K-1
7-6

S.S Redacted

REVIEW SHEET

MALE / FEMALE

AOG: ✓
AMG: ____ CMG: ____
FMG: ____ DPM: ____
FLEX: ____
ENDORSEMENT: NB

NAME: EVANS, Mark Lisa

BIRTHDATE: 5/4/52 BIRTHPLACE: Brooklyn, NY CODE #: ____

SCHOOL OF GRADUATION: SUNY Downstate Med Ctr SCHOOL LOCATION: B., NY

DATE DEGREE CONFERRED: 5/25/78 # 03508 DEGREE CONFERRED: MD

ECFMG NUMBER: ____ DATE ISSUED: ____

5TH PATHWAY: ____

INTERNSHIP: ____

RESIDENCY: U of Chicago (OB/GYN) C., IL 7/78-6/81
Chicago Lying-In H. " " 7/81-6/82

FELLOWSHIP: Nat. Inst. of Hlth. (GENE) Bethesda, MD 7/82-6/84

DIPLOMATE OF NATIONAL BOARDS: 7/2/79 GENERAL AVERAGE OR CERT #: 79.2

LMCC: ____

DATE FLEX EXAM TAKEN: ____ STATE: ____

BS: ____ CS: ____ CC: ____ FWA: ____ COMP I: ____ COMP II: ____

LICENSED IN: ____ BASIS: ____

NATIONAL BOARD OF PODIATRY EXAMINERS: PART I PASSED ____ PART II PASSED ____

LETTERS OF RECOMMENDATION: Robert D. Eden, MD Detroit, MI
Zaman S. Moghissi, MD "

SPECIALTY: OB/GYN / Med. Gen. SPECIALTY BOARDS: 1985 / 1984 USA

TSE: ____ FORM 2: ____ FORM 3: ____ FORM 4: MI, MO, DC, VA, IL, CA

REMARKS:

DATE SENT

3/1/90 -AMA / AOA

-RECS - Wayne St.

ok -FED / HAS FLEX

-ECFMG VERIFICATION

~~diploma~~

~~2 form 1's~~

~~Resume - % clin. tadm.~~

~~form 2 - real inst~~

~~form 4 - CA~~

INCOMPLETE NOTICE SENT: 3/21/90

STATE MEDICAL BOARD OF OHIO
REQUEST FOR APPLICATION FORMS

APP-SENT 12/29/89

PLEASE TYPE OR PRINT CLEARLY

STATE MEDICAL BOARD OF OHIO
89 DEC 27 AM 11:49

I hereby submit the following information in order to receive an application for licensure:

NAME: EVANS (LAST (Surname)) MARK (FIRST) J. (MIDDLE) (SUFFIX (Jr., II))

ADDRESS: 4734 Rolling Ridge (STREET & NUMBER) West Bloomfield (CITY) MI (STATE) 48033 (ZIP) USA (COUNTRY)

TELEPHONE: BUSINESS: (313) 745-7066 (AREA CODE & NUMBER) HOME: (313) 855-4839 (AREA CODE & NUMBER)

BIRTH DATE: 5/ 4/ 52 (MO/DAY/YR) BIRTH PLACE: Brooklyn, NY (CITY) (STATE) USA (COUNTRY)

MEDICAL EDUCATION

MEDICAL SCHOOL OF GRADUATION: SUNY-Downstate Medical Center (SCHOOL NAME) (STREET ADDRESS) Brooklyn (CITY) NY (STATE) USA (COUNTRY)

9 / 1 / 74 (FROM: MO/DAY/YR) / / (TO: MO/DAY/YR) MD (DEGREE RECEIVED) 5 /25 / 78 (DATE RECEIVED: MO/DAY/YR)

OTHER MEDICAL SCHOOLS ATTENDED: (IF "NONE" ENTER "NONE")

(SCHOOL NAME) (STREET ADDRESS) (CITY) (STATE) (COUNTRY)

/ / (FROM: MO/DAY/YR) / / (TO: MO/DAY/YR) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

(SCHOOL NAME) (STREET ADDRESS) (CITY) (STATE) (COUNTRY)

/ / (FROM: MO/DAY/YR) / / (TO: MO/DAY/YR) (REASON EDUCATION NOT COMPLETED AT THIS SCHOOL)

E.C.F.M.G. CERTIFICATE: YES _____ NO _____ NUMBER _____ DATE ISSUED / /

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: _____ (HOSPITAL OR INSTITUTION) AFFILIATED WITH: _____ (NAME OF MEDICAL SCHOOL)
(IF "NONE", ENTER "NONE")

ADDRESS: _____ (STREET & NUMBER) (CITY) (STATE) (ZIP) DATE: / / (FROM) / / (TO)

QUALIFYING EXAM TAKEN: _____ DATE: / /

POSTGRADUATE TRAINING

LIST ALL POSTGRADUATE TRAINING (INTERNSHIP, RESIDENCY OR CLINICAL FELLOWSHIP), UNDERTAKEN IN THE U.S. OR CANADA. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

HOSPITAL: University of Chicago/Pritzker School of Medicine (NAME) Chicago (STREET ADDRESS) Illinois (CITY) (STATE)
POSITION: 1st, 2nd, 3rd yr Resident DEPARTMENT: OB/GYN DATE: 7 /78 (FROM: MO/YR) 6 / 81 (TO: MO/YR)

HOSPITAL: Chicago Lying-In Hospital (NAME) Chicago (STREET ADDRESS) Illinois (CITY) (STATE)
POSITION: Chief Resident DEPARTMENT: OB/GYN DATE: 7 / 81 (FROM: MO/YR) 6 / 82 (TO: MO/YR)

HOSPITAL: Interinstitute Med/National Institutes of Health, (NAME) Bethesda (STREET ADDRESS) Maryland (CITY) (STATE)
POSITION: Genetics Fellow DEPARTMENT: Medical Genetics DATE: 7 /82 (FROM: MO/YR) 6 / 84 (TO: MO/YR)

HOSPITAL: (NAME) (STREET ADDRESS) (CITY) (STATE)
POSITION: _____ DEPARTMENT: _____ DATE: / (FROM: MO/YR) / (TO: MO/YR)

