural Route*): 2006 N. Howe Street, #2

City, state, ZIP code: Chicago, Illinois (60614-4414)

Telephone number (*daytime*)	Birthdate (*mo., day, yr.*)	Birthplace
(312) 932-0171	5/1/41	Cambridge, Massachusetts

TEMPORARY PERMIT INFORMATION

Do you desire a temporary permit?
☑ Yes ☐ No

DOCTOR OF MEDICINE / OSTEOPATHIC DEGREE GRANTED BY

Name of School	Location	Date of Graduation (*Month, Day, Year*)
Tufts	Boston, Mass	6/30/1967

EXAMINATION

Check appropriate box(es) indicating which examination or combination of examinations you have taken.
(*Please review instruction sheet for address and telephone numbers on how scores may be obtained.*)

☐ FLEX EXAMINATION	☐ STATE BOARD EXAMINATION
☐ Component I ☐ Component II ☐ Other	Examination taken in which state?
☑ NATIONAL BOARD OF MEDICAL EXAMINERS	☐ LMCC EXAMINATION
☑ Part I ☑ Part II ☑ Part III	
☐ USMLE EXAMINATION	☐ NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS
☐ Step I ☐ Step II ☐ Step III	☐ Part I ☐ Part II ☐ Part III

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PRE-MEDICAL OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED
HARVARD COLLEGE	CAMBRIDGE, MASS.	1959 - 1963

MEDICAL OSTEOPATHIC EDUCATION		
NAME OF SCHOOL	LOCATION	DATES ATTENDED
TUFTS	BOSTON, MASS.	1963 - 1967

POSTGRADUATE MEDICAL OSTEOPATHIC EDUCATION AND TRAINING IN THE UNITED STATES OR CANADA (Include ALL internships, residencies and / or fellowships)			
NAME OF PROGRAM	LOCATION	FROM (month, year)	TO (month, year)
PEDIATRIC INTERNSHIP DUKE UNIVERSITY	DURHAM, NC. 27710	7/67	6/68
OB-GYN RESIDENCY BETH ISRAEL HOSPITAL	BOSTON, MASS. 02215	7/68	6/71
MEDICAL GENETICS FELLOWSHIP UCLA - HARBOR GENERAL HOSPITAL	TORRANCE, CALIFORNIA 90509	7/73	6/75

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL	
GENERAL LOCATION	DATE
DURHAM, N.C.	1967 - 8
BOSTON, MASS.	1968 - 1971
NORTH KINGSTOWN, R.I.	1971 - 1973
SAN PEDRO, CALIFORNIA	1973 - 1975

(CONTINUED)

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM MEDICAL OR OSTEOPATHIC SCHOOL		
NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE
US NAVY QUONSET POINT, R.I.	OBSTETRICIAN	1971 - 1973
UNIVERSITY OF NEW MEXICO ALBUQUERQUE, N.M.	ASSISTANT PROFESSOR, OB-GYN DEPT.	1975 - 1981
RIO GRANDE OB-GYN ALBUQUERQUE, N.M.	PRIVATE PRACTICE, OB-GYN	1981 - 1993
UNIVERSITY OF NEW MEXICO ALBUQUERQUE, N.M.	ASSOCIATE PROFESSOR, OB-GYN DEPT.	1993 - 6/98

(CONTINUED)

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION				
STATE	TYPE OF LICENSE, CERTIFICATE, REGISTRATION OR PERMIT	NUMBER	DATE ISSUED	CURRENT STATUS
MASS	MEDICAL	32027	1970	INACTIVE
CAL		G-20901	1970	INACTIVE
RI		4355	1971	INACTIVE
NM		75-197	1975	ACTIVE
MT		4301062685	1993	ACTIVE
NY		194894	1994	ACTIVE

(CONT)

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and diposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?	☐ Yes ☑ No
2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (*including Indiana*) or country?	☐ Yes ☑ No
3. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem?	☐ Yes ☑ No
4. Have you ever been charged with drug addiction?	☐ Yes ☑ No
5. Have you ever been convicted of, plead guilty or *nolo contendere* to: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines.*)	☐ Yes ☑ No ☐ Yes ☑ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☑ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☑ No
8. Have you ever had a malpractice judgment against you or settled any malpractice action?	☑ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)
Maulall D. Patel	10/13/99

