Date Approved: 3-18-92

License No.: 059142

Approved by: KO

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATION
BOARD OF MEDICINE
P.O. BOX 30492
LANSING, MICHIGAN 48909
(517) 373-0630

LMD-040 (5/90)

This form is required by P.A. 368 of 1978 in order for you to be licensed in Michigan

APPLICATION FOR MEDICAL AND CONTROLLED SUBSTANCE LICENSES

I am applying for the following:

- ☐ License by examination (National Boards or FLEX) $90.00
- ☒ License by endorsement (Must be currently licensed in another state) $90.00
- ☒ Controlled Substance License $60.00

I am applying on the basis of the following examination:

☐ FLEX ☒ NATIONAL BOARDS ☐ OTHER

NAME OF APPLICANT (last, first, middle)	LIST PREVIOUS NAME(S) USED:
Puder, Karoline Suzanne	—

ADDRESS (no., street, city, state, ZIP)

333 E. 93rd St., New York NY 10128

DATE OF BIRTH	SOCIAL SECURITY NUMBER
[redacted]	[redacted]

CHECK THE APPROPRIATE ANSWER TO EACH OF THE FOLLOWING QUESTIONS. ATTACH DETAILED EXPLANATION FOR ANY YES ANSWER YOU CHECK.

Have you ever been convicted of a crime?	☐ YES	☒ NO
Have you ever been under treatment for addition or insobriety?	☐ YES	☒ NO
Have you ever been warned, censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges modified?	☐ YES	☒ NO
Are you now or have you ever been a defendant in a medical malpractice civil suit?	☐ YES	☒ NO
Have you ever been refused a license to practice professionally for any reason by any state or federal agency?	☐ YES	☒ NO
Have you ever been denied the privilege of taking an examination by any state medical board?	☐ YES	☒ NO
Have you ever had your medical or controlled substance license, certificate, registration or approval revoked or syspended, or have you ever been otherwise disciplined by a medical board or a board responsible for regulating controlled substances?	☐ YES	☒ NO
Do you currently have any charges or complaints pending against you before a medical board or a board responsible for regulating controlled substance?	☐ YES	☒ NO
Have you ever held a restricted state or federal license, certificate, registration, or approval?	☐ YES	☒ NO
Do you hold or have you ever held a medical license in this or any other state? If yes, list each state below and the date such license was issued and cause certification of license in good standing to be submitted directly from all other states:	☒ YES	☐ NO

New York 8/16/89

Provide a complete chronological record of all your educational preparation and work experience to the present date. Attach additional sheets if necessary.

NAME AND ADDRESS OF INSTITUTION	DATES OF ATTENDANCE From	To	DEGREE OBTAINED
City College of the City Univ. of New York.	9/81	6/86	B.S.
Mt. Sinai School of Medicine, NY	8/86	6/88	M.D.
Mt. Sinai Medical Center, Newyork NY Dept. of Obs/Gyn	7/88	Present	

I understand that it is the policy of the Department of Licensing and Regulation to secure conviction criminal history information as part of their pre-licensure screening process, and I authorize the department to use the information provided in this application to obtain a conviction criminal history file search from the Central Records Division of the Michigan Department of State Police. I hereby certify that the information in this application is true and correct and I hereby make application for medical licensure in Michigan.

Signature [signature] Date 2/18/92

Subscribed and sworn to before me this 19th day of February, 1992

Signature of Notary Public Kathuryn E. Green

County of New York My commission expires 12/29/92

KATHURYN E. GREEN
Notary Public, State of New York
No. 31-4872970
Qualified in New York County
Commission Expires December 29, 1992

CONTROLLED SUBSTANCE LICENSE APPLICATION

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. A separate controlled substance license is required for each business location from which you manufacture, distribute, prescribe, or dispense controlled substances. If you will practice at an additional location or in a methadone program, please request in writing an Application for Additional Location from the Michigan Board of Pharmacy, P.O. Box 30018, Lansing, Michigan 48909.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 357 Federal Building, 231 Lafayette, Detroit, Michigan 48226 (Telephone 313-226-7290).

I hereby make application for a Michigan controlled substance license.

Signature [signature] Date 2/18/92

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CUSTOMER SERVICE UNIT
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

3 1 6 92

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, PUDER KAROLINE SUZANNE
WAS ISSUED LICENSE/CERTIFICATE NUMBER 179533 FOR THE PRACTICE OF MEDICINE ON 08/16/89.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: [redacted]
SCHOOL ATTENDED: MT SINAI SCHOOL MEDICINE
DATE OF GRADUATION: 05/17/88
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 #360356 DATED 07/03/89

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: 12/31/92
ADDRESS: 333 E 93RD STREET NEW YORK NY 10128-0000

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

COMMENTS:

I FRANCES HARRIS, 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

Frances Harris 03/10/92
PRINCIPAL CLERK

OP026 028

OPR/BHS-001 (11/91)

State of Michigan
Office of Health Services
P. O. Box 30018
Lansing, Michigan 48909

VERIFICATION OF LICENSURE OR REGISTRATION

AUTHORITY: Public Act 368 of 1978, as amended. Failure to complete may result in applicant being denied licensure in Michigan.