LICENSES IN OTHER COUNTRIES

LIST ALL FOREIGN COUNTRIES IN WHICH YOU HOLD OR HAVE HELD A FULL RIGHT TO PRACTICE MEDICINE AND SURGERY. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

COUNTRY: _____ ISSUE DATE: __/__/__ LICENSE # _____ CURRENT: YES__ NO__

COUNTRY _____ ISSUE DATE: __/__/__ LICENSE # _____ CURRENT: YES__ NO__

LICENSES IN THE UNITED STATES

LIST ALL STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY. INDICATE THE LICENSE NUMBER, DATE OF ISSUANCE, WHETHER OR NOT THE LICENSE IS CURRENT, AND THE BASIS OF LICENSURE (E.G., FLEX EXAM, ENDORSEMENT OF OTHER STATE LICENSE, ENDORSEMENT OF DIPLOMATE STATUS, ETC.) IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

STATE: Michigan ISSUE DATE: 5/1/84 LICENSE #: 047149 CURRENT: YES x NO__

BASIS OF LICENSURE: NBME License to practice as a medical doctor, expiration date: 01/31/91

STATE: Maryland ISSUE DATE: 5/1/82 LICENSE #: _____ CURRENT: YES__ NO__

BASIS OF LICENSURE: NBME

STATE: District of Columbia ISSUE DATE: 5/1/82 LICENSE #: _____ CURRENT: YES__ NO__
Virginia, Illinois, California

BASIS OF LICENSURE: NBME

STATE BOARD OR FLEX EXAMINATIONS TAKEN

LIST EACH AND EVERY STATE BOARD OR FLEX EXAM WHICH YOU HAVE TAKEN WHETHER IN OHIO OR ANY OTHER STATE, TERRITORY OR PROVINCE. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET.

STATE: _____ DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

STATE: _____ DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

STATE: _____ DATE TAKEN: _____ PASS: ____ FAIL: ____ FULL ( ) PARTIAL ( )

ADDITIONAL ELIGIBILITY INFORMATION - ANSWER ALL QUESTIONS

DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS? PENDING ___ YES x NO ___ DATE 7/79

DIPLOMATE OF THE NATL BOARD OF OSTEO MEDICAL EXAMINERS? PENDING ___ YES___ NO x DATE __/__

ARE YOU APPLYING TO SIT FOR THE FLEX EXAM IN OHIO? YES ___ NO x

A LICENTIATE OF THE MEDICAL COUNSEL OF CANADA? YES ___ NO x DATE __/__/__

A U.S. CITIZEN? YES x NO ___ BASIS OF CITIZENSHIP Birth DATE: 5/14/52

A GRADUATE OF A MEXICAN MEDICAL SCHOOL? YES ___ NO x DATE __/__/__

DEGREE OBTAINED (CHECK ONLY ONE): ACTA_____ TITULO_____ MEDICO CIRUJANO_____

HAVE YOU ACHIEVED A SCORE OF AT LEAST TWO HUNDRED THIRTY (230) ON THE TEST OF SPOKEN ENGLISH OF THE EDUCATIONAL TESTING SERVICE AS REQUIRED UNDER SECTION 4731.09, O.R.C.? (THE TOEFL, ECFMG EXAM, etc., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TSE) YES___ NO___

OHIO RESIDENT AT THE TIME OF ADMISSION TO MEDICAL SCHOOL? YES ___ NO ___

IF YES, GIVE FULL ADDRESS AT THAT TIME:

STREET ADDRESS CITY STATE ZIP

CERTIFICATION

I, MARK I EVANS MD, HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING REQUEST FOR APPLICATION FORM; THAT THE STATEMENTS THEREIN ARE STRICTLY TRUE IN EVERY RESPECT AND THAT I HAVE READ AND UNDERSTAND THIS CERTIFICATION.

SIGNATURE 12/15/89 DATE

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OHIO 43266-0315

Anna
Ute. Wayne St
3-1-90

APPLICATION FOR MEDICAL & OSTEOPATHIC LICENSURE

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

STATE MEDICAL BOARD

ALL RESPONSES MUST BE TYPED

1. SOCIAL SECURITY NUMBER: Redacted

2. FULL NAME (Use no initials): Evans (LAST (Surname)) Mark (FIRST) Ira (MIDDLE) (SUFFIX (Jr., II

3. NAME (As you prefer it inscribed on your Ohio license): Evans (LAST (Surname)) Mark (FIRST) Ira (MIDDLE) (SUFFIX (Jr., II

4. ALTERNATE NAMES (IF "NONE" ENTER "NONE"): None (LAST (Surname)) (FIRST) (MIDDLE) (SUFFIX (Jr., II

5. CURRENT ADDRESS: Hutzel Hospital/Wayne State University, Division of Reproductive Genetics
4707 St Antoine Boulevard (STREET NUMBER & NAME)

Detroit (CITY) Michigan (STATE) 48201 (ZIP CODE) USA (COUNTRY)

6. PHYSICAL DESCRIPTION: 6'6" (HEIGHT) 300 (WEIGHT) Brown (HAIR COLOR) Blue (COLOR OF EYES) None (IDENTIFYING MARKS)

7. SEX MALE [x] FEMALE [ ] FOR STATISTICS ONLY (Optional

8. CITY IN OHIO WHERE YOU PLAN TO PRACTICE: Toledo (CITY) OR (COUNTY)

PLANS OF PRACTICE: Reproductive Genetics - Prenatal Diagnosis & Therapy

9. SPECIALTY BOARDS (USA, Canada and foreign countries)

NAME OF SPECIALTY BOARD	BOARD CERTIFIED YES	NO	YEAR CERTIFIED	COUNTRY
Am Bd Ob/Gyn	[x]	[ ]	1985	USA
Am B Med Genetics	[x]	[ ]	1984	USA
	[ ]	[ ]		