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorized, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for medical licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosure.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Date signed (*month, day, year*)	Signature of applicant
10/13/99	Maulall D. Patel

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States where I have been Licensed

State	Type	Number	Date issued	Status
WI	Medical	39498	1997	Active
MINN	↓	38015	1997	Active
IL		36-097170	1998	Active
ND		8155	1999	Active

Places of Employment

Name / Address of Employer	Responsibilities	
Self Employed Independent Contractor	OB-GYN Locum Tenens	1993 to Present

Places Lived (Cont.):

General Location	Date
Albuquerque, N.M.	1975 - 1998
Chicago, Illinois	1998 to present

SUPPLEMENTAL CLAIM INFORMATION

Please supply the following information regarding any instance of claim, suit or incident which may give rise to a claim whether dismissed, settled out of court, judgement or pending. Answer all questions completely. This form should be photocopied and filled out seperately for each claim. Please type or print clearly.

Applicant (Defendant's) name: Marchon D. Levine

Claimant (Plaintiff's) name: T G.

Date of alleged error: 11/21/86 Date of Claim: (11/21/86)

Indicate whether: ____ Claim ____ Suit or ____ Incident that has been reported to your insurance carrier

Name of Insurer: NM Physician's Mutual Liability Co.

Location of court where original complaint was filed: Unknown

Case #: Unknown

Defendant's Legal Representative: (include name, address and telephone #) Rice Reitzel, 6565 American Parkway, Albuquerque, NM 881-6060

Plaintiff's Legal Representative: (include name, address and telephone #) Unknown

STATUS OF COMPLAINT

If closed please indicate:

____ Court Judgement — Finding for: YOU ____ PLAINTIFF ____ Date: ____/____/____

Determined by: JUDGE ____ JURY ____

✓ Out of Court Settlement — Date of Settlement: 11/25/87

Amount paid on your behalf: $ 11,000

Compensation: $ Unknown Punitive: $ Unknown

Total Settlement amount: $ 11,000

____ Case Dismissed: Against YOU ✓ Against ALL DEFENDANTS ____ Date: 11/25/87

If pending please indicate: Claimant's settlement demand: $ _____ Defendant's offer for settlement: $ _____

Insurer's loss reserve: $ _____ Defense reserve: $ _____ Deductible: $ _____

Claim in suit ____ Yes ____ No If Yes, amount asked in summons: $ _____ Compensation: $ _____

Punitive: $ _____

DESCRIPTION OF CLAIM

Provide enough information to allow evaluation:

1. Incident Location: Labor And Delivery, Presbyterian
2. Alleged act, error or omission upon which Claimant bases claim: Negligence: Sponge left in Abdomen
3. Description of type and extent of injury or damage allegedly sustained: Reoperation to remove Sponge, Pain, Suffering
4. Patient's Condition at point of your involvement: Good
5. Patient's Condition at end of treatment: Good
6. Give a complete narration of the case, relating events in chronological order emphasizing the dates of service and stating in detail what was done each time the patient was seen professionally. Use reverse side for additional space required. (Please type or print)

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DATES _____

3/4/94

Signature Marchon D. Levine MD

IMPORTANT: IN ADDITION TO THE INFORMATION ABOVE, PLEASE ATTACH COPIES OF THE COMPLAINT, YOUR DEPOSITION, FINAL JUDGEMENT, SETTLEMENT & RELEASE, OR OTHER FINAL DISPOSITION OF THE CLAIM.

