

Board of Registration in Medicine

1033 So. Washington Avenue
Lansing, Michigan 48926

(DO NOT WRITE IN THIS SPACE)

JUN 22 11 71 594543 ***100.00

ENDORSEMENT APPLICATION

I hereby apply for endorsement of my certificate of registration No. _____, issued by the _____ on the _____ day of _____, 19____, and submit the following:

SWORN STATEMENT:

- Name Thomas William Michaelis
 - Place of birth _____ Date of birth _____ Age _____
 - Are you a citizen of the United States? yes
 - Present mail address 100 Michigan NE, Grand Rapids, Michigan 49503
 - Present residence 347 Bostwick NE, Grand Rapids, Michigan 49503
Name and address of nearest relative Karen Michaelis (wife) 347 Bostwick NE, G.R., Mich.
 - Intended residence 1643 Lafayette NE, Grand Rapids, Michigan 49505
 - In what states do you hold a license? Ohio
 - In what states have you practiced medicine? Michigan
 - Have you ever practiced any other branch of the healing arts? no If so, where? _____
 - Have you ever been notified by any state medical board or any medical society of any complaint against you relative to the practice of medicine? no If so, explain _____
 - Have you ever been charged with violation of any law relative to practice of medicine or relative to any crime? no If so, state the nature of the charge and whether you were convicted. State circumstances surrounding it. _____
 - Military service: Date of Entry _____ Date of Discharge _____
Branch of service and particulars Air Force, 3 yr. deferment begins July, 1971 (Berry Plan)
 - What was your premedical education?
Name and location of institutions attended. Univ. of Michigan, Ann Arbor, Michigan Period and date of study. 4 yrs. Sept. 1962 - May 1966
- What degrees did you obtain, when and from what schools and colleges?
BS in zoology, May 1966 Univ. of Michigan

14. MEDICAL EDUCATION:

Day	Month	Year		Day	Month	Year	Name and Address of Medical College
	9	1966	to	12	6	1970	Ohio State Univ., Columbus, Ohio
26	9	66	to	13	6	67	The Ohio State University College of Medicine
25	9	67	to	8	6	68	The Ohio State University College of Medicine
1	7	68	to	30	6	69	The Ohio State University College of Medicine
1	7	69	to	12	6	70	The Ohio State University College of Medicine
			to				

- Have you been certified by the Michigan State Board of Examiners in the Basic Sciences? no
Certificate number _____

16. POST GRADUATE EDUCATION:

Year		Year	School or Clinic	Degrees Obtained
.....	to	.....	.....	.....
.....	to	.....	.....	.....
.....	to	.....	.....	.....
.....	to	.....	.....	.....
.....	to	.....	.....	.....

17. Internship at Butterworth Hospital, located at Grand Rapids, Michigan, from July 1, 1970 to June 30, 1971

18. Received degree of Doctor of Medicine from The Ohio State University, School of Medicine, on 12th day of June, 1970

19. Have you carefully read Michigan Medical Practice Act No. 237 of 1899 as Amended? yes

20. Have you ever been connected, directly or indirectly, with any concern, company, institution, or individual medical advertising organization? no

21. Do you hereby agree, should a certificate of registration or license be granted entitling you to practice medicine and surgery in the State of Michigan, not to become connected, directly or indirectly, with any medical concern, company, institute, advertising physician or advertising specialist? yes

22. Do you unreservedly agree to comply with all the provisions in the laws governing the practice of medicine in Michigan? yes

23. Do you intend to practice medicine in Michigan continuously for at least one year following date of your registration? yes

24. In what town or city do you intend to practice for one year following your registration? Grand Rapids, Michigan

(Signed) Thomas W. Medsker, M.D.

AFFIDAVIT OF APPLICANT.

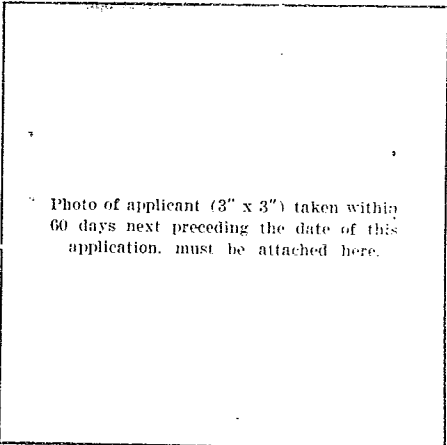
State of Michigan }
County of Grand Rapids } ss.

