APPLICATION FOR INDIANA CONTROLLED SUBSTANCES REGISTRATION (CSR) FOR PRACTITIONERS

State Form 34617 (R14 / 6-07)
Approved by State Board of Accounts, 2007

PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
www.pla.IN.gov

* Your Social Security number is being requested by this state agency in accordance with IC 4-1-8-1. Disclosure is mandatory and this record cannot be processed without it.

INSTRUCTIONS: Please type or print all information.

FOR OFFICE USE ONLY

CSR number		Date of issuance *(month, day, year)*
01068292B		8/27/10
Receipt number 3351594	Application fee $60.00	Date fee paid *(month, day, year)* 8/27/10

DO NOT WRITE ABOVE THIS LINE

PRACTITIONERS

(Please check one box)

☐ Dentist ☑ Physician ☐ Osteopathic Physician ☐ Podiatrist ☐ Veterinarian ☐ Advanced Practice Nurse ☐ Physician Assistant

Name of practitioner		Specialty	
Virgil Cayton Reid III		Obstetrcis and Gynecology	
Telephone number	Professional license number	Date of birth *(month, day year)*	Social Security number *
redacted	01068292A	redacted	redacted
Name of Facility *(if applicable)*		E-mail address	
Planned Parenthood of Indiana		redacted	

Indiana practice address *(number and street [may **not** be a PO Box], city, state, and ZIP code)*
8645 Connecticut Street, Merrillville, IN, 46410

Drug schedules: *(Check all applicable)*
☑ 1 ☑ 2 ☑ 2 Narcotic ☑ 3 ☑ 3 Narcotic ☑ 4 ☑ 5

If your answer is **Yes** to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a registration issued pursuant to this application.

1. Have you ever been convicted of, or plead guilty or nolo contendere to: a violation of any federal, state, or local law relating to the use, manufacturing, distribution, or dispensing of controlled substances or are formal charges pending? ☐ Yes ☑ No
2. Have you ever been convicted of, or plead guilty or nolo contendere to: any offense, misdemeanor, or felony, in any state (except minor traffic laws/fines) or are formal charges pending? ☐ Yes ☑ No
3. Have you ever had any action, discipline or revocation on your DEA (US Drug Enforcement Administration) registration or entered into a Memorandum of Understanding (MOU) on said registration? ☐ Yes ☑ No

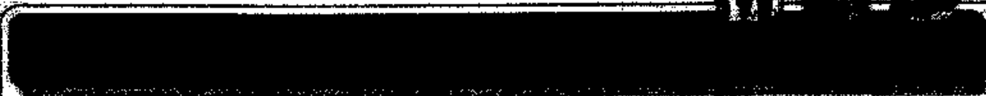
APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of practitioner	Date *(month, day, year)*
[signature]	8/24/10

RECEIVED
AUG 2 7 2010
Indiana Professional
Licensing Agency

Uniform Application for Physician State Licensure



Navigation Options:

Welcome Virgil Reid!

Application Submitted - View Status Start New/Edit

Logout

UA Home

State Instructions | Personal Information | Education & Certification | Licensure & Employment | Malpractice & Liability | Review & Submit | Forms & Affidavit

Review & Submit

Please review all of you entries prior to submission: If you see anything you need to correct, you can navigate back to that section by using the navigation above. **It is strongly advised that you print a copy for your records.**

When the applicant clicks submit, the Federation will forward this application, a board action report and a licensure history report to the Board for their application approval procedure. If the applicant has questions at this point, the applicant will need to address those questions directly with the Board.

Uniform Application for Physician State Licensure - Self-Reported

UA Username: reid..gii@gmail.com Submitted on: 3/10/2010 10:03:21 AM

1. Name

Name Virgil Cayton Reid, III, M.D.
Maiden Name
Alternate Name(s)

2. Address/Phone

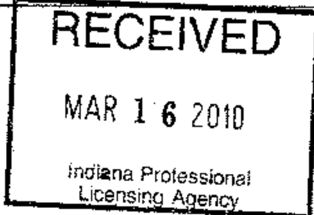
Practice Address : 1701 West Superior St
Chicago, IL 60622
USA
Public Access: Y **Mailing:** N

Home Address: 675 N Peoria St Apt 3S
Chicago, IL 60642
USA
Public Access: N **Mailing:** Y

Business Phone: 312-666-3494 **Business Fax:** 312-666-5867
Home Phone: redacted **Home Fax**
Primary Email: redacted
Secondary Email:

3. Identification

Birth Date redacted
Location: Highpoint, NC
USA
SSN redacted
National Provider ID 1881704492
U.S. Citizen Y
Gender M



4. Medical Education

School Name: University of North Carolina at Chapel Hill School of Medicine
Attendance Dates : 08/1992 - 05/1996
Date Degree Conferred/Issued: 05/12/1996
Type of Degree: Doctor of Medicine

5. Fifth Pathway

6. Postgraduate Medical Education

Hospital Name : University of North Carolina
Address : 30134 NC Womens Hospital CB 7600
UNC School of Medicine
Chapel Hill, NC 27514
USA
Post Graduate Year : Residency
Accredited By :
Department/Specialty : Obstetrics and Gynecology
Rotation Dates : 07/1996 - 06/2000
Successfully Completed? : Y