FOR OFFICE USE ONLY 34 35

1-7
12-6-71
2-21-90
185.00 pm 29-79

PAPERCLIP (DO NOT STAPLE) YOUR CHECK OR MONEY ORDER HERE

RESUME

DC

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time you must state on the resume exactly what your activities were, such as "vacation" or "looking for residency program", as well as your permanent address for this period. For any time in which you worked for an "emergency medical group" or did locum tenens you must list all hospitals where you worked. I in private practice, indicate the hospitals where you hold or have held privileges and include complete addresses. Failure to include complete addresses will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

EVANS, Mark

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
a. July (month) 1978 (year)	Department OB/GYN The University of Chicago-Pritzker School of Medicine Hospital/University/Other	1st, 2nd, and 3rd yr residency — OB GYN	100	0
TO June (month) 1981 (year)	The Chicago Lying-In Hospital Chicago, Illinois Street Address City/State Zip			
b. July (month) 1981 (year)	University of Chicago, Pritzker School of Medicine, Chicago Lying-In Hospital Hospital/University/Other	Chief Resident in Obstetrics/Gynecology	100	0
TO June (month) 1982 (year)	Chicago, Illinois Street Address City/State Zip			
c. July (month) 1982 (year)	Interinstitute Medical Genetics Warren G. Magnuson Clinical Center National Institutes of Health Hospital/University/Other	2-year Fellowship Medical Genetics	50	50
TO June (month) 1984 (year)	Bethesda, Maryland Street Address City/State Zip			
d. July (month) 1982 (year)	The George Washington University School of Medicine Hospital/University/Other	Instructor, Dept OB/GYN	100	0
TO June (month) 1984 (year)	Washington, DC Street Address City/State Zip			
e. July (month) 1984 (year)	Wayne State University School of Medicine Hospital/University/Other	Assistant Professor of Ob/Gyn	80	20
TO July (month) 1988 (year)	4707 St Antoine Blvd Detroit, MI 48201 Street Address City/State Zip			

90 APR -6 PM 4:10
STATE MEDICAL BOARD

90 FEB 21 AM 9:06
STATE MEDICAL BOARD

4/90 RV

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
f. July 1987 (month year) TO July 1988 (month year)	Wayne State University School of Medicine Hospital/University/Other 4707 St Antoine Blvd Detroit, MI 48201 Street Address City/State Zip	Assistant Professor, Department of Molecular Biology & Genetics	80	20
g. July 1988 (month year) TO PRESENT (month year)	Wayne State Univ School of Med Hospital/University/Other 4707 St Antoine Blvd Detoit, MI 48201 Street Address City/State Zip	Associate Professor with Tenure Dept OB/GYN and Molecular Biology and Genetics	80	20
h. month year TO month year	Hospital/University/Other Street Address City/State Zip			
i. month year TO month year	Hospital/University/Other Street Address City/State Zip			
j. month year TO month year	Hospital/University/other Street Address City/State Zip			
k. month year TO month year	Hospital/University/Other Street Address City/State Zip			
l. month year TO month year	Hospital/University/Other Street Address City/State Zip			

RESUME

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time you must state on the resume exactly what your activities were, such as "vacation" or "looking for residency program", as well as your permanent address for this period. For any time in which you worked for an "emergency medical group" or did locum tenens you must list all hospitals where you worked. If in private practice, indicate the hospitals where you hold or have held privileges and include complete addresses. Failure to include complete addresses will result in delay in processing your application. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

EVANS

DATES IN CHRONOLOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
a. July (month) 1978 (year)	Department OB/GYN The University of Chicago-Pritzker School of Medicine Hospital/University/Other	1st, 2nd, and 3rd yr residency		
TO June (month) 1981 (year)	The Chicago Lying-In Hospital Chicago, Illinois Street Address City/State Zip			
b. July (month) 1981 (year)	University of Chicago, Pritzker School of Medicine, Chicago Lying-In Hospital Hospital/University/Other	Chief Resident in Obstetrics/Gynecology		
TO [illegible] (month) [illegible] (year)	Chicago, Illinois Street Address City/State Zip			
c. July [illegible] (month) [illegible] (year)	Interinstitute Medical Genetics Warren G. Magnuson Clinical Center National Institutes of Health Hospital/University/Other	2-year Fellowship		
TO June (month) 1964 (year)	Bethesda, Maryland Street Address City/State Zip			
d. July (month) 1982 (year)	The George Washington University School of Medicine Hospital/University/Other	Instructor, Dept OB/GYN		
TO June (month) 1984 (year)	Washington, DC Street Address City/State Zip			
e. July (month) 1984 (year)	Wayne State University School of Medicine Hospital/University/Other	Assistant Professor of Ob/Gyn		
TO July (month) 1988 (year)	4707 St Antoine Blvd Detroit, MI 48201 Street Address City/State Zip			

DATES IN CHRONO-LOGICAL ORDER	ENTER NAME OF HOSPITAL/ UNIVERSITY WHERE TRAINED OR EMPLOYED, OR OTHER WORKING OR NON-WORKING ACTIVITY AND COMPLETE ADDRESSES	POSITION & DEPARTMENT	CLIN. %	ADMIN. %
f. July 1987 month year TO July 1988 month year	Wayne State University School of Medicine Hospital/University/Other 4707 St Antoine Blvd Detroit, MI 48201 Street Address City/State Zip	Assistant Professor, Department of Molecular Biology & Genetics		
g. July 1988 month year TO PRESENT month year	Wayne State Univ School of Med Hospital/University/Other 4707 St Antoine Blvd Detoit, MI 48201 Street Address City/State Zip	Associate Professor with Tenure Dept OB/GYN and Molecular Biology and Genetics		
h. month year TO month year	Hospital/University/Other Street Address City/State Zip			
i. month year TO month year	Hospital/University/Other Street Address City/State Zip			
j. month year TO month year	Hospital/University/other Street Address City/State Zip			
k. month year TO month year	Hospital/University/Other Street Address City/State Zip			
l. month year TO month year	Hospital/University/Other Street Address City/State Zip			

FORM 1

DC

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, Robert D. Eden, M.D., a licensed and practicing physician in the state of
Name of Recommending Physician

Sent 4/9/90

Michigan affirm that Mark Evans, M.D., has been known
Name of Applicant

to me personally and professionally for _____ years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Excellent
His/her command of the English language is: Excellent
I rate his/her ability to work well with peers and medical staff as: Excellent
His/her relationship with patients is: Excellent
Additional comments: _____

I hereby recommend him/her for full licensure to practice medicine/osteopathic medicine in Ohio.

