8 6 0 1 4 8 0 3 5 9

STATE BOARD OF MEDICINE
P.O. BOX 2649 HARRISBURG PENNSYLVANIA 17105-2649
(717) 787-2381

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE AND SURGERY

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE

Exam Date: 8-6-86
Deadline:
Required for Scheduling: Pgs 1,1a,2,6 for and ECFMG Certification

(PLEASE PRINT OR TYPE)

SECTION 1 PERSONAL DATA

LAST NAME: EISENBERG FIRST: DAVID MIDDLE: Lee

STREET ADDRESS: [redacted]

CITY: [redacted] STATE: ZIP CODE:

NOTIFY BOARD OF ANY NAME OR ADDRESS CHANGE WITHIN 15 DAYS
LICENSE AND CORRESPONDENCE WILL BE SENT TO THE ABOVE ADDRESS

THIS APPLICATION IS FOR (Check One) FEE

- ☐ SITTING FOR FLEX I IN PA $175.00
- ☐ SITTING FOR FLEX II IN PA $200.00
- ☐ SITTING FOR FLEX I AND II IN PA $275.00
- ☒ ENDORSEMENT $100.00

ALL FEES MUST BE MADE PAYABLE TO THE COMMONWEALTH OF PENNSYLVANIA

APPLICATION FEES ARE NOT REFUNDABLE

DATE OF BIRTH: [redacted] PLACE OF BIRTH: [redacted] U.S. CITIZEN: ☒ Yes ☐ No HOW CITIZENSHIP OBTAINED: ☒ Birth ☐ Naturalization SOCIAL SECURITY NUMBER: [redacted]

VISA STATUS: ☐ Exchange Student ☐ Immigrant ☐ Immigrant Petition ☐ Other

DO YOU INTEND TO BECOME A U.S. CITIZEN: ☐ Yes ☐ No

Name of Medical School(s) Attended: Chicago Medical School

Dates of Attendance: 8/81 (Mo Yr) to 5/85 (Mo Yr)

(Mo Yr) to (Mo Yr)

Type of Examination (check one)

- X National Board
- ___ FLEX
- ___ LMCC-Canadian
- ___ State Board
- ___ Name State ___

22112
100.00
Pd
TYP
TRANS 7-8-86

SECTION 2 HISTORY

1. By this application are you applying to take the FLEX in Pennsylvania? ☐ Yes ☒ No
   If yes have you previously taken the FLEX in PA or any other state? ☐ Yes ☒ No
   If yes give date (month and year) and location of each examination ☐ Yes ☒ No

2. List all states, territories and countries in which you have possessed a license to practice medicine and surgery (active or inactive)

   None

3. Have you ever had an application for a license denied in another state, territory or jurisdiction of the United States or in any other country? ☐ Yes ☒ No
4. Have you ever possessed a license to practice medicine or surgery (or other professional license) that was revoked, suspended or subjected to other disciplinary conditions? ☐ Yes ☒ No
5. Have you ever had provider privileges denied or restricted by a drug enforcement agency, medical assistance agency or other authority? ☐ Yes ☒ No
6. Are you or have you ever been addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? ☐ Yes ☒ No
7. Have you ever been convicted of a crime (other than parking or traffic violation) in the courts of Pennsylvania or any other state, territory or country? ☐ Yes ☒ No

If you have answered Yes to any of the above questions, please give details on a separate 8½ x 11 sheet

To Be Completed by Applicant

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)

Preceptor

Frank Rosenberg — 5/8/86

SIGNATURE — DATE

FRANK ROSENBERG M.D. PA MD 021855

PRINT OR TYPE NAME AS SIGNED ABOVE — STATE LICENSED — LICENSE NUMBER

(Attach 8½ x 11 Sheet 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 applicant for _____ year(s) 10 month(s). (Explain your professional affiliation or relationship with applicant)

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

Vicki March — 5/8/86

SIGNATURE — DATE

VICKI MARCH M.D. Pennsylvania MD034968

PRINT OR TYPE NAME AS SIGNED ABOVE — STATE LICENSED — LICENSE NUMBER

(Attach 8½ x 11 Sheet If Necessary)