7. Examination History

Exam	State	Date	(P)ass/(F)ail	Attempts
USMLE Step 1			P	1
USMLE Step 2			P	1
USMLE Step 3			P	1

8. ECFMG

Certificate Number :
Issue Date :
Valid Through Date :

9. State or Professional Licensure

Type	Other Type	State	Number	Status	Issue Date
Doctor of Medicine		Illinois	036-102311	Active	08/01/2008

10. Chronology of Activities

Type of Activity: Work
Start Date: 08/2000 **End Date:**
Practice/Employment Name: Erie Family Health Center
Address: 1701 West Superior St
Chicago, IL 60622
USA
Position: physician
Department: ob/gyn
% Clinical: 90 **% Administrative:** 10
Employment: Y **Staff Privileges:** N **Affiliation:** N **Other:**

Type of Activity: Work
Start Date: 08/2000 **End Date:**
Practice/Employment Name: Northwestern Hospital
Address: 201 E Huron
Chicago, IL 60610
USA
Position: physician
Department: ob/gyn
% Clinical: 100 **% Administrative:**
Employment: N **Staff Privileges:** Y **Affiliation:** N **Other:**

Type of Activity: Work
Start Date: 04/2007 **End Date:**
Practice/Employment Name: Planned Parenthood of Illinois
Address: 1201 N LaSalle
Chicago, IL 60610
USA
Position: physician
Department: medical services
% Clinical: 100 **% Administrative:**
Employment: Y **Staff Privileges:** N **Affiliation:** N **Other:**

11. Malpractice Liability Claims Information

If you have completed all necessary pages of your application, and printed the appropriate forms you need to send out, use the "Submit Application" button below. An electronic version of your application will be available to the licensing agency immediately.

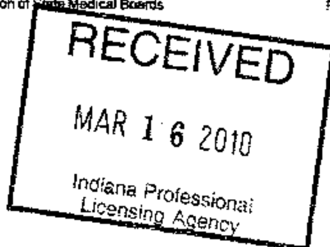
NOTE: Once you submit your application, no changes can be made to that particular copy that is sent. A copy of your information will be available if you need to send your application to another licensing agency.

When the applicant clicks submit, the Federation will forward this application, a board action report and a licensure history report to the Board for their application approval procedure. If the applicant has questions at this point, the applicant will need to address those questions directly with the Board.

This application has been submitted and cannot be modified. Please Click Here if you want to start another application.

SUBMIT APPLICATION

© 2008 Federation of State Medical Boards PO Box 619850 Dallas TX, 75261-9850 Tel: (817) 868-4000 - www.fsmb.org v1.0.0.0Contact Us



Addendum 1

Answer the following questions. For questions 1-10: If your answer is "Yes" to any of these questions, explain fully in a signed, sworn and notarized affidavit, including all related details. Include the violation, location, date and disposition. If applicable, please submit copies of all court documents and/or arrest records. **If malpractice, complete the "Malpractice Liability Claims Information" section of the Online Uniform Application for Physician State Licensure (UA) for each claim.** Letters from attorneys or insurance companies are not accepted in lieu of your statement, but may be submitted with your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

☐ Yes ☑ No 1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held?

☐ Yes ☑ No 2. Have you ever been denied a license, certificate, registration or permit to practice medicine, osteopathic medicine or any regulated health occupation in any state (*including Indiana*) or country, or surrendered your license?

☐ Yes ☑ No 3. Are you now being, or have you ever been treated for drug or alcohol abuse or addiction?

☐ Yes ☑ No 4. Have you ever been the subject of an investigation by a regulatory agency concerning your license?

5. Have you ever been convicted of, plead guilty or *nolo contendere* to, or are charges pending:

☐ Yes ☑ No A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction?

☐ Yes ☑ No B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines.*)

☐ Yes ☑ No 6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?

☐ Yes ☑ No 7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?

☐ Yes ☑ No 8. Have you ever had a malpractice judgment against you or settled any malpractice action?

☐ Yes ☑ No 9. Have you ever surrendered your DEA registration at any time or had any limitations placed on your DEA registration?

☐ Yes ☑ No 10. Have you ever been disciplined by your employer while practicing as a physician or resigned in lieu of discipline?

Temporary Permit Information:

11. Do you desire a temporary permit? ☑ Yes ■ [illegible]
If yes, an additional fee of $100 is required.

List any Specialties / Board Certification:

12. Specialties: Obstetrics and Gynecology

13. Board Certification (list ABMS certification): ABOG

Addendum 2

VOLUNTARY RACE / ETHNICITY / GENDER QUESTIONS**

This information is completely voluntary and will NOT affect your application in any way.

Applicant Name: Reid III (Last) Virgil (First) Cayton (Middle)

1. **Ethnicity:** White (Northern European)
2. **Race:** White
3. **Gender:** ☒ Male ☐ Female

** Note: This information is being requested for workforce statistical purposes only; disclosure is voluntary.

Medical Licensing Board of Indiana

Addendum Instructions

Addendum Instructions: Complete the addendums as instructed below. Please type or print your responses. Return the completed addendums and this cover page along with any and all supporting documentation to the Indiana Board.

✓ **Addendum 1:** These questions must be completed by the applicant. Any "yes" responses to questions 1-10 will need additional documentation as explained in the form.

