MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
ONLINE APPLICATION FOR A MEDICAL DOCTOR
OBTAINED BY WEB ENDORSEMENT < 10 YEARS

Amount Paid - $150.00
Date Paid - 07/09/2010

License #	047541
License #	
Issue Date	8/31/10

FIRST NAME:	MIDDLE NAME:	LAST NAME:	SUFFIX:
Jennifer	Marie	Brown	

SSN:	DATE OF BIRTH:	DAYTIME TELEPHONE NUMBER:
[redacted]	[redacted]	[redacted]

License Address - [redacted]

Email Address - [redacted]

APPLICATION QUESTIONS

Have you been convicted of a felony?	N
Have you been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	N
Have you been convicted of a misdemeanor involving the illegal delivery, possession or use of alcohol or a controlled substance (including motor vehicle violations)?	N
Have you been censured or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?	N
Have you been treated for substance abuse in the past 2 years?	N
Have you had 3 or more malpractice settlements, awards or judgments in any consecutive 5 year period?	N
Have you had one or more malpractice settlements, awards or judgments totaling $200,000 or more in any consecutive 5 year period?	N
Have you had a federal or state health professional or registration revoked, suspended or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	N
Have you been denied the privilege of taking an examination by any state medical board?	N
If you have held a permanent license in another state, list the state's in which you hold or have held a medicine license.	Illinois
If you ever held a health professional license in Michigan, please provide the Permanent ID Number (License Number) and Expiration date	
<font face='arial, helvetica, sans-serif' color='#000000' size='2'>List all previous names used.	

EDUCATION School Name	DATE FROM	DATE TO
UT-Houston Medical School Houston, TX , U.S.A.	07/01/1999	06/30/2003

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

APPLICATION FOR MEDICAL DOCTOR LICENSE

Authority: Public Act 368 of 1978, as amended

If this form is not completed, a license will not be issued

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. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539)

[redacted]

License Number

Controlled Substance License Number 091103

Date of Licensure 8/31/10

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- [X] **License by Examination Fee: $150.00 71-4301-01**
- [X] **Controlled Substance Fee: $85.00 43-01 71-5315**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
Jennifer	Marie	Brown
U.S. Social Security Number	**Date of Birth**	**Daytime Phone Number**
[redacted]	[redacted]	[redacted]
Street Address		
[redacted]		
City	**State**	**ZIP Code**
[redacted]	[redacted]	[redacted]
All Previous Names and/or Birth Name Used (if applica		
[redacted]		

Have you ever held a health professional license in Michigan?	Michigan Permanent I.D. Number and Expiration Date
☐ Yes ☒ No	

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	☐ Yes	☒ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	☐ Yes	☒ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ Yes	☒ No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes	☒ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	☐ Yes	☒ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☒ No
7. Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes	☒ No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	☐ Yes	☒ No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name: Jennifer Marie Brown

9. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privilege involuntarily modified? ☐ Yes ☒ No

10. Do you hold or have you ever held a permanent medical license in any state, U.S. Territory or Canadian Province? If yes, list the state(s) U.S. Territory or Province in which you hold or have held a medicine license, the license or registration number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. **You must have each licensing agency verify licensure directly to this board office. (Attach additional sheets, if necessary)** ☒ Yes ☐ No

State, U.S. Territory or Province	License Number	Date of Issue	How obtained (Endorsement or examination)
Illinois	036.112814	2007	Examination

Provide a complete chronological record of your educational preparation.
Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From	To	Degree
Loyola University Medical Center 2160 S. First Ave Maywood IL 60153	7/2004	6/2007	Internship, Residency
University of Texas-Houston Medical School 6431 Fannin St, MSB 6.420 Houston, TX 77030	7/1999	6/2003	M.D.

Provide a description of your professional medical experience.
Attach additional sheets if necessary.

Name and Address of Employer	Dates of Practice From	To	Duties
Planned Parenthood of Illinois 18 S. Michigan Ave, 6th Floor Chicago IL 60603	8/2007	7/2010 (current)	Provide IV sedation, airway management
Affiliated Health Group, Ltd. 1616 N. Arlington Heights Rd. #110 Arlington Heights, IL 60004	6/2010	7/2010 (current)	Provide IV Sedation, airway management

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant: Jennifer M. Brown

Date: 7/16/2010

STATE OF MICHIGAN

JENNIFER M. GRANHOLM
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

Name : Jennifer Marie Brown
License Number : Pending
Tracking Number : 2216540
Profession : Medicine
License Type : Medical Doctor
Process : Apply for Initial License process

Certification:

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization. I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country. The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature : Jennifer Marie Brown

Sign on the signature line and mail this page along with any required attachments to:

Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

Print Page

Close Window

Norris, Brittany

From: allasresponse@michigan.gov
Sent: Thursday, August 05, 2010 1:52 AM
To: bhpdata
Subject: Administrative Hit/No Hit Notification

STATE OF MICHIGAN
DEPARTMENT OF STATE POLICE
CRIMINAL RECORDS DIVISION
PO BOX 30634, LANSING MI 48913

DATE: 08/05/2010

TCN: AD10961729K01

Requester: MI DEPT OF COMMUNITY HEALTH
Reason Printed: LHP - Licensed Health Care Professional (MCL 333.16174) Subject Printed: BROWN, JENNIFER M
DOB: [redacted]

The following e-mail response(s) is computer generated and is based on the criminal history information on file as of the date noted above.