"OFFICIAL SEAL"
WILLIAM LA LUZ JR.
NOTARY PUBLIC STATE OF ILLINOIS
My Commission Expires 10/27/99

Notary Public
Comm. Expires: 10/27/99

DATES: OBESE PATIENT / SPINAL DEFORMITY WEARING OFF / SPONGE COUNT INCORRECT / SPONGE MISSING → EXPLORATION OF ABDOMEN BY SURGEON (LEWIS) AND ASSISTANT DONE LOCATE SPONGE → PORTABLE ABDOMINAL XRAY READ BY LEWINE AND RADIOLOGIST: NO SPONGE SEEN → SURGEON TO ADVISE PT/FAMILY OF MISSING SPONGE, POSSIBLE INTRA ABDOMINAL LOCATION DECISION NOT TO DO EXPLORATORY INCISION BUT TO CLOSE → XRAY NEXT DAY REVEALED SPONGE IN UPPER ABDOMEN / REVIEW OF RADIOLOGIST OF PREVIOUS XRAY: INACCURATE AS DID NOT COVER UPPER ABDOMEN → RECEIVABLE: SPONGE REMOVED → NO COMPLICATIONS → PATIENT SUED

Decision to settle as cost to fight in court exceeds settlement and uncertainty of jury decision.

Additional Comments:

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"OFFICIAL SEAL"
WILLIAM LA LUZ JR.
NOTARY PUBLIC STATE OF ILLINOIS
Commission Expires 10/27/99

William La Luz
Notary Public

SUPPLEMENTAL CLAIM INFORMATION

Please supply the following information regarding any instance of claim, suit or incident which may give rise to a claim whether dismissed, settled out of court, judgement or pending. Answer all questions completely. This form should be photocopied and filled out separately for each claim. Please type or print clearly.

Applicant (Defendant's) name: Maureen D. Lavin

Claimant (Plaintiff's) name: _____

Date of alleged error: July, 1975 Date of Claim: ? 1976

Indicate whether: ✓ Claim ____ Suit or ____ Incident that has been reported to your insurance carrier

Name of Insurer: _____

Location of court where original complaint was filed: _____

Case #: _____

Defendant's Legal Representative: (include name, address and telephone #) _____

Plaintiff's Legal Representative: (include name, address and telephone #) Dan Chacon

STATUS OF COMPLAINT

If closed please indicate: ____ Court Judgement — Finding for: YOU ____ PLAINTIFF ____ Date: ____/____/____

Determined by: JUDGE ____ JURY ____

____ Out of Court Settlement — Date of Settlement: ____/____/____

Amount paid on your behalf: $ _____

Compensation: $ _____ Punitive: $ _____

Total Settlement amount: $ _____

✓ Case Dismissed: Against YOU ____ Against ALL DEFENDANTS ____ Date: ____/____/____

If pending please indicate: Claimant's settlement demand: $ _____ Defendant's offer for settlement: $ _____

Insurer's loss reserve: $ _____ Defense reserve: $ _____ Deductible: $ _____

Claim in suit ____ Yes ____ No If Yes, amount asked in summons: $ _____ Compensation: $ _____

Punitive: $ _____

DESCRIPTION OF CLAIM

Provide enough information to allow evaluation:

1. Incident Location: University of New Mexico Hospital
2. Alleged act, error or omission upon which Claimant bases claim: Negligence during Cesarean Section
3. Description of type and extent of injury or damage allegedly sustained: Vesicovaginal fistula
4. Patient's Condition at point of your involvement: Good
5. Patient's Condition at end of treatment: Good

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6. Give a complete narration of the case, relating events in chronological order emphasizing the dates of service and stating in detail what was done each time the patient was seen professionally. Use reverse side for additional space required. (Please type or print)

DATES _____

3/4/94

Signature _____

IMPORTANT: IN ADDITION TO THE INFORMATION ABOVE, PLEASE ATTACH COPIES OF THE COMPLAINT, YOUR DEPOSITION, FINAL JUDGEMENT/SETTLEMENT & RELEASE OR OTHER FINAL DISPOSITION OF THE CLAIM.

"OFFICIAL SEAL"
WILLIAM LA LUZ JR.
NOTARY PUBLIC STATE OF ILLINOIS
My Commission Expires 10/27/99

Notary Public

Comm. Expires: 10/27/99

DATES: Very Limited Information

From 1975 - 1980, I taught full time @ the University of New Mexico in the Department of OB/Gyn. In July, 1975, I was the attending physician supervising House staff in the performance of a cesarean section. Postoperatively, the patient developed urinary incontinence. After 2 years, a vesico vaginal fistula was diagnosed and repaired. I was sued along with a number of the members of the OB-Gyn and Urology departments @ UNM under the State Tort Claims Act. I was dropped from the case.