✓ **Addendum 2:** The completion of this form is **voluntary** and will **NOT** affect your application in any way.

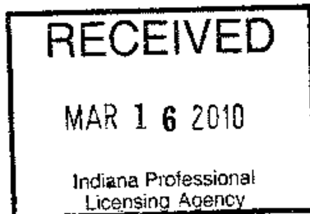
Applicant's Name Virgil Cayton Reid III

Signature [signature]

Date 3/10/10

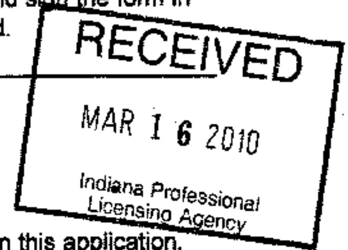
Please return a copy of the application, completed addendums and payment to the:

Medical Licensing Board of Indiana
402 West Washington Street, Room W072
Indianapolis, IN 46204



FOR OFFICE USE ONLY	
Application fee $ 250.00	**Date fee paid** ***(month, day, year)*** 3/16/10
Receipt number 3212165	**Application number**
License number 01068292A	**License issuance date** ***(month, day, year)*** 5/25/10
Permit fee $ 100.00	**Date fee paid** ***(month, day, year)*** 3/16/10
Receipt number 3212165	**Permit number** 96041601A
Permit issuance date ***(month, day, year)*** 3/19/10	

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.



Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

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

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully denial, revocation, or other disciplinary sanction of my license or permit to practic

[signature]
Applicant's Signature (must be signed in the presence of a notary)

Reid III
Applicant's Printed Last Name

Virgil Cayton III
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

3/12/10
Date of Signature

NOTARY

Dated 12TH MARCH, 2010 Signed [signature]

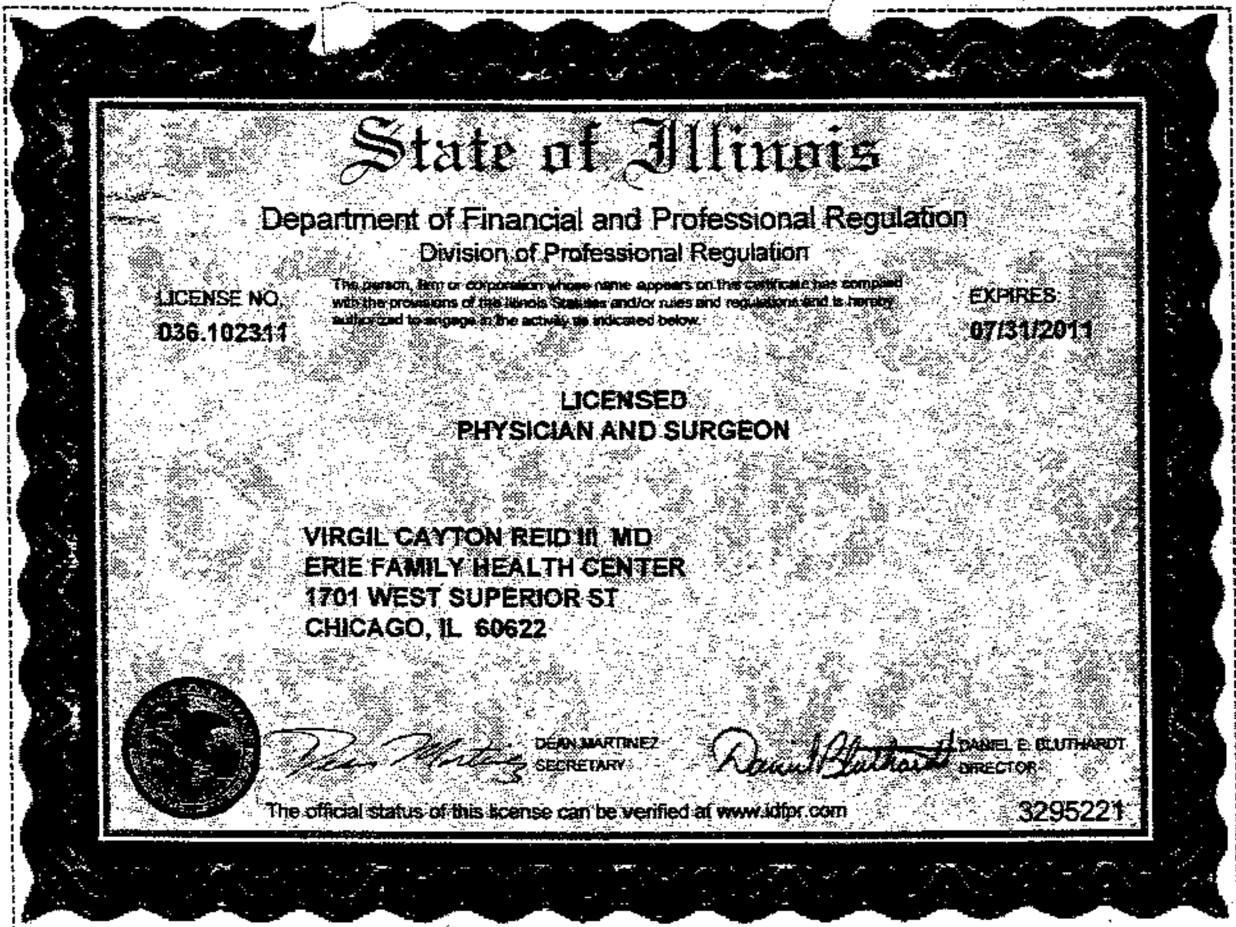
State of Illinois County of COOK

SUBSCRIBED AND SWORN TO before me this 12TH day of, March 20 10.