Signature of Recommending Physician

Robert D. Eden, M.D.
Name of Recommending Physician
(Please print or type)

4707 St. Antoine, Detroit, MI 48201
Address of Recommending Physician
(Include City, State, Zip)

(313) 745-7292
Telephone Number
(Include Area Code)

Michigan #053464
State of Licensure and License Number
of Recommending Physician

(SEAL)

Subscribed and sworn to this 30TH day of MARCH, 1990.

Stella M. Miller
Notary Public

FEB 20 1991
Date Commission Expires

STATE MEDICAL BOARD
90 APR -4 AM 11:02

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

Signature of Applicant

2-1-90
Date Photo Taken

STATE MEDICAL BOARD
90 APR -2 PM 2:42

FORM 1

DC

CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physicians must be sufficiently acquainted with the applicant for at least SIX months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS PHOTOGRAPH OF APPLICANT IS ATTACHED

I, KAMRAN S. MOGHISSI, M.D., a licensed and practicing physician in the state of
Name of Recommending Physician

Michigan affirm that MARK I. EVANS, M.D., has been known
Name of Applicant

to me personally and professionally for 6 years and that he/she is of good moral and ethical character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Excellent
His/her command of the English language is: Excellent
I rate his/her ability to work well with peers and medical staff as: Excellent
His/her relationship with patients is: Excellent
Additional comments: _____

I hereby recommend him/her for full licensure to practice medicine/osteopathic medicine in Ohio.

X Kamran Moghissi (M.D.)
Signature of Recommending Physician

4707 St. Antoine
Detroit, MI 48201
Address of Recommending Physician
(Include City, State, Zip)

(SEAL)

KAMRAN S. MOGHISSI, M.D.
Name of Recommending Physician
(Please print or type)

(313) 745-7283
Telephone Number
(Include Area Code)

MICHIGAN #26287
State of Licensure and License Number
of Recommending Physician

Subscribed and sworn to this 29th day of March, 1990.

Nancy J. Wasztyl
Notary Public

November 18, 1992
Date Commission Expires

STA[illegible]OTO

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

MK
Signature of Applicant

2-1-90
Date Photo Taken

FORM 4

VERIFICATION OF LICENSE

$10.00 Fee

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

TO BE COMPLETED BY APPLICANTS

Mark I. Evans, M.D. — Name in Full

0101034107 — License Number

1982/exp 5/90 — Issue Date

Hutzel Hospital/Wayne State University
Division of Reproductive Genetics
4707 St Antoine Blvd., Detroit, Michigan 48201
Complete Address (Include zip code)

5/14/52
Date of Birth

State Univeristy of New York - Downstate Medical Center
Medical School Graduation

I hereby authorize the licensing agency of the state or province of Virginia to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant — 1/17/90 Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province _____ Name of Licensee _____

License Number _____ Date Issued _____

Is license current? _____

If not, please explain _____

What is the basis of the license?

[ ] 1. Flex examination in _____
[ ] 2. Written examination prepared by this state or province
[ ] 3. National Boards
[ ] 4. LMCC
[ ] 5. Endorsement from _____ State/Province
[ ] 6. Other (Please Specify) _____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

(BOARD SEAL)

Signed: _____
Title: _____
Date: _____

ORIGINALS SIGNATURES ONLY. NAME STAMPS WILL NOT BE ACCEPTED.

Please return to:
STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

STATE MEDICAL BOARD OF OHIO
90 FEB 9 AM 8:41

FORM 4

VERIFICATION OF LICENSE

$20 pd

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

TO BE COMPLETED BY APPLICANTS

Mark I. Evans, M.D. — -013346 — 1982/inactive
Name in Full — License Number — Issue Date

Hutzel Hospital/Wayne State University
Division of Reproductive Genetics
4707 St Antoine Blvd., Detroit, Michigan 48201 — 5/14/52
Complete Address (Include zip code) — Date of Birth

State University of New York - Downstate Medical Center
Medical School Graduation

STATE MEDICAL BOARD OF OHIO
90 FEB 13 PM 3:37

I hereby authorize the licensing agency of the state or province of District of Columbia to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant — 1/17/90 Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province D.C. Name of Licensee Mark Ira Evans

License Number 13346 Date Issued 4.20.82
Is license current? NO
If not, please explain Lapsed

What is the basis of the license?

[ ] 1. Flex examination in _____
[✓] 2. Written examination prepared by this state or province
[ ] 3. National Boards
[ ] 4. LMCC
[ ] 5. Endorsement from _____ State/Province
[ ] 6. Other (Please Specify) _____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES _____ NO ✓ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state? YES _____ NO ✓ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state? YES ____ NO ✓ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

(BOARD SEAL)

Signed: _____
Title: CLERK
Date: 2/7/90

ORIGINALS SIGNATURES ONLY. NAME STAMPS WILL NOT BE ACCEPTED.

Please return to:
STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

DC

FORM 2

CERTIFICATE OF POST-GRADUATE TRAINING

MAIL TO HOSPITAL OR INSTITUTION OF POSTGRADUATE TRAINING IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice medicine in the State of Ohio. The State Medical Boar of Ohio requires that my postgraduate training be certified. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

This certifies that Mark I. Evans, M.D. (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[ ] intern
[XX] resident in Obstetrics and Gynecology (Department)
[ ] clinical fellow

at The University of Chicago Chicago Lying In Hospital (Name of Hospital), 5841 S. Maryland Avenue Chicago, IL 60637 (Complete Address of Hospital)

from July 1, 1978 (beginning (month/day/year)) to June 30, 1982 (ending (month/day/year)). It is further certified that the above name

[X] was awarded a certificate on 6/30/82 (month/day/year)
[ ] was not

and that the training

[X] was accredited by ACGME/AOA.
[ ] was not

(SEAL OF HOSPITAL)

Signature of Medical Director or Program Director
(Original signatures only, name stamps will not be accepted)

Arthur L. Herbst, M.D.
Name (Please print or type)

February 13, 1990
Date

If the hospital has no seal, please indicate and have form notarized.