SECTION 4 AFFIDAVIT AND PHOTOGRAPH CERTIFI[redacted]

STATE OF

COUNTY OF

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

NAME OF APPLICANT

David Eisenberg

SIGNATURE OF APPLICANT

SUBSCRIBED AND SWORN TO BEFORE ME THIS

11th DAY OF June 19 86

MY COMMISSION EXPIRES Nov. 13, 1989

MARCELLA STEVENS
Notary Public, Phila., Phila. Co.
My Commission Expires Nov. 13, 1989

(NOTARY SEAL)

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 11, 1986

SIGNATURE OF NOTARY — DATE

Applicant – Have Completed and Notarized

(2)

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GRADUATE TRAINING CERTIFICATE

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE

DATE: 6/30/86

NAME OF APPLICANT-LAST FIRST MIDDLE: Tinsley, Paul Lee

NAME OF HOSPITAL: Hahnemann Hospital

STREET ADDRESS: [redacted]

STREET ADDRESS: Broad & Vine Street

CITY STATE ZIP CODE: [redacted]

CITY: Phil STATE: PA ZIP CODE: 19107

FILL IN NUMBER OF MONTHS OF TRAINING BY SPECIALTY
DEPARTMENT HEAD MUST SIGN FOR EACH SPECIALTY

PERIOD OF TRAINING

BEGINNING MONTH	BEGINNING DAY	BEGINNING YEAR	ENDING MONTH	ENDING DAY	ENDING 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		
FAMILY PRACTICE			PREVENTIVE MEDICINE		
FEMORALE			PSYCHIATRY		
INTERNAL MEDICINE	12	R J DeHoratius	RADIOLOGY		
NEUROLOGY		MT-014496-T	SURGERY		
NUCLEAR MEDICINE			UROLOGY		
OBSTETRICS GYNECOLOGY		7-1-85 6-30-86	OTHER		
OPHTHALMOLOGY			NOTE: Signature of professional Department Head Above Must Be Other Than The Signature of the HOSPITAL HEAD Below or Application Will Be Returned		
OTOLARYNGOLOGY					

THIS SPACE FOR HOSPITAL ADMINISTRATION ONLY

PLACE SEAL OF HOSPITAL OVER SIGNATURE OF HOSPITAL HEAD.

NOTARIZE 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/SHE HAS PROVEN TO BE WORTHY OF THE MEDICAL PROFESSION.

Signature of HOSPITAL HEAD: [illegible]

DATE: 6/30/86

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

(3)

8 6 0 1 4 8 0 3 5 9

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CERTIFICATE OF MEDICAL EDUCATION

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE

[MT-01496-T]

TO BE COMPLETED BY APPLICANT

NAME OF APPLICANT (Last, First, Middle) Lindsey, David Lee	DATE 5/12/86
STREET ADDRESS [redacted]	ZIP CODE / TELEPHONE NO. OF APPLICANT [redacted]
NAME OF MEDICAL SCHOOL Loyola Medical School	
STREET ADDRESS 2160 N. Green Bay Road	CITY North Chicago, Ill. / STATE OR COUNTRY / ZIP CODE
ATTACH TWO (2) PHOTOGRAPHS IN SPACES PROVIDED BELOW	SIGNATURE OF APPLICANT David Lindsey

TO BE COMPLETED BY DEAN OR REGISTRAR

Applicant [redacted]

(SEAL IMPRINT)

If Photographs are Likeness of Applicant
IMPRINT SCHOOL SEAL OVER
PART OF EACH PHOTOGRAPH

Applicant [redacted]

(SEAL IMPRINT)

BEGINNING DATE			GRADUATION DATE		
MONTH	DAY	YEAR	MONTH	DAY	YEAR
8	3	81	6	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.

Milton A. Gaynor
SIGNATURE OF DEAN OR REGISTRAR
PLACE SEAL OF SCHOOL OVER SIGNATURE

(SEAL)

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

(4)

Admissions and
Records

University of
Health Sciences/The Chicago
Medical School

3333 Green Bay Road
North Chicago, Illinois 60064

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