

860148 0359

SECTION 3 CERTIFICATE OF MORAL CHARACTER

(TO BE COMPLETED BY TWO PHYSICIANS WITH AN UNRESTRICTED LICENSE IN GOOD STANDING IN THE UNITED STATES)

I hereby certify that I know the applicant to be of good moral character and, to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania. I have been personally acquainted with the applicant for year(s) 6 month(s). (Explain your professional affiliation or relationship with applicant)

James Rosenberg
SIGNATURE

5/2/86
DATE

FRANK ROSENBERG M.D. PA No. 021855-1
PRINT OR TYPE NAME AS SIGNED ABOVE STATE LICENSED LICENSE NUMBER
(AMER. BY 1) Check if necessary

I hereby certify that I know the applicant to be of good moral character and, to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania. I have been personally acquainted with the applicant for year(s) 10 month(s). (Explain your professional affiliation or relationship with applicant)

James Dr. Eisenberg, resident for 10 weeks and found him to have a good moral character.

Vicki March
SIGNATURE

5/8/86
DATE

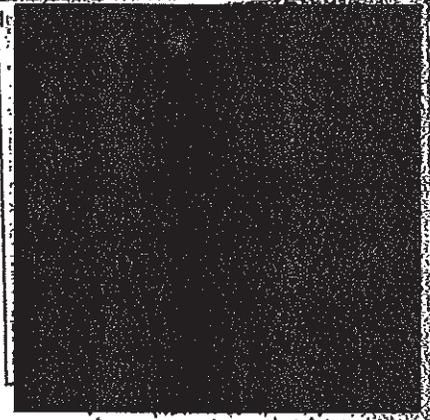
Dr. MARSH M.D. PA No. 011034-1886
PRINT OR TYPE NAME AS SIGNED ABOVE STATE LICENSED LICENSE NUMBER
(AMER. BY 1) Check if necessary

SECTION 4 AFFIDAVIT AND PHOTOGRAPH CERTIFICATE

STATE OF
COUNTY OF

I, David Eisenberg, being duly sworn according to law depose and say that in the deponent completing this application and that all statements therein are true and complete to the best of my knowledge and belief

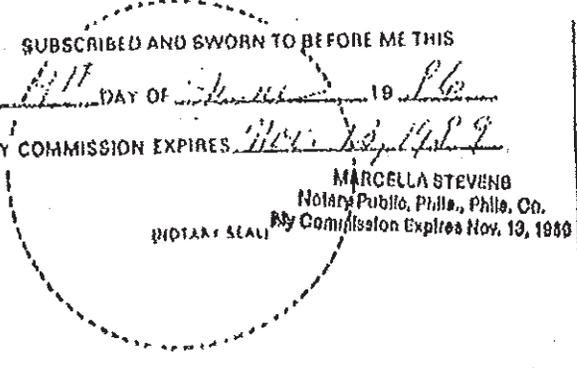
David Eisenberg
SIGNATURE OF APPLICANT



SUBSCRIBED AND SWORN TO BEFORE ME THIS

11 DAY OF June 19 86

MY COMMISSION EXPIRES Nov. 13, 1989



NOTARY TO COMPLETE THIS SECTION AND IMPRINT PART OF SEAL ON PHOTOGRAPH AS SHOWN

I hereby certify the photograph attached above is the likeness of the applicant making the sworn statement.

Marcella Stevens June 9, 1986
SIGNATURE OF NOTARY DATE

GRADUATE TRAINING CERTIFICATE

860148

STATE BOARD OF MEDICINE
PO BOX 2648 HARRISBURG PA 17105-2648
(717) 787-2281



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE

DATE
6/30/86

NAME OF APPLICANT - LAST FIRST MIDDLE <i>Vincenzo, Paul Lee</i>			NAME OF HOSPITAL <i>Hahnemann Hospital</i>		
STREET ADDRESS [REDACTED]			STREET ADDRESS <i>Broad & Vine Street</i>		
CITY [REDACTED]	STATE [REDACTED]	ZIP CODE [REDACTED]	CITY <i>Phil</i>	STATE <i>PA</i>	ZIP CODE <i>19104</i>

FILL IN NUMBER OF MONTHS OF TRAINING BY SPECIALTY DEPARTMENT HEAD MUST SIGN FOR EACH SPECIALTY	PERIOD OF TRAINING					
	MONTH	BEGINNING DAY	YEAR	MONTH	ENDING DAY	YEAR
	6	23	85	6	23	86