Upon completion return to:

"OFFICIAL SEAL"
MARILYN DE GROOT
Notary Public, State of Illinois
My Commission Expires 8/22/90

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

State of Ill., County of Cook
Signed before me on this 5th day
of April, 1990 by Arthur L. Herbst
Notary Public Marilyn De Groot

FORM 2

CERTIFICATE OF POST-GRADUATE TRAINING

MAIL TO HOSPITAL OR INSTITUTION OF POSTGRADUATE TRAINING IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice medicine in the State of Ohio. The State Medical Board of Ohio requires that my postgraduate training be certified. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

This certifies that Mark I. Evans, M.D. (Name of Applicant) has rendered satisfactory and continuous service as a(n)

[ ] intern
[XX] resident in Obstetrics and Gynecology (Department)
[ ] clinical fellow

at The University of Chicago Chicago Lying In Hospital (Name of Hospital), 5841 S. Maryland Avenue Chicago, Il 60637 (Complete Address of Hospital)

from July 1, 1978 (beginning (month/day/year)) to June 30, 1982 (ending (month/day/year)). It is further certified that the above name

[X] was awarded a certificate on 6/30/82 (month/day/year)
[ ] was not

and that the training

[X] was accredited by ACGME/AOA.
[ ] was not

(SEAL OF HOSPITAL)

Signature of Medical Director or Program Director
(Original signatures only, name stamps will not be accepted)

Arthur L. Herbst, M.D.
Name (Please print or type)

February 13, 1990
Date

If the hospital has no seal, please indicate and have form notarized.

Upon completion return to:

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

FORM 4

VERIFICATION OF LICENSE

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

TO BE COMPLETED BY APPLICANTS

Mark I. Evans, M.D. — Name in Full
D28119 — License Number
1982/exp 9/90 — Issue Date

Hutzel Hospital/Wayne State University
Division of Reproductive Genetics
4707 St Antoine Blvd., Detroit, Michigan 48201
Complete Address (Include zip code)

5/14/52
Date of Birth

State University of New York - Downstate Medical Center
Medical School Graduation

I hereby authorize the licensing agency of the state or province of Maryland to furnish the information below to the State Medical Board of Ohio.

MR — Signature of Applicant
1/17/90 — Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province _____ Name of Licensee Mark Evans

License Number D28119 Date Issued 7/19/82
Is license current? yes
If not, please explain _____

What is the basis of the license?

[ ] 1. Flex examination in _____
[ ] 2. Written examination prepared by this state or province
[✓] 3. National Boards
[ ] 4. LMCC
[ ] 5. Endorsement from _____ State/Province
[ ] 6. Other (Please Specify) _____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES _____ NO ✓ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state? YES _____ NO ✓ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state? YES ___ NO ✓ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

(BOARD SEAL)

Signed: Bertha D. Hall
Title: Bertha D. Hall, Secretary
Date: 7/19/82 Certifications

ORIGINALS SIGNATURES ONLY. NAME STAMPS WILL NOT BE ACCEPTED.

Please return to:
STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

FORM 1

VERIFICATION OF LICENSE

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

RECEIVED
FEB 09 1990
DEPT. OF LIC. & REG.
BOARD OF MEDICINE

TO BE COMPLETED BY APPLICANTS

Mark I. Evans, M.D.
Name in Full

047149
License Number

1984/exp 1/91
Issue Date

Hutzel Hospital/Wayne State University
Division of Reproductive Genetics
4707 St Antoine Blvd, Detroit, Michigan 48201
Complete Address (Include zip code)

5/14/52
Date of Birth

State University of New York - Downstate Medical Center
Medical School Graduation

I hereby authorize the licensing agency of the state or province of Michigan to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant

1/17/90
Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province _____ Name of Licensee _____

License Number _____ Date Issued _____
Is license current? _____
If not, please explain _____

What is the basis of the license?

[ ] 1. Flex examination in _____
[ ] 2. Written examination prepared by this state or province
[ ] 3. National Boards
[ ] 4. LMCC
[ ] 5. Endorsement from _____ State/Province
[ ] 6. Other (Please Specify) _____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

(BOARD SEAL)

Signed: _____
Title: _____
Date: _____

ORIGINALS SIGNATURES ONLY. NAME STAMPS WILL NOT BE ACCEPTED.

Please return to:
STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF LICENSING AND REGULATION

RAYMOND W. HOOD, SR., Director
P.O. Box 30018
Lansing, Michigan 48909
Telephone: (517) 373-1870
Telecommunication Device for the Deaf (517) 335-4478

February 15, 1990

State Medical Board
77 South High Street
17th Floor
Columbus, OH 43215

TO WHOM IT MAY CONCERN:

I hereby certify that a standard search of the available records of the Michigan Department of Licensing and Regulation, Bureau of Health Services indicates the following:

Mark I. Evans

WAS ISSUED LICENSE NO.:	047149
ON:	05/04/84
TO PRACTICE AS A:	Medical Doctor
LICENSURE STATUS IS:	Active - 01/31/91
ISSUED ON THE BASIS OF:	National Boards
REGULATORY INFORMATION:	None

The above format is the standard format prepared for all the professions regulated by this Bureau. If other information is needed, please contact this office at (517) 373-0680.

Sincerely,

Penny Dipple

Penny Dipple
MICHIGAN BOARD OF MEDICINE

Fee Received: 02/05/90

COMMONWEALTH of VIRGINIA

Department of Health Professions

BOARD OF MEDICINE
1601 ROLLING HILLS DRIVE
RICHMOND, VIRGINIA 23229-5005

FEBRUARY 06, 1990

REF: MARK I EVANS, MD
4734 ROLLING RIDGE

WEST BLOOMFIELD, MI 48033

THIS IS TO CERTIFY THAT THE RECORD OF THE ABOVE PHYSICIAN INDICATES THE FOLLOWING:

LICENSE NUMBER: 0101034107 DATE ISSUED: 03-25-82 EXPIRES: 05-31-90

TO PRACTICE MEDICINE & SURGERY

LICENSED BY: FLEX _____ NATIONAL BOARD ✓ STATE EXAM _____

AM BOARD _____ CANADIAN BOARD _____

ENDORSEMENT/RECIPROCITY WITH _____

ACCORDING TO OUR RECORDS, THIS LICENSE HAS / HAS NOT BEEN ENCUMBERED.