Additional Comments:

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"OFFICIAL SEAL"
WILLIAM LA LUZ JR.
NOTARY PUBLIC, STATE OF ILLINOIS
My Commission Expires 10/27/99

COMM. EXPIRES 10/27/99

BETH·ISRAEL·HOSPITAL

BOSTON · MASSACHUSETTS

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THIS CERTIFIES THAT

Marshall D. Levine

HAS FAITHFULLY SERVED AS

Assistant Resident in Obstetrics-Gynecology

FROM July 1, 1968 TO June 30, 1971

CHIEF OF SERVICE

PRESIDENT OF BOARD OF TRUSTEES

Charlotte Ciotti
Notary Republic
My Commission
Expires
August 19, 1996

Mitchell T. Rabkin, MD
GENERAL DIRECTOR

WITNESSED ORIGINAL DOCUMENT.
WILLIAM LA LUZ, JR
NOTARY PUBLIC (ILLINOIS)
COMM. EXPIRES 10/27/99

"OFFICIAL SEAL"
WILLIAM LA LUZ JR.
NOTARY PUBLIC STATE OF ILLINOIS
My Commission Expires 10/27/99

VERIFICATION OF STATE LICENSURE

State Form 7143 (R2 / 10-91)

*** PRIVACY NOTICE ***

This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1. Disclosure is mandatory, and this form will not be processed without it.

HEALTH PROFESSIONS BUREAU
Indiana Government Center South
402 W. Washington St., Rm 041
Indianapolis, Indiana 46204
Telephone: (317) 232-2960

INSTRUCTIONS: Type and complete the top section. Make copies to send to each state that you hold or have held a license. Have the state(s) send this directly to our office.

Name (Last, first, middle, maiden)	Health Profession License Held	Social Security Number *
LEVINE, MARSHALL DAVID	MEDICAL	

Address (Number, street, or rural route)	City	State	ZIP Code
2006 N. HOWE ST., #2	CHICAGO	ILLINOIS	60614-4414

License number	Date of Issuance (month, day, year)	Date of Birth (month, day, year)
A355	1971	5/1/41

I hereby authorize the State of RI., to furnish the Health Profession Bureau of Indiana with the information below.

Signature: Marshall D. Levine

* Required pursuant to IC 4-1-8-1

DO NOT WRITE BELOW THIS LINE

License number	Date of Issuance (month, day, year)	Licensed by
4355	11-371	☐ Exam ☒ Endorsement ☐ Other

Type of Examination	Date of Administration (month, day, year)	Please Affix Board Seal
NBME	Exp. 11-4-71-Lapsed	

Attach subjects, scores, date of examination and average.

License is current and in good standing	License is or has been invalid	Any derogatory information ?
was ☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No

If license has been encumbered in any way, please provide certified copies of all related documents.

FORM COMPLETED BY:

Name	Title	
Nikki Samaras Sears	Chief Hlth Prof. Reg	
Signature	**State Board**	**Date (month, day, year)**
Nikki Samaras Sears	IN Med. Bd	10-26-99

NOS
11-22-99

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OCT 25 1999
BOARD OF MEDICAL DISCIPLINE

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NOV 01 1999
Health Professions Bureau

North Dakota State Board of Medical Examiners

ROLF P. SLETTEN
Executive Secretary and Treasurer

LYNETTE LEWIS
Administrative Assistant

October 25, 1999

Health Professions Bureau
IN Government Center South
402 W. Washington St. Rm 041
Indianapolis, IN 46204

This is to certify that a standard search of the available records of the North Dakota State Board of Medical Examiners indicates the following:

PHYSICIAN:	Marshall David Levine M.D.
DATE OF BIRTH:	05/01/1941
LICENSE NUMBER:	8155
DATE ISSUED:	03/12/1999
EXPIRATION DATE:	12/31/1999
STATUS:	Active - Unconditioned
BASIS OF ISSUANCE:	National Boards
DISCIPLINARY ACTION:	NO

No disciplinary action has been taken against this physician by the North Dakota State Board of Medical Examiners.