My commission expires: 8-25-2013 (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: Reid, Virgil Cayton Date: 3/12/10

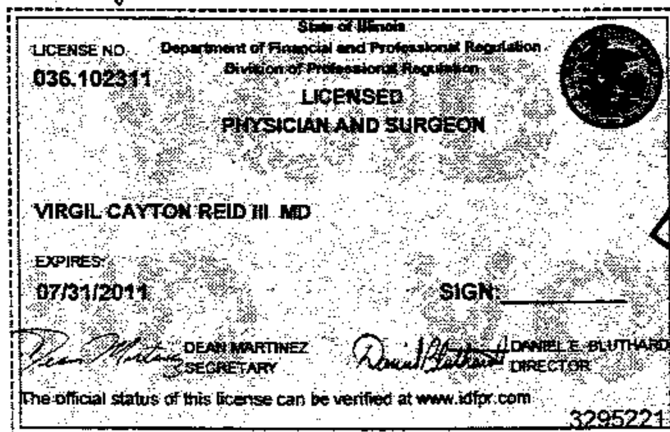
UA User : reid..gil@gmail.com

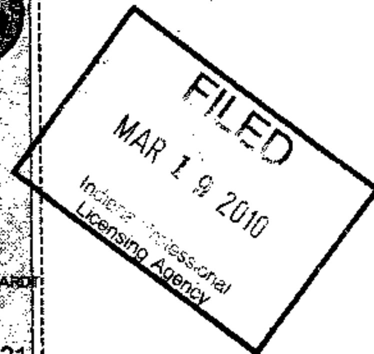

State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation
LICENSE NO. 036.102311
The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.
EXPIRES: 07/31/2011
LICENSED
PHYSICIAN AND SURGEON
VIRGIL CAYTON REID III MD
ERIE FAMILY HEALTH CENTER
1701 WEST SUPERIOR ST
CHICAGO, IL 60622
DEAN MARTINEZ
SECRETARY
DANIEL E. BLUTHARDT
DIRECTOR
The official status of this license can be verified at www.idfpr.com
3295221

Cut on Dotted Line

I TESTIFY THAT THIS IS
COPY OF THE ORIGINAL.
Maria J Rocha 3/16/2010

OFFICIAL SEAL
MARIA J. ROCHA
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8-25-2013


State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation
LICENSE NO. 036.102311
LICENSED
PHYSICIAN AND SURGEON
VIRGIL CAYTON REID III MD
EXPIRES: 07/31/2011
SIGN:
DEAN MARTINEZ
SECRETARY
DANIEL E. BLUTHARDT
DIRECTOR
The official status of this license can be verified at www.idfpr.com
3295221



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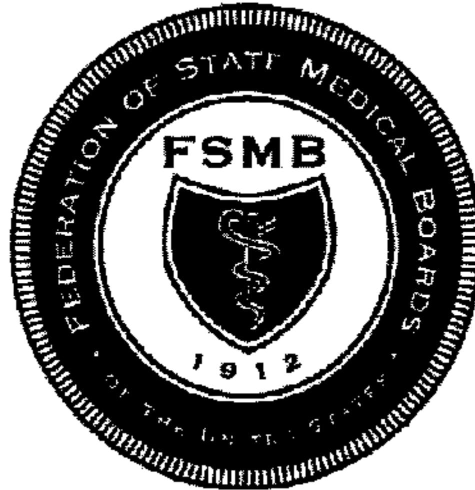
20080520-1/00411

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
P.O. Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4099

RECEIVED
2010
Indiana ... Licensing Agency

Physician Information Profile



This report is compiled exclusively for:

Name:	**Virgil Cayton Reid III**
SSN:	redacted
DOB:	
Packet ID:	**115471**
Recipient:	**Medical Licensing Board of Indiana**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

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FEDERATION CREDENTIALS VERIFICATION SERVICE

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Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Virgil Cayton Reid III**	
Other Name Used:	**N/A**	
Gender:	**Male**	
Date of Birth:	**01/23/1970**	
Place of Birth:	**High Point, NC USA**	
SSN:	redacted	
Current Address:	**675 North Peoria Street # 3S** **Chicago, IL 60642**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**N/A**
	Fax:	**N/A**
	Home:	redacted
	Other:	
Physical Description:	Height:	**6' 04"**
	Weight:	**240 lbs**
	Eye Color:	**Blue**
	Hair Color:	**Blond**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

Premedical Education (Reported by physician. Not verified by FCVS):

Institution:	**University of North Carolina - Chapel Hill, Chapel Hill, NC 27599-2100**
Dates of Attendance:	**08/1988 - 05/1992**
Degree Conferred/Issued:	**Bachelor of Arts**

Medical Education:

Medical School:	**University of North Carolina at Chapel Hill School of Medicine** **University Registrar's Office** **121 MacNider,CB#9535** **Chapel Hill, NC 27599-2100**
Dates of Attendance:	**08/19/1992 - 03/22/1996**
Date Degree Conferred/Issued:	**05/12/1996**
Degree Conferred/Issued:	**Doctor of Medicine**
Unusual Circumstance:	**None**

Graduate Medical Education:

Institution:	**University of North Carolina** **Department of Obstetrics and Gynecology** **30134 NC Womens Hospital CB 7600** **UNC School of Medicine** **Chapel Hill, NC 27514**
Training Level:	**1**
Program Type:	**Internship**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**06/24/1996 - 06/23/1997**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**2**
Program Type:	**Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**06/24/1997 - 06/23/1999**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**4**
Program Type:	**Chief Resident**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**06/24/1999 - 06/23/2000**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Virgil Cayton Reid III
DOB:	redacted
SSN:	
Packet ID:	115471
Request ID:	21930786

OMISSIONS

There are none identified.