Thomas W. Medsker, M.D., being duly sworn, deposes and says that he is the applicant named in the foregoing application for a Reciprocity Certificate to practice Medicine and Surgery in the State of Michigan; that he has read the foregoing application and knows the contents thereof and swears the same to be true.

Thomas W. Medsker, M.D.
Signature of applicant in full.

Subscribed and sworn to before me, Vera Overly, a Notary Public, this 11th day of June, 19 71. Address Grand Rapids, Mich.

My Commission expires Notary Public, Kent County, Mich.
VERA OVERLY
My commission expires Dec. 2, 1973



I hereby certify that the photograph hereto attached is a genuine likeness of Thomas W. Medsker, M.D.

of Grand Rapids, Mich.

(SEAL)

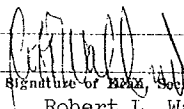
VERA OVERLY
Notary Public, Kent County, Mich.
My commission expires Dec. 2, 1973

25. CERTIFICATE OF DEAN, SECRETARY OR REGISTRAR OF MEDICAL COLLEGE.

In the application of Thomas William Michaelis, of Grand Rapids, Michigan, dated April 16, 19 71, I hereby certify that I have reviewed the answers of the above named applicant. I certify that to the best of my knowledge all of the within answers or statements are true and are a matter of official record in this school, and that said applicant is of good moral and professional character.

I further certify that Thomas William Michaelis, M. D., matriculated in the The Ohio State University College of Medicine, (Name of Medical School) on September 26, 1966, and was graduated on June 12, 1970 at which time he was granted the degree, Doctor of Medicine. If the degree, Bachelor of Medicine, is conferred upon completion of four years of medical school further state the conditions and time the degree, Doctor of Medicine, will be granted.

Dated at Columbus, Ohio this 16th day of April, 19 71. The Ohio State University College of Medicine
Columbus, Ohio 43210
Name and address of medical college.


Signature of Robert L. Wall, M.D.
Name and address of medical college.

(SEAL)
Seal of college must be affixed.

26. CERTIFICATION OF SECRETARY OF STATE BOARD WHICH ISSUED THE LICENSE USED AS THE BASIS OF THIS APPLICATION.

NOTE: If you are a Diplomate of the National Boards please submit National Board Certificate of Record in lieu of completion of Section #26.

I, Henry G. Cramblett, M.D., Secretary of the Ohio State Medical Board (Board or Department), certify that License No. 32590 to practice Medicine and Surgery was issued to Dr. Thomas Wm. Michaelis, M.D., on the 4th day of August, 19 70, based on written examination (examination or credentials) and prior graduation from Ohio State University (Name of Medical School), on the 12th day of June, 19 70, and that said certificate of Registration or License has never been revoked.


I further certify that the aforesaid Dr. Michaelis, M.D. passed the regular written examination given by this Board on the 16-18 days of June, 19 70, and obtained a general average of [redacted] per cent in the following subjects.

- Anatomy, ~~gross and microscopic~~
- Biological Chemistry
- ~~Bacteriology~~, Microbiology and ~~Immunology~~
- Physiology
- Pathology
- Medicine, ~~including Dermatology~~
- ~~Executive Medicine~~ and Public Health
- ~~Materia Medica~~, Pharmacology and ~~Therapeutics~~
- ~~Medical Jurisprudence~~ Clinical Comp.
- ~~Eye, Ear, Nose and Throat~~
- Obstetrics ~~and Gynecology~~
- Surgery, ~~including Ophthalmology and Radiology~~
- ~~Neurology~~ and Psychiatry
- Pediatrics



I believe the above applicant to be a fit and proper person to receive a Reciprocity Certificate.

(SEAL)
Seal of Board or Department must be affixed.

(Signed) 
Secretary.