TEMPORARY LICENSE **DATE ISSUED**
LT 8155 **FROM** 02/11/1999 **TO** 05/11/1999

PT-Provisional Temporary
LT-Locum Tenens

If our records above show that the license has been disciplined, photocopies from the public file are available upon written request.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this Board.

Sincerely,

COREEN REDMANN
Records Specialist

(Board Seal)

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NOV 01 1999
Health Professions Bureau

CITY CENTER PLAZA • 418 E. BROADWAY AVE., SUITE 12 • BISMARCK, NORTH DAKOTA 58501
PHONE (701) 328-6500 • FAX (701) 328-6505

State of Wisconsin \ DEPARTMENT OF REGULATION & LICENSING

Tommy G. Thompson
Governor

Marlene A. Cummings
Secretary

1400 E. WASHINGTON AVENUE
P.O. BOX 8935
MADISON, WISCONSIN 53708-8935
E-Mail: dorl@mail.state.wi.us
(608) 266-2112
FAX#: (608) 267-0644

CERTIFICATION

10/27/1999

I, Patrick D. Braatz, do hereby certify that I am the director of the Bureau of Health Professions in the Department of Regulation and Licensing, a department of the government of the State of Wisconsin; that I am the custodian of the records of the Medical Examining Board and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT: MARSHALL LEVINE MD
WAS ISSUED LICENSE NO: 36498
ON: 04/28/1995
CREDENTIAL TYPE: Medicine and Surgery
LICENSE EXPIRATION DATE: 10/31/2001

Credential Holder History Section

DATE	CODE DESCRIPTION	PRIMARY DESCRIPTION	SECONDARY DESCRIPTION
04/28/1995	endorsed from	ENDORSED NATIONAL BOARD	
06/03/1967	graduated from		TUFTS U-BOSTON MA

According to our records this credential holder has not been disciplined.

The information above is the only certification information provided by this Department. To expedite the certification process, the above format is the standard format for all professions regulated by this Department.

SEAL

Patrick D. Braatz, Director

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NOV 01 1999
Health Professions Bureau

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

ARGEO PAUL CELLUCCI
GOVERNOR

JANE SWIFT
LIEUTENANT GOVERNOR

NANCY ACHIN SULLIVAN
EXECUTIVE DIRECTOR

MARY ANNA SULLIVAN, M.D.
CHAIR

WALTER B. PRINCE
VICE-CHAIR

PETER N. MADRAS, M.D.
SECRETARY

NISHAN J. KECHEJIAN, M.D.
BOARD MEMBER

ARNOLD S. RELMAN, M.D.
BOARD MEMBER

RAFIK ATTIA, M.D.
BOARD MEMBER

PETER E. GELHAAR
BOARD MEMBER

Date: 11/3/99

To Whom It May Concern:

This is to certify Harshaw Levine, a graduate of Tufts University School of Medicine in the year 1967, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 32027 was issued to Dr. Levine on 1-1570. THIS LICENSE IS EXPIRED.

Our files contain NO open or closed complaints, and NO formal disciplinary actions regarding this physician.

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Health Professions Bureau

SEAL

Mary Anna Sullivan M.D.
Mary Anna Sullivan, M.D., Chair

Please be advised that the above information is based entirely on examination of our open and closed complaint file. It is not based on a review of the application for licensure, renewal of licensure or any reports that the Board is required to receive by statute (from courts, insurers, hospitals, etc...).

[e:share/verify3.doc]

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
Licensing Program
1426 Howe Avenue #56
Sacramento, CA 95825
(916) 263-2360

October 29, 1999

Indiana Health Professions Bureau
402 W. Washington St, Room 041
Indianapolis, IN 46204

TO WHOM IT MAY CONCERN:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

PHYSICIAN:	Marshall David Levine
LICENSE NUMBER:	G20901
ISSUED:	07/20/71
EXAM TYPE:	a written examination
STATUS:	Canceled

This certification is the only information provided by this office. If additional information is needed, it must be obtained directly from the individual, agency or institution which initially generated the information. To expedite the certification process, this is the standard format prepared for all professions regulated by the Medical Board of California.