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.

L. G. Hinkston
VERIFICATION CLERK

SEAL

Illinois Department of Professional Regulation

Robert C. Thompson
Acting Director

James R. Thompson
Governor

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

February 22, 1990

State Medical Board
77 South High Street, 17th Floor
Columbus, OH 43215

I, Robert C. Thompson, do hereby certify that I am the Acting Director of the Department of Professional Regulation, a department of the government of the State of Illinois; that I am the keeper of the records of the Department of Professional Regulation and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	MARK IRA EVANS
WAS ISSUED LICENSE NO:	036-58892
ON:	07/20/79
TO PRACTICE AS A:	LICENSED PHYSICIAN & SURGEON
LICENSED BY:	NATIONAL BOARD ENDORSEMENT
CURRENT LICENSURE STATUS IS:	NONRENEWED

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.

For detailed information regarding the type and length of discipline, if any, submit a written request to the Regulatory Unit at the Department's Chicago office.

R C Thompson

Robert C. Thompson
Acting Director

S E A L

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800

State of Illinois Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/814-4500

FORM 2

VERIFICATION OF LICENSE

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio at the address listed below. Thank you.

TO BE COMPLETED BY APPLICANTS

Mark I. Evans, M.D.
Name in Full

036-058892
License Number

1979/inactive
Issue Date

Hutzel Hospital/Wayne State University
Division of Reproductive Genetics
4707 St Antoine Blvd., Detroit, Michigan 48201
Complete Address (Include zip code)

5/14/52
Date of Birth

State University of New York - Downstate Medical Center
Medical School Graduation

I hereby authorize the licensing agency of the state or province of Illinois to furnish the information below to the State Medical Board of Ohio.

1/17/90
Signature of Applicant — Date

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province _____ Name of Licensee _____

License Number _____ Date Issued _____
Is license current? _____
If not, please explain _____

What is the basis of the license?

[ ] 1. Flex examination in _____
[ ] 2. Written examination prepared by this state or province
[ ] 3. National Boards
[ ] 4. LMCC
[ ] 5. Endorsement from _____ State/Province
[ ] 6. Other (Please Specify) _____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details. Include information as to whether licensee is aware of investigation.

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state? YES _____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state? YES ____ NO _____ CANNOT ANSWER UNDER CURRENT STATE LAW _____
If yes, please attach details.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

(BOARD SEAL)

Signed: _____
Title: _____
Date: _____

ORIGINALS SIGNATURES ONLY. NAME STAMPS WILL NOT BE ACCEPTED.

Please return to:
STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS, OHIO 43215

STATE MEDICAL BOARD

30 FEB 21 AM 9:06

ADDITIONAL INFORMATION

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO FURNISH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON AND DISPOSITION OF THE MATTER. ALL AFFIRMATIVE ANSWER MUST BE THOROUGHLY EXPLAINED ON A SEPARATE SHEET OF PAPER.

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	[ ]	[X]
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges for other than reasons of failure to maintain records on a timely basis or failure to attend staff or section meetings?	[ ]	[X]
3.	Have you ever resigned, withdrawn, or terminated, or have you ever been requested to resign, withdraw, or otherwise terminate your position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	[ ]	[X]
4.	Have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from a medical school, clinical clerkship, externship, preceptorship, or postdoctoral training program?	[ ]	[X]
5.	Have you ever transferred from one postdoctoral training program to another?	[ ]	[X]
6.	Have you ever, for any reason, lost Specialty Board Certification in the U.S. or elsewhere?	[ ]	[X]
7.	Has any board, bureau, department, agency, or other body limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand against you?	[ ]	[X]
8.	Have you ever voluntarily surrendered any professional license, certificate, or registration issued to you by a board, bureau, department, agency, or other body?	[ ]	[X]
9.	Have you ever been requested to appear before any board, bureau, department, agency, or other body concerning allegations against you?	[ ]	[X]
10.	Have you ever entered into an agreement of any kind with respect to a professional license, whether oral or written, in lieu of formal disciplinary action, with any board, bureau, department, agency or other body?	[ ]	[X]
11.	Have you ever been notified of any charges or complaints filed against you with any board, bureau, deparment, agency, or other body with respect to a professional license?	[ ]	[X]
12.	Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or other drugs affecting the central nervous system, or any drugs which may cause physical or psychological dependence?	[ ]	[X]

13.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[x]
14.	Have you ever been treated but not hospitalized, for emotional or mental illness, drug addiction or abuse, or alcohol problem?	[ ]	[x]
15.	Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, been requested to appear before or fined by the responsible agency?	[ ]	[x]
16.	Have you ever been convicted or been found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	[ ]	[x]
17.	Have you ever forfeited collateral, bail or bond for breach or violation of any law, police regulation, or ordinance other than for minor traffic violation, been summoned into court as a defendant, or had any lawsuit (other than malpractice suit) filed against you?	[ ]	[x]
18.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf or paid such a claim yourself?	[ ]	[x]
19.	Have you ever been denied, or relinquished, participation in any third party reimbursement program, whether governmental or private, or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	[ ]	[x]
20.	Have you ever been denied licensure, application for licensure, or privilege of taking examination, or withdrawn any application, in any state, territory, province, or country for any reasons?	[ ]	[x]

AFFIDAVIT AND RELEASE

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below must be completec by ALL applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being returned to you.

ss STATE OF Michigan

COUNTY OF Wayne

I, Mark I. Evans hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine i the State of Ohio; that all statements I have or shall make with respect thereto are true, th I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my applicati are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants ar the Routes to Licensure and I have answered all questions in compliance with these instructic and understand that the fee I submitted is not refundable or transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report wi be privileged.

I further understand that failure to complete this application as requested by the Board with six months can be considered as abandonment of any request for licensure and that any fee I submitted is not refundable or transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having contrc of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent da and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives, and any person furnishing information, any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize t State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization, or similar institution; or to any professional association.