SPECIALTY	NO MOS	SIGNATURE OF PROFESSIONAL DEPARTMENT HEAD	SPECIALTY	NO MOS	SIGNATURE OF PROFESSIONAL DEPARTMENT HEAD
ALLERGY IMMUNOLOGY			PATHOLOGY		
ANESTHESIOLOGY			PEDIATRICS		
DERMATOLOGY			PHYSICAL MEDICINE		
EMERGENCY PRACTICE			PREVENTIVE MEDICINE		
FLORIDA			PSYCHIATRY		
INTERNAL MEDICINE	12	<i>R. DeHoratius</i>	RADIOLOGY		
NEUROLOGY			SURGERY		
NUCLEAR MEDICINE		<i>ANT - 014496-T</i>	UROLOGY		
OBSTETRICS GYNECOLOGY		<i>7-1-85</i>	OTHER		
OPHTHALMOLOGY		<i>6-30-86</i>			
OTO-LARYNGOLOGY					

NOTE: Signature of professional Department Head Above Must Be Other Than The Signature of the HOSPITAL HEAD Below of Applicant Will Be Returned

THIS SPACE FOR HOSPITAL ADMINISTRATION ONLY

PLACE SEAL OF HOSPITAL OVER SIGNATURE OF HOSPITAL HEAD.
Notaric statement required if hospital has no seal.

I HEREBY CERTIFY THAT THE APPLICANT HAS RENDERED SATISFACTORY SERVICE AS A RESIDENT AT THIS HOSPITAL. I ALSO CERTIFY THAT THE APPLICANT IS A PERSON OF GOOD MORAL CHARACTER, AND THAT HE/HIS HAS PROVEN TO BE WORTHY OF THE MEDICAL PROFESSION.
Signature of HOSPITAL HEAD: *Joseph K. Hartgering*
DATE: *6/30/86*

To be completed by the hospital where applicant did approved graduate training. Return to applicant

CERTIFICATE OF MEDICAL EDUCATION



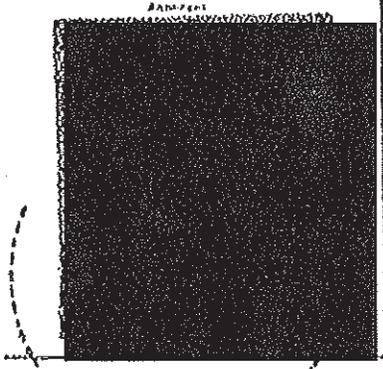
COMMONWEALTH OF PENNSYLVANIA
 DEPARTMENT OF STATE

MT-014496-T

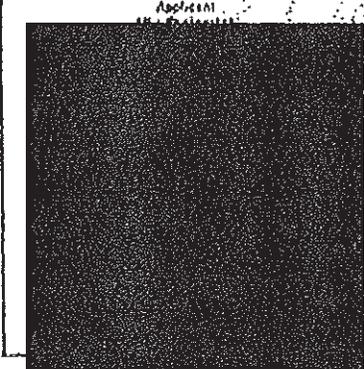
TO BE COMPLETED BY APPLICANT

NAME OF APPLICANT (Last, First, Middle) Leach, David Lee DATE 5/12/86
 STATE ADDRESS [REDACTED] ZIP CODE [REDACTED] TELEPHONE NO. OF APPLICANT [REDACTED]
 NAME OF MEDICAL SCHOOL Lehigh Medical School
 STREET ADDRESS 2132 N. Green Bay Road CITY Lehigh, PA STATE OR COUNTRY PA ZIP CODE 18106
 SIGNATURE OF APPLICANT David Leach
 ATTENTION: TWO 2x2 PHOTOGRAPHS IN SPACES PROVIDED BELOW

TO BE COMPLETED BY DEAN OR REGISTRAR



Two photographs are likeness of applicant
 IMPRINT SCHOOL, SEAL OVER
 PART OF EACH PHOTOGRAPH



BEGINNING DATE			GRADUATION DATE		
MONTH	DAY	YEAR	MONTH	DAY	YEAR
8	5	81	5	14	85

I hereby certify that (1) The applicant has graduated from the above named medical school (2) The applicant's signature above appears to be genuine; and (3) the photographs above are a true likeness of the applicant.

Melton B. Beards
 SIGNATURE OF DEAN OR REGISTRAR
 PLACE SEAL OF SCHOOL OVER SIGNATURE

May 27, 1986
 DATE

NOTE: If the applicant transferred to your school, please submit a letter of explanation.

To be completed and certified by the dean or registrar of the medical school. Do not return to applicant.
 RETURN DIRECTLY TO BOARD AT ADDRESS ABOVE

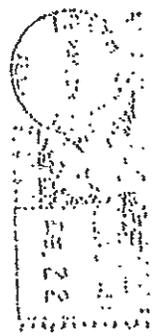
Admissions and
Records



3303 Grand Ave. Room 202
North Chicago, Illinois 60064

University of
Health Sciences/The Chicago
Medical School

State Board of Medicine
P. O. Box 2649
Harrisburg, Pa. 17105-2649



OFFICE OF THE
SECRETARY