If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

Kim Marquardt

Kim Marquardt, Manager
Licensing Operations

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NOV 03 1999
Health Professions Bureau

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

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.
2004 N HOWE ST
CHICAGO, IL 60614-4414

LICENSE NUMBER: **75-197**

DATE OF BIRTH: **May 1, 1941**

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.

Julie A. Martinez
Verification Officer

Date: October 29, 1999

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NOV 03 1999
Health Professions Bureau

State of Michigan
John Engler, Governor

Department of Consumer & Industry Services
Kathleen M. Wilbur, Director

Office of Health Services
Thomas C. Lindsay II, Director

Ottawa Building
P.O. Box 30670
Lansing, Michigan 48909-8170
Telephone: 517-335-0918
TDD: 517-373-7489

MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 11/01/1999

HEALTH PROFESSIONS BUREAU
INDIANA GOVERNMENT CENTER SOUTH
402 W WASHINGTON ST RM 041
INDIANAPOLIS IN 46204

Board: 43 Profession 01 ID Number: 062685 Type: R Format: Y

Name: MARSHALL D LEVINE MD SSN:
Address: 2006 N HOWE ST #2 Birth Date: 05/01/1941
CHICAGO IL 60614-4414

Type: MEDICAL DOCTOR Original Date: 09/28/1993
License Number: 4301062685 Status: LICENSED Expiration Date: 01/31/2000
Qualified By: ENDORSEMENT

Fee Received: 10/25/1999

Disciplinary Action: NONE
Open Formal Complaints: NONE

Kari Johnson
Kari Johnson

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NOV 04 1999
Health Professions Bureau

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CERTIFICATION & VERIFICATION UNIT
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, LEVINE MARSHALL DAVID
WAS ISSUED LICENSE/CERTIFICATE NUMBER 194894 FOR THE PRACTICE OF MEDICINE ON 02/07/94.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: 05/01/41
SCHOOL ATTENDED: TUFTS UNIVERSITY
DATE OF GRADUATION: 06/04/67
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:
NAT BD CERT #093965 DATED 7/1/68

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NOV 03 1999
Health Professions Bureau

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: YES REG PERIOD ENDS: 04/30/00
ADDRESS: 2004 N HOWE STREET CHICAGO IL 60614-4414

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I FRANK GEBOSKY, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

Frank Gebosky 10/26/99
PRINCIPAL CLERK

OP026 056

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza 2829 University Avenue SE Suite 400 Minneapolis, MN 55414-3246
**Telephone (612) 617-2130 *Fax (612) 617-2166*
MN Relay Service for Hearing Impaired (800) 627-3529

October 26, 1999

INDIANA HEALTH PROFESSIONS
SERVICE BUREAU
IN Gov't. Center Rm. 41
South Bldg.
INDIANAPOLIS IN 46204

This is to certify that a standard search of the available records of the Minnesota Board of Medical Practice indicates the following:

PHYSICIAN: Marshall Levine
DATE OF BIRTH: May 01, 1941
WAS ISSUED LICENSE NUMBER: 38015
ON: July 08, 1995
EXPIRATION DATE IS: May 31, 2000
STATUS: ACTIVE
ISSUED ON THE BASIS OF: NBME
CORRECTIVE ACTION: NONE
DISCIPLINARY ACTION: NONE

The above format is the standard format prepared for all physicians regulated by this board.

Please be advised that the Board does not release information as to whether there has been a complaint filed or an investigation conducted on individual verifications. All physicians are considered in good standing unless noted otherwise.

If other information is needed, please contact the Minnesota Board of Medical Practice.