I further understand that a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained therein or to be furnished, which if false, can subject me to permanent denial of said certificate.

Mark Evans
Signature of Applicant

Subscribed and sworn to before me this 15TH day of FEBRUARY 1990.

Stella M. Miller
Notary Public Signature

(NOTARY SEAL)

FEB 20 1991
Date Commission Expires

90 FEB 21 AM 9:06

STATE MEDICAL BOARD

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO _____

This is to certify that this applicant has met preliminary education requirements for the study of medicine in conformity with the statutes of Ohio and the regulations of the State Medical Board of Ohio.

Ray L. Bumgarner
Entrance Examiner

Harry S. Crawford M.D.
Secretary

Date Issued

FOR BOARD USE ONLY

034306

NAME: Evans, Mark L

CERTIFICATE #: 60460 DATE ISSUED 8-24-90

FILED December 29, 19 89

FEE _____

DETERMINATION: 5/90BM

BOARD ACTION:

BASIS OF LICENSURE:

PRELIMINARY EDUCATION FORM

1-1
17-6
2/21/90

STATE MEDICAL BOARD
89 DEC 27 AM 11:49

My name IN FULL is EVANS (LAST) MARK (FIRST) J (MIDDLE)

High School or Equivalent: Poly Prep (SCHOOL NAME) Brooklyn (CITY) NY (STATE) USA (COUNTRY)

9/ 65 (FROM: MO/YR) 6/ 69 (TO: MO/YR) High School Diploma (DEGREE)

Undergraduate College or Equivalent: New York University (SCHOOL NAME) Bronx (CITY) NY (STATE) USA (COUNTRY)

6/ 69 (FROM: MO/YR) 6/70 (TO: MO/YR) (DEGREE)

A2BPO

Tufts University (SCHOOL NAME) Medford (CITY) Massachusetts (STATE) USA (COUNTRY)

9 / 70 (FROM: MO/YR) 6/ 73 (TO: MO/YR) BS Dept Psychology (Magna Cum Laude with Special Honor (DEGREE)

Medical School of Graduation: State University of New York, Brooklyn, (SCHOOL NAME) NY (CITY) USA (STATE) (COUNTRY)

9/ 74 (FROM: MO/YR) 5/ 78 (TO: MO/YR) MD (Distinction in Research) (DEGREE)

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: 76132

DATE ISSUED: 3/30/90

This is to certify that this applicant has met preliminary education requirements for the study of medicine in conformity with the statutes of Ohio and the regulations of the State Medical Board of Ohio.

Ray L. Bumgarner

Entrance Examiner

Henry G. Cramblett M.D.

Secretary

Wayne St.

STATE OF OHIO
THE STATE MEDICAL BOARD
17th Floor
77 South High Street
Columbus, Ohio 43266-0315

DATE March 1, 1990

Dear Doctor:

Dr. EVANS, Mark Ira who is/was Instructor/OB-GYN 7/82-6/84 Asst Prof7/84-7/88 Asst Prof/Molecular Biology 7/87-7/88 Assoc. Prof/OB-GYN 7/ is applying for licensure in the State of Ohio. We would appreciate your assistance in -now filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 7 years

(2) What was/is your supervisory capacity? CHAIRMAN

(3) At what hospital? Hutzel Hospital

(4) How would you rate this doctor's medical knowledge and techniques? Excellent

(5) In your opinion, is this doctor a person of good moral and ethical character? Yes

(6) Does this doctor work well with peers and medical staff? Yes

(7) Does he/she relate well to patients? Yes

(8) How is his/her command of the English language? (if applicable) Excellent

(9) Would you recommend this doctor for licensure? Yes

Additional comments, please: (if needed, an extra sheet of paper may be used)

Please return this form to the Ohio State Medical Board at the above address,
Sincerely,

Dawn Cales
Dawn Cales
Licensure Assistant

STATE MEDICAL BOARD
90 MAR 23 PM 3:09

M. Moghissi MD
Signature of Doctor, please type or print name legibly beneath

KAMRAN S. MOGHISSI, M.D.

PROFESSOR + CHAIRMAN
Position

DATE: 3/19/90

Telephone No. (313) 745-7283 (Include Area Code)

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

Mark Ira Evans, 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 WILLIAM B. HOLDEN, M.D.
Chairman of the Board

SEAL EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa.
07/02/79 Certificate # 193288

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 SUNY HLTH SCI CTR BRKLYN in MAY 1978 and whose birth date is 05/14/1952. 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 06/76		
Anatomy	430	76
Physiology	470	79
Biochemistry	515	81
Pathology	340	70
Microbiology	565	85
Pharmacology	490	80
Behavioral Sciences	660	91
TOTAL TEST (Minimum Passing Score 380/75)	495	80
PART II passed 09/77		
Medicine	360	75
Surgery	335	75
Obstetrics and Gynecology	535	84
Public Health and Preventive Medicine	600	87
Pediatrics	410	78
Psychiatry	470	81
TOTAL TEST (Minimum Passing Score 290/75)	435	79
PART III passed 03/79		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	400	78.5
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		79.2

*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.

STATE MEDICAL BOARD
90 FEB 13 PM 12:36

Melanie Valente
Secretary for Certification

SEAL

02/08/90
Date

2/2

Wayne State University
School of Medicine

HUTZEL HOSPITAL
THE DETROIT MEDICAL CENTER

Department of
Obstetrics-Gynecology
4707 St. Antoine Boulevard
Detroit, Michigan 48201
(313) 745-7066

Mark I. Evans, M.D., Director
Division of Reproductive Genetics

Kamran S. Moghissi, M.D.
Professor, Chairman and Chief

This is a certified photograph of Mark Ira Evans' State University of New York, Doctor of Medicine degree.