Dated at Columbus, Ohio this 3rd day of June, 19 71. Ohio State Medical Board
(Board or Department)

27. HOSPITAL INTERNSHIP:

I hereby certify that Dr. Thomas W. Michaelis satisfactorily served a rotating internship in Butterworth Hospital, from the 1st day of July, 1970, to the 30th day of June, 1971.

(Signed) [Signature] Executive Vice President & Director Butterworth Hospital (Name and address of hospital.)

Date June 15, 1971

(SEAL) Seal of Hospital must be affixed.

28. SOCIETY RECOMMENDATION:

I, _____, Secretary of the _____ Medical Society, certify that Dr. _____ is personally known to me, and that he is an ethical practitioner and of good moral character. I have carefully examined all the statements made by the applicant and believe them to be true in every respect.

Date _____ Secretary. (SEAL) Name and address of Society.

29. INSTRUCTIONS TO APPLICANTS.

1. Give names and addresses of three legally registered practitioners of medicine in good standing to whom reference may be made.

Ralph Mathis MD (Name) _____ (Address) Edward Monhead MD (Name) _____ (Address) Kenneth VanderKolk MA (Name) _____ (Address)

- 2. This application will not be received unless properly signed and sworn to by the applicant, and unless all blank spaces are properly filled in. 3. Material omissions covering questions in this application will bring applicant under the provisions of Section C, Subdivisions Fourth to Seventh inclusive of Act No. 368, P. A. of 1913. 4. The filing of this application does not grant any special privileges. 5. Graduates of foreign medical schools are required to complete the extra educational requirement and one year's rotating internship in an approved hospital of the United States or Canada. 6. Applicants may be required to present to the Board at the office of the Secretary, Lansing, Michigan, for verification, an accredited medical school diploma with M. D. degree. Credentials are to be presented in person; if mailed it is at owner's risk and expense. 7. The fee of \$100.00 must accompany the endorsement application. Remittance to be, in U.S. currency, made payable to State of Michigan - Medicine. 8. Two certificates are issued: a certified copy for filing with the county clerk, and the original which is to be retained by the licensee and framed for display in his office. 9. Before issuance, a personal appearance may be required. 10. If, after a license has been issued on this endorsement, it is ascertained that misrepresentation of facts, or fraudulent statements have been made, the license so issued will be immediately revoked by this Board and the applicant becomes subject to legal prosecution.

ENDORSEMENT APPLICATION

Certificate No. Name Address

STATE OF MICHIGAN BOARD OF REGISTRATION IN MEDICINE

1033 S. Washington Avenue Lansing, Michigan 48926

30192

BIOGRAPHICAL DATA ON PHYSICIANS
from the Biographical - Historical files of
American Medical Association
535 N. Dearborn St.
Chicago, Illinois 60610

SEARCHED
JUL 1971
INDEXED

This form is provided for your convenience in making routine inquiries regarding physicians seeking medical licensure in your state, hospital staff privileges or faculty positions. Please enter on this form data you wish verified and mail to the Member Services Unit of the AMA.

Full name of M.D. Thomas William Michaelis

Place of birth [REDACTED] Date of birth [REDACTED]

Professional Mailing Address 100 Michigan NE Grand Rapids, MI

Medical Education:

School Name Ohio State Univ. M.D. Degree 1970
(Year)

Internships:

Hospital	Location	Dates
Butterworth	Grand Rapids, MI	1970 to 1971
		to

Residencies and Fellowships:

Hospital	Location	Dates
		to
		to

M.D. Licensed to Practice Medicine in the Following States:

State Ohio Year 70; State _____ Year _____; State _____ Year _____

Inquiry Submitted by John M. Wellman MD Title Executive Secretary
(Your Name Here)
MICH. STATE BOARD OF REGISTRATION IN MEDICINE

(Affiliation - Licensing Board, Hospital or Medical School) City-State Lansing, Mich.

AMA Department of Investigation

- Our records do not reveal any derogatory information.
- See attached memo for comments regarding applicant.

MEMBER OF AMA

..... YES

..... NO

A check mark (✓) indicates that the data given corresponds to that listed in the AMA Master File of Physicians. Any discrepancies are as noted.

Date 7/14/71

Joan Alvarez
Joan Alvarez,
Member Services Unit