Sincerely,

Terri Anderson
Terri Anderson
Licensure Specialist

Illinois Department of Professional Regulation

Leonard A. Sherman
Director

George H. Ryan
Governor

C E R T I F I C A T I O N

December 13, 1999

Health Professions Bureau
Indiana Government Center South
402 W. Washington St., Rm. 041
Indianapolis, IN 46204

I, Russ Friedewald, do hereby certify that I have been designated by the Director as keeper of the records and seal of the Department of Professional Regulation, a department of the government of the State of Illinois, and that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	MARSHALL DAVID LEVINE
WAS ISSUED LICENSE NO:	036-097170
ON:	01-12-98
TO PRACTICE AS A:	LICENSED PHYSICIAN AND SURGEON
LICENSED BY:	ENDORSEMENT FROM MA
CURRENT LICENSURE STATUS IS:	ACTIVE
CURRENT LICENSE EXPIRES:	07-31-2002

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED.

The information above is the only certification information provided by this Department. If other information is needed, it must be obtained from the above-named individual or the agency or institution which initially generated the information. To expedite the certification process, the above format is the standard format prepared for all professions regulated by this Department.

Russ Friedewald
Division Manager
Licensing & Testing

S E A L

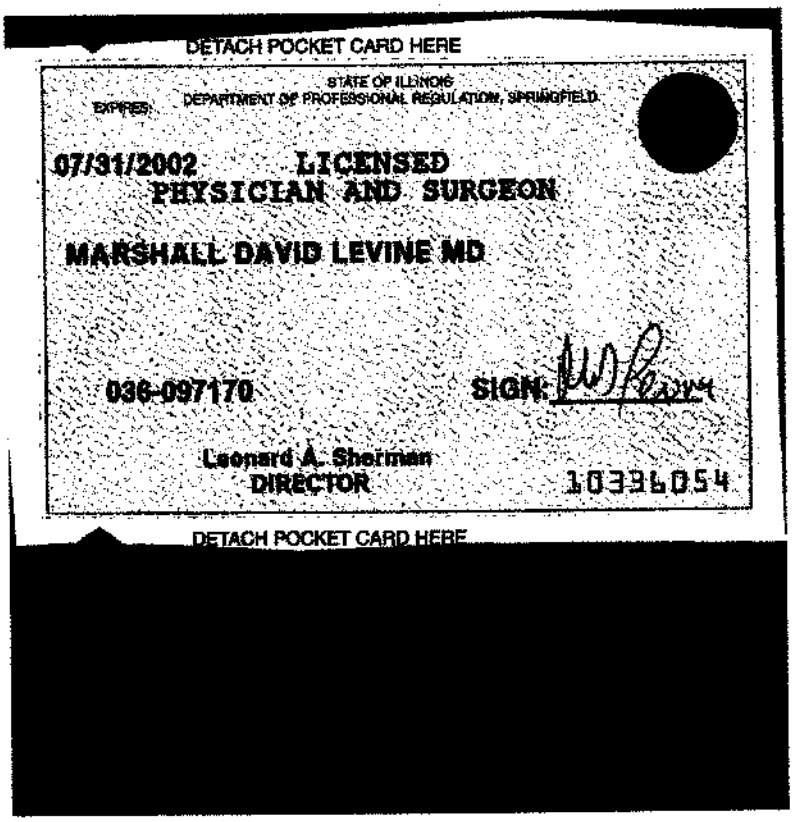
RECEIVED
DEC 17 1999
Health Professions Bureau

Respond to:
☐ 320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800
TDD 217/524-6735

http://www.state.il.us/dpr

☐ James R. Thompson Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/814-4500

TA


DETACH POCKET CARD HERE

STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION, SPRINGFIELD

EXPIRES:

07/31/2002 LICENSED
PHYSICIAN AND SURGEON

MARSHALL DAVID LEVINE MD

036-097170 SIGN:

Leonard A. Sherman
DIRECTOR

10336054

DETACH POCKET CARD HERE

WITNESSED ORIGINAL DOCUMENT.
WILLIAM LALUZ, SR.
NOTARY PUBLIC (ILLINOIS)
COMM. EXPIRES 10/27/99

"OFFICIAL SEAL"
WILLIAM LA LUZ JR.
NOTARY PUBLIC STATE OF ILLINOIS
My Commission Expires 10/27/99

RECEIVED

OCT 27 1999

Health Professions Bureau