DISCREPANCIES

Discrepancy 1:

Section of Profile: **Medical Education**

Discrepancy: The applicant reports attendance at Univ No Carolina Sch Med from 08/1992 to 05/1996. The institution reports attendance from 08/19/1992 to 03/22/1996.

Follow-Up: FCVS does not follow up with the applicant or the institution for resolution of discrepant attendance dates less than one year.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile: **Post-Graduate Education**

Issue: The applicant reports program type for 07/1996 to 06/2000 is Residency. University of North Carolina reports program type for 06/24/1996 to 06/23/2000 is Internship/Residency/Chief Resident.

Follow-Up: FCVS does not follow up on program type based on the definition of a resident per ACGME (A physician at any level of GME in a program accredited by the ACGME is considered a resident.).

End of report for Virgil Cayton Reid III

Packet Id: 115471 Request Id: 21930786 Report Created By: TMD

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

May 19, 2010

FCVS
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: May 19, 2010
Your Reference Number: fcvs-tmd
FSMB Batch Number: BQ1762702

The following is a final report of the search results from the Board Action Data Bank as of May 19, 2010 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 19, 2010

Item	Name	DOB	School	Yr/Grad	Request ID
2	Reid, Virgil Cayton III	01/23/1970	034040	1996	22276075

LICENSE HISTORY
State Board
ILLINOIS
NORTH CAROLINA

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 5/20/2010

State Queried For:	Medical Licensing Board of Indiana
Physician Name:	Virgil Cayton Reid III
Date of Birth:	redacted
Year of Graduation:	(Doctor of Medicine)
Social Security Number:	redacted
ABMSU ID:	733409

Certification:

Board:	Obstetrics and Gynecology
Specialty:	Obstetrics and Gynecology
Status:	ACTIVE
Initial Certification:	12/13/2002

All information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

Section II

Identity

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

[signature]

Applicant's Signature (must be signed in the presence of a notary)

Reid

Applicant's Printed Last Name

Virgil C. III

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

3/25/2010 redacted

Date of Signature Date of Birth

redacted

Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of Illinois County of Cook

SUBSCRIBED AND SWORN TO before me this 25 day of March, 2010

My commission expires: March 19, 2012

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: [signature]

"OFFICIAL SEAL"
Brittany Baltuff
Notary Public, State of Illinois
Cook County
My Commission Expires March 19, 2012

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

CAC

I HEREBY CERTIFY THAT THIS IS A TRUE AND ACCURATE COPY WHICH APPEARS ON RECORD IN THE OFFICE OF REGISTER OF DEEDS, GUILFORD COUNTY, N. C. IN BOOK 398 PAGE 337.

WITNESS MY HAND AND SEAL THIS 20 (DAY) OF Jan. (MONTH), 1988 (YEAR).

KAY E. PATSEAVOURAS, REGISTER OF DEEDS

BY: Betty H Case

DEPUTY REGISTER OF DEEDS

SEAL VERIFIED

337

NORTH CAROLINA STATE BOARD OF HEALTH
OFFICE OF VITAL STATISTICS

CERTIFICATE OF LIVE BIRTH

Registration District No. 41-96 Local No.

BIRTH NO. - 132

Field	Entry
1. Name of Child (First, Middle, Last)	VIRGIL CAYTON REID, III
2. Sex	Male
3a. This birth (single, twin, triplet, etc.)	Single
3b. If not single birth	
4a. Date of Birth (Month, Day, Year)	redacted
4b. Hour of Birth	9:17 A.M.
5a. Place of Birth: County	Guilford
5b. City or Town	High Point
5c. Name of Hospital or Institution	High Point Memorila Hospital
5d. Inside City Limits	Yes
6a. Usual Residence of Mother: State	North Carolina
6b. County	Guilford
6c. City or Town	High Point
6d. Street Address or R.F.D. No.	1604-J Long Street
6e. Inside City Limits	Yes
7a. Name of Father (First, Middle, Last)	Virgil Cayton Reid, II
7b. Age (at time of this birth)	22 years
7c. State of Birth	North Carolina
8a. Maiden Name of Mother (First, Middle, Last)	Sarah Lee Kendall
8b. Age (at time of this birth)	22 years
8c. State of Birth	North Carolina
9. Informant's Name	Mrs. Reid
10. Relation to Child	mother
11. Has mother inspected certificate for accuracy?	Yes
12a. Signature (certifier)	A. R. Cross
12b. Attendant (M.D., midwife, other)	M. D.
12c. Date Signed	1-27-70
12d. Attendant's Name	A. R. Cross, M. D.
12e. Address	624 Quaker Lane, High Point, N. C.
13. Date Recd by Local Reg.	1-28-70
14. Signature of Registrar	Sarah T. Morrow, M. D./vk
15. Date Name Added	
16. Date Amended	