Since entry of new arrests, court dispositions for prior arrests or other database changes occur daily, a future record search for this person could be different.

STATE RESPONSE:
A Michigan record has not been found that meets the dissemination criteria.

FBI RESPONSE:
An FBI record has not been found that meets the dissemination criteria.

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

PAT QUINN
Governor

BRENT E. ADAMS
Secretary

DONALD W. SEASOCK
Acting Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

August 16, 2010

BUREAU OF HEALTH PROFESSIONS
PO BOX 30670
LANSING, MI 48909

Licensee:	JENNIFER M BROWN
License Number:	036.117814
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	03/09/2007
Expiration Date:	07/31/2011
License Status:	ACTIVE
License Method:	LIC BY EXAM - USMLE
Disciplinary History:	Has not been disciplined

RECEIVED
AUG 18 2010
DEPT. OF LEG

Temporary certificate physician and surgeon no. 125-047377 was issued with a starting date of 07/01/2004. No disciplinary action on file. This was a medical residency training certificate only.

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

Donald W. Seasock
Acting Director
Division of Professional Regulation

ILL. DEPT. OF FINANCIAL & PROFESSIONAL REGULATION
DIV. OF PROFESSIONAL REGULATION

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

Please contact the *Division of Professional Regulation, Licensure Maintenance Unit*, at 217-782-0458 if you have any questions.

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Jennifer	Marie	Brown
Social Security Number	**Date of Birth**	**Daytime Telephone Number**
[redacted]	[redacted]	[redacted]
Street Address		
[redacted]		
City	**State**	**ZIP Code**
[redacted]	[redacted]	[redacted]
All Previous Names and/or Birth Name Used (if applicable)		
—		
Date of Admission		**Date of Graduation**
Fall 1999		Spring 2003

Signature of Applicant	Date
Jennifer Marie Brown	7/16/2010

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

Name Jennifer Marie Brown

TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

INSTRUCTIONS FOR COMPLETING SECTION II:
Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School

University of Texas Health Science Center at Houston Medical School

Street Address of Medical School

7000 Fannin Street Ste 2250

City, State and ZIP Code

Houston, Texas

I certify that Jennifer Marie Brown (Applicant's Name) attended the medical school named above from 8/16/1999 (Month/Day/Year) to 5/31/2003 (Month/Day/Year) and was/will be granted the degree of Doctor of Medicine on June 7, 2003 (Month/Day/Year)

Robert L Jenkins
Signature of Dean or Registrar

August 2, 2010
Date of Signature

(S E A L)

Robert L. Jenkins
Print or Type Name of Dean or Registrar

If school has no seal, please indicate

JKO

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

CERTIFICATION OF POSTGRADUATE TRAINING

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Jennifer	Marie	Brown
Social Security Number	**Date of Birth**	
[redacted]	[redacted]	
Street Address		
[redacted]		
City	**State**	**ZIP Code**
[redacted]	[redacted]	[redacted]
Daytime Telephone Number	**All Previous Names and/or Birth Name Used (if applicable)**	
[redacted]	—	

Signature of Applicant	Date
Jennifer Marie Brown	7/16/2010

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.

Name: Jennifer Marie Brown

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital: Loyola University Medical Center

Street Address of Hospital: 2160 S. 1st Ave ~~Ann~~

City, State and ZIP Code: Maywood, IL 60546

I certify that Jennifer Brown M.D. (Applicant's Name) a graduate of the University of Texas medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 07/01/04 (Month/Day/Year), to 08/10/07 (Month/Day/Year)

In the clinical area of Clinical Base Year Internship/Anesthesiology

* successfully completed 2 years and 6 months of postgraduate clinical training between above dates.

Is this an active training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? ☒ Yes ☐ No

Amy Murray MD

Signature of Director of Medical Education

7/29/10

Date of Signature

Amy Murray MD

Print or Type Name of Director of Medical Education

If hospital has no seal, please indicate

FOSTER G. McGAW HOSPITAL LOYOLA UNIVERSITY SEAL OF CHICAGO MAYWOOD ILLINOIS

NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.

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

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

Date : 07/26/2010

Recipient:

Michigan Board of Medicine
ATTN: Carole Hakala Engle, Licensing Director
611 W Ottawa
1st Floor
Lansing, MI 48933

Examinee: Brown, Jennifer
Alt Name(s): Brown, Jennifer Marie

Examinee ID#: 5-093-147-6
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

		Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
06/13/2001	[redacted]					

USMLE STEP 2

Clinical Knowledge (CK)

		Three-Digit Score		Two-Digit Score		
Test Date	Pass/Fail	Total	MP	Total	MP	Comments
11/25/2002	[redacted]					

USMLE STEP 3

		Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
ILLINOIS	02/13/2006	[redacted]					

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