Stella M. Miller
Wayne County
Notary Public
Comm. Expires 2/20/91

STATE MEDICAL BOARD
90 APR 23 PM 12:09

5/90

(AMG) / FMG / CMG / DPM / FLEX
(please circle)

DATE CALLED IN: 12-1-89

Mark Evans (MD) / DO / DPM

47341 Rolling Ridge

West Bloomfield, MI

48033

SCREEN SENT 12/4/89

(please circle or fill in)

HAS NATIONAL BOARDS

FLEX IN _____

LICENSED IN _____

STATE BOARD _____ (19)

EVANS, MARK

Wayne State University
School of Medicine

HUTZEL HOSPITAL
THE DETROIT MEDICAL CENTER

Department of
Obstetrics-Gynecology
4707 St. Antoine Boulevard
Detroit, Michigan 48201
(313) 745-7292

Robert D. Eden, M.D.
Associate Professor
Associate Residency Program Director

Kamran S. Moghissi, M.D.
Professor, Chairman and Chief
Residency Program Director

April 25, 1990

State Medical Board
77 South High Street
17th Floor
Columbus, Ohio 43215

To Whom it may concern,

I, Robert D. Eden, M.D., have known Mark I. Evans, M.D. for 16 years. We were classmates at S.U.N.Y. Downstate Medical School in Brooklyn, N.Y..

Sincerely,

Robert D. Eden, M.D.

Sworn to before me this 25TH day of APRIL 1990.

Stella M. Miller

Notary Public Comm EXPIRES 2/20/91

5/90 BM

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 6/5/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0460	$160.00	07/01/92

MARK IRA EVANS, M.D.
HUTZEL HOSPITAL
4707 ST ANTOINE BLVD
DETROIT MI 48201

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY
85 UNSPECIFIED

PROCESSED

SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

⑆969696962⑆ 0935060460⑈ ⑈0000016000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City State Zip Code

County

083 00165 062992 00688 3 160.00 062992 935060460
TAX BATCH B.DATE SEQ# C# AMOUNT BAT DATE ACCOUNT #

HAVE YOU BEEN FOUND GUILTY OF, OR PLED GUILTY OR NO CONTEST TO :

YES	NO	
☐	☒	A.) A felony or misdemeanor.
☐	☒	B.) A federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES	NO	
☐	☒	1.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.
☐	☒	2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?
☐	☒	3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?
☐	☒	4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

[redacted]

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 4/18/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0460	$250.00	05/01/94

MARK IRA EVANS,M.D.
HUTZEL HOSPITAL
4707 ST ANTOINE BLVD
DETROIT MI 48201

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY
US UNSPECIFIED

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1: OBG CODE2: GG CODE3:

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935060460 :00000 25000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES ☒ NO ☐

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES ☐ NO ☒

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES ☐ NO ☒

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES ☐ NO ☒

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES ☐ NO ☒

6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES ☐ NO ☒

7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES ☐ NO ☒

8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has

MCA 150.00 950394
AMOUNT BATCHDATE
93506046O
ACCOUNT

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DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 7/1/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0460	$250.00	05/01/96

MARK IRA EVANS, M.D.
HUTZEL HOSPITAL
4707 ST ANTOINE BLVD
DETROIT MI 48201

62-1
#09520
275.00
8-13-96

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY
CG CLINICAL GENETICS

☒ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES NO
☐ ☒ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES NO
☐ ☒ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES NO
☐ ☒ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO
☐ ☒ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO
☐ ☒ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO
☐ ☒ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO
☐ ☒ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO
☐ ☒ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 4/1/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0460-E	$307.00	05/01/98

MARK IRA EVANS,M.D.
HUTZEL HOSPITAL
4707 ST ANTOINE BLVD
DETROIT MI 48201

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY
CG CLINICAL GENETICS

☒ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935060460" "0000030700"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

	YES	NO
1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.		X
2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?		X
3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.		X
4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?		X
5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?		X
6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?		X
7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?		X
8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or		X

DATE 10/7/98
935060460
ACCOUNT #

Redacted

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 7/9/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-0460-E	$305.00	10/01/2000

MARK IRA EVANS,M.D.
HUTZEL HOSPITAL
4707 ST ANTOINE BLVD
DETROIT MI 48201

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY
CG CLINICAL GENETICS

☒ **SPECIALTY CODE(S) CORRECT AS LISTED**

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.
4734 ROLLING RIDGE
STREET
STREET
W BLOOMFIELD MI 48323
CITY STATE ZIP CODE
OAKLAND
COUNTY

:96969696 2: 0935060460" "0000030500"

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
HUTZEL HOSPITAL
Street
4707 ST ANTOINE
Street
DETROIT MI 48201
City State Zip Code
WAYNE
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :

YES ☐ NO ☒ 1.) *Have you been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a misdemeanor or felony?*

YES ☐ NO ☒ 2.) *Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?* ***You may answer "NO" to this question if*** *you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.*

YES ☐ NO ☒ 3.) *Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?*

YES ☐ NO ☒ 4.) *Has any board, bureau, department, agency, or other body, including those in Ohio,* ***other than this board,*** *filed any charges, allegations or complaints against you?*

YES ☐ NO ☒ 5.) *Have you surrendered, or consented to limitation of a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.*

YES ☐ NO ☒ 6.) *Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons* ***other than failure to maintain records on a timely basis or to attend staff meetings?***

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2000 - 2002 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 10/1/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-0460-E	$305.00	10/01/02	01/01/03

MARK IRA EVANS,M.D.
4734 ROLLING RIDGE
W BLOOMFIELD MI 48323

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY
CG CLINICAL GENETICS

☒ **SPECIALTY CODE(S) CORRECT AS LISTED**

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

107 WISTERIA LANE
STREET
~~MEDIA~~
STREET
MEDIA PA 19063
CITY STATE ZIP CODE
DELAWARE
COUNTY

0935060460 30500

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony? YES ☐ NO ☒

2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices. YES ☐ NO ☒

3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio? YES ☐ NO ☒

4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you? YES ☐ NO ☒

5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board. YES ☐ NO ☒

6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?** YES ☐ NO ☒

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL

☐ Check this Box if you have NO principal Practice address.

1000 ~~16TH~~ AVE
Street
SUITE 114
Street
KING OF PRUSSIA PA 19406
City State Zip Code
MONTGOMERY
County

REQUIRED:
SOCIAL SECURITY NUMBER

11182002 711700
0220 189
060460
1 SE 00000305000