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of North Carolina at Chapel Hill School of Medicine

Complete Address: Registrar

Street Address: 1001 Bondurant Hall, CB# 9535

City: Chapel Hill **State:** NC **ZIP Code (Postal Code):** 27599-9535

If name of institution was different when this individual attended, please note this name below:

Premedical Education:

Years of education required for admission to your medical school: 4 undergraduate

Credential/degree presented by the applicant for admission to your medical school: BA - UNC Chapel Hill

Enrollment and Participation: Our records indicate that Virgil Cayton Reid III
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 147 weeks of medical education on the following dates (mm/dd/yy):

From August / 19 / 1992 (Month / Date / Year) **To** March / 22 / 1996 (Month / Date / Year)

This individual (check one):

Was awarded the degree of Doctor of Medicine on May / 12 / 1996 (Month / Date / Year)

Was NOT awarded a degree because: ____
(please explain - attach additional pages if necessary)

Certification: By my signature, I, Forrest H. Page (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Signature: [signature]

Title: Registrar

Date of Signature: March 16, 2010

Phone: (919) 962-8335 **Fax:** (919) 966-9930

Email:

SEAL VERIFIED

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)
(continued)

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☐ NO ☒

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: __________

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education?
   Response YES ☐ NO ☒

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: __________

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university?
   Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university?
   Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
   Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Medical Education

School	034040 - University of North Carolina at Chapel Hill School of Medicine		
Address	Office of Student Affairs/Guy Winstead Chapel Hill, NC 27599-7000 USA		
Phone			
Dates	08/1992 - 05/1996	**Grad Date**	05/12/1996
Degree	MD - Doctor of Medicine		
Program 6+ years:	N		
Completed clinical clerkship in a country other than where my medical school was located:	N		
Clinical Training			
Unusual Circumstances			
Leaves/Extensions	N		
Probation	N		
Disciplined	N		
Negative Reports	N		
Limitations	N		

PROVIDED BY APPLICANT

DEAN'S LETTER OF EVALUATION

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

Office of the Dean
The School of Medicine

CB# 7000, MacNider Bldg.
The University of North Carolina at Chapel Hill
Chapel Hill, N.C. 27599-7000

DEAN'S LETTER OF EVALUATION

Virgil Cayton Reid, III
Class of 1996

November 1, 1995

Education and experience prior to medical school: Mr. Reid graduated from the University of North Carolina (UNC) at Chapel Hill with a Bachelor of Arts degree with Distinction in Chemistry and German. He was elected to Phi Beta Kappa and to the German honor society, Delta Phi Alpha, during his senior year. Mr. Reid spent his junior year at Eberhard-Karls University in Tübingen, Germany, studying German culture, language, and art.

Mr. Reid became familiar with the work of health care through volunteer efforts and employment. At our University hospital, he volunteered in Pediatrics: the Neonatal Intensive Care Unit and the Screening and Oncology Clinics. During his senior year, and the following summer, he worked as a unit secretary for the Department of Pediatrics and the Division of Pediatric Surgery.

An accomplished trumpet player, he performed with the University's marching, pep, and concert bands, and with our wind ensemble. In preparation for his junior year abroad, Mr. Reid participated in the University's Living and Learning Program during his sophomore year. He lived in the German House, where residents speak only German and meet to hear talks about German history and culture. While there, he volunteered as a tutor in conversational English for German students at UNC. During his senior year, Mr. Reid was employed as a teaching assistant and laboratory instructor for the Department of Chemistry. He continued this work during the summer following graduation.

Preclinical record: Mr. Reid earned overall year end grades of Pass for each of the first two years of medical school with individual course grades of Honors in Cell Biology, Medicine and Society, and in his Biomedical Sciences Seminar: Basic Cellular and Molecular Mechanisms in Autoimmunity. Small group seminar instructors were impressed with Mr. Reid's critical thinking ability, sensitivity, and sense of humor. In his Humanities and Social Sciences selective: Case Histories from the Inside: Pain and Narrative, he was "always willing to start a good-natured but substantive argument" in which he "sought to cut to assumptions and examine them. He is rigorously skeptical in the best ways; not negative or pessimistic but imaginative and demanding." His instructor appreciated his grasp of German literature and language, noting that he "translated for the class some poetry by the German physician-author Gottfried Benn." In Clinical Epidemiology and Preventive Medicine he "did an excellent job challenging conventional wisdom on many topics. He goes after a topic from many different angles until he's sure that he understands it. This is a trait that will serve him well." For his

paper about the use of streptokinaise versus TPA in the treatment of myocardial infarction, "he found the appropriate articles, was able to adequately interpret some very difficult biostatistical issues in these large trials and came to a definite conclusion. I was impressed."