PART I: To be completed by the applicant and forwarded to the appropriate State licensing board for completion.

1. Please indicate profession for which you are requesting verification:

☐ Chiropractic	☐ Optometry	☐ Podiatry
☐ Counseling	☐ Osteopathy	☐ Psychology
☐ Dentistry	☐ Pharmacy	☐ Sanitarians
☒ Medicine	☐ Physical Therapy	☐ Veterinary
☐ Nursing	☐ Physician's Assistants	☐ _____

2. Applicant's Full Name (First, Middle, Last): Karoline Suzanne Puder

3. Previous Names Used:	4. Date of Birth:	5. Social Security Number:
—	[redacted]	[redacted]
6. State Board:	**7. License Number:**	**8. Date of Issue:**
New York	179533	8/16/89

PART II: To be completed by the State Licensing Board

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

1. Basis for Issuance of License:
   - ☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
   - ☐ Endorsement - Please indicate name of State:

2. License Status:	3. Original Issue Date:	4. Expiration Date:
☐ Current ☐ Lapsed ☐ Inactive		

5. Has the applicant incurred any disciplinary proceedings in your State?
   ☐ No ☐ Yes - If Yes, please attach **certified** copies of any actions.

6. Are disciplinary proceedings pending?
   ☐ No ☐ Yes

7. Has the applicant's license ever been **limited, denied, surrendered, reprimanded, suspended or revoked?**
   ☐ No ☐ Yes - If Yes, please attach **certified** copies of any actions.

RECEIVED
MAR 10 1992
RAU

AFFIDAVIT

I hereby certify that, to the best of my knowledge, the information above is true to the records of this board.

Signature _____ Date _____

Type or Print Name _____

Title _____ (SEAL)

Full Name of Licensing Board _____

LMD-200 (7/89)

State of Michigan
Department of Licensing and Regulation
BOARD OF MEDICINE
P.O. Box 30192
Lansing, Michigan 48909

This form is required by P.A. 368 of 1978 in order for you to be licensed in Michigan.

CERTIFICATION OF POSTGRADUATE TRAINING

APPLICANT INSTRUCTIONS

Type or print your name in Section I exactly as it appears on your application. Send this form to be completed and mailed directly to the board by the director of medical education where you completed your postgraduate training.

SECTION I: APPLICANT INFORMATION

NAME OF APPLICANT (last, first, middle)
Puder, Karoline Suzanne

ADDRESS (no., street, city, state, ZIP)
333 E. 93rd St, NY, NY 10128

SOCIAL SECURITY NUMBER
[redacted]

DATE OF BIRTH
[redacted]

SECTION I: APPLICANT INFORMATION

HOSPITAL NAME
Mt. Sinai Medical Center

HOSPITAL'S COMPLETE ADDRESS
1 Gustave L. Levy Pl., New York, NY 10029

I certify that Karoline Puder a graduate of the Mount Sinai medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 7/1 19 88 through present 19 ____ in the clinical area of OBS/Gyn.

2/19/92
Date

[signature] MD
Signature of Director of Medical Education

Michael Brodman
Type or Print Name of Director of Medical Education

(SEAL)

No seal
If hospital has no seal, please so indicate.

Is this training program accredited by ACGME or by the national joint committee on accreditation of preregristration physican training programs of the Canadian medical association?

☐ YES ☒ NO

NOTE: Certification of postgraduate training will not be accepted if certified more than 15 days prior to actual completion.

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Karoline Suzanne Puder, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest L. THOMPSON BOWLES, M.D., PH.D.
Chairman of the Board

SEAL ROBERT L. VOLLE, PH.D.
President of the Board

Philadelphia, Pa.
07/03/89

Certificate # 360356

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from MT SINAI SCHOOL MEDICINE in MAY 1988 and whose birth date is [redacted]. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/86		
Anatomy	[redacted]	
Physiology		
Biochemistry		
Pathology		
Microbiology		
Pharmacology		
Behavioral Sciences		
TOTAL TEST (Minimum Passing Score 380/75)		
PART II passed 09/87		
Medicine	[redacted]	
Surgery		
Obstetrics and Gynecology		
Public Health and Preventive Medicine		
Pediatrics		
Psychiatry		
TOTAL TEST (Minimum Passing Score 290/75)		
PART III passed 03/89		
A General Test of Clinical Competence	[redacted]	
TOTAL TEST (Minimum Passing Score 290/75)		
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		[redacted]

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Melanie Valente
Secretary for Certification

SEAL

03/06/92
Date