Clinical clerkship and elective record: Mr. Reid earned Honors in two of his six third year clinical clerkships: Family Medicine and Obstetrics/Gynecology. Throughout his clerkships, supervisors were impressed with Mr. Reid's independent learning, deductive reasoning, and ability to present pertinent material in a succinct, clear manner. In his third clerkship, Medicine, he showed "a deep understanding of medical problems and was capable of analyzing them in a very sophisticated manner. He has shown an ability to develop differential diagnoses far in advance of his level of training." Also in Medicine, "his presentation skills were among the best I've seen with students." He followed "patients closely and already presents cases as though he were a house officer." He was described by attendings in Family Medicine as "the best student that they had had in recent memory." He developed rapport with patients easily, gained their trust, and conducted himself in a "helpful, professional manner." He was "very mature and poised." In his Obstetrics/Gynecology clerkship "he showed a great deal of initiative and worked hard, thoroughly, and efficiently. He was great with patients. He obviously liked the specialty and will make an excellent ObGyn resident."

In his two senior electives completed thus far, he has earned Honors. In Maternal-Fetal Medicine, "his knowledge base and his ability to incorporate it into patient evaluations and development of plans of management is considerably above that of most students at his level. He is very mature and established good rapport with patients. His presentation on the use of corticosteroids to enhance fetal pulmonary maturity was well researched, efficiently summarized, and clearly articulated." Mr. Reid was considered "outstanding" in his Ambulatory Care Selective in ObGyn. He demonstrated "clinical skills and judgement, appreciation of the broadest definitions of health, and insights into primary and secondary prevention which far exceed expectations." His project explored repeat pregnancies in teenagers. When he formally presented his findings to the clinic staff, they were "surprised by the scope of the problem and began to meet about Mr. Reid's suggested interventions." (For detailed comments about each third year clerkship and fourth year elective performance, please refer to the attached summary sheet.)

Research and extracurricular activities: During the summer after his first year in medical school, Mr. Reid was sponsored by Dr. Hartwig Bunzendahl of our Department of Surgery to work with Dr. Rheinhard Schwinzer of the Department of Transplant Immunology at the Medizinische Hochschule Hannover in Hannover,. Germany. There he used flow cytometry to measure the movement of calcium into activated T-cells. His research was funded in part by our school's National Institutes of Health (NIH) student research training grant and by one of our foreign fellowships.

For his first two years in medical school, Mr. Reid volunteered with the North Carolina Student Rural Health Coalition (RHC), a group of health professions students who provide care and health education to medically underserved indigent patients in a rural community of eastern North Carolina. During his second year, he was one of three Co-Presidents of the group with responsibility for scheduling and coordinating the monthly clinics and for working with local community leaders to determine the need for specific services and to develop new programs and sources of funding. During

his first year, Mr. Reid volunteered in our Student Health Action Committee (SHAC) Clinic, a student-run free community health care clinic for local indigent patients.

Summary: Mr. Virgil Cayton Reid, III is an excellent candidate for success in residency training. He demonstrated outstanding clinical skills and judgement, independent learning, and sophisticated problem analysis. His presentations of patient material and scientific research were careful, succinct, and clear. As one of three co-presidents of the North Carolina Student Rural Health Coalition, he gave leadership to a medical student extracurricular activity emphasizing community participation in health maintenance.

Respectfully submitted by,

Cheryl F. McCartney M.D.

Cheryl F. McCartney, M.D.
Associate Dean for Student Affairs

CFM/clh

Addendum: Performance rating categories at the University of North Carolina School of Medicine are Outstanding, Excellent, Very Good, Good, and Adequate.

Addendum: In accordance with the Family Educational Rights and Privacy Act of 1974, it is the expressed condition of this institution that information contained in this letter of evaluation not be transferred to any other individual, agency or organization without the written consent of the student.

The University of North Carolina
at Chapel Hill

To all to whom these presents shall come

Greeting

Be it known that

Virgil Cayton Reid III

having completed the studies and fulfilled the requirements of the Faculty for the degree of

Doctor of Medicine

has accordingly been admitted to that degree, with all the rights, honors, and privileges thereunto appertaining.
In witness whereof, the Seal of the University and the signatures of duly authorized officers are affixed to this diploma.

Given at Chapel Hill, in the State of North Carolina, this twelfth day of May in the year nineteen hundred and ninety-six and of this University the two hundred and seventh.

Chairman of the Board of Governors
The University of North Carolina

President
The University of North Carolina

Chairman of the Board of Trustees
The University of North Carolina at Chapel Hill

Chancellor
The University of North Carolina at Chapel Hill

Dean

SEAL
VERIFIED

To Whom It May Concern:

Certified to be a true copy of a valid DIPLOMA from
The University of North Carolina at Chapel Hill.
Chapel Hill, North Carolina, U.S.A.

[signature]

Forrest H. Page, Registrar
School of Medicine
University of North Carolina at Chapel Hill

North Carolina
Orange County

I, Randee Cecile Alsten, a Notary Public, do

hereby certify that Forrest Page
personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal, this the 16 day of March 2010.

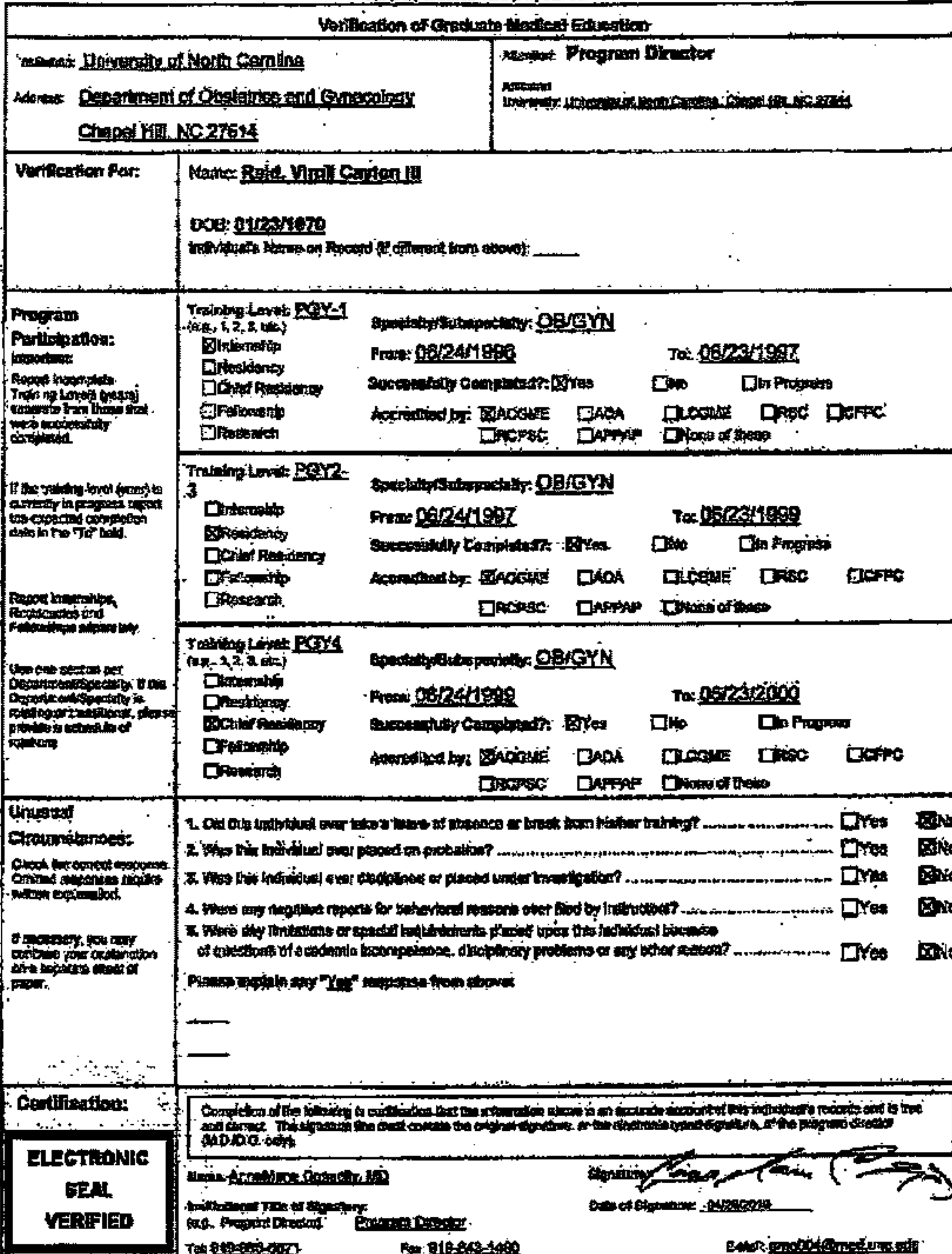
(Official Seal) [signature: Randee Cecile Alsten]
Notary Public

My commission expires February 7, 20~~10~~ 11.

SEAL VERIFIED

Section IV

Graduate Medical Education Training



Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-4000 Fax: (817) 868-5030

Verification of Graduate Medical Education

Institution: University of North Carolina
Address: Department of Obstetrics and Gynecology
Chapel Hill, NC 27514

Attention: **Program Director**
Affiliated University: University of North Carolina, Chapel Hill, NC 27514

Verification For:
Name: **Reid, Virgil Carlton III**
DOB: 01/23/1970
Individual's Name on Record (if different from above): ______

Program Participation:
Important: Report incomplete Training Levels (years) separate from those that were successfully completed.
If the training level (year) is currently in progress report the expected completion date in the "To" field.
Report Internships, Residencies and Fellowships separately.
Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: PGY-1 (e.g., 1, 2, 3, etc.)
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB/GYN
From: 06/24/1996 To: 06/23/1997
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: PGY2-3
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB/GYN
From: 06/24/1997 To: 06/23/1999
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: PGY4 (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☒ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB/GYN
From: 06/24/1999 To: 06/23/2000
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:
Check the correct response. Omitted responses require written explanation.
If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

Certification:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

ELECTRONIC SEAL VERIFIED

Name: AnneMarie Gotschy, MD
Signature: [signature]
Institutional Title of Signatory: (e.g., Program Director) Program Director
Date of Signature: 04/26/2018
Tel: [illegible] Fax: 919-843-1490 E-mail: [illegible]@med.unc.edu

Rev. [illegible] Packet ID: [illegible] Request ID: 21930788 site code [10693]

Postgraduate Medical Education

PROVIDED BY APPLICANT

Hospital	UNC Hospital
Affiliated School	University of North Carolina
	Manning Drive
	Chapel Hill, NC 27599

Year(s)	1-4	Program Type	Residency
Complete?	Yes	Specialty/Subspecialty	Obstetrics and Gynecology
Dates	07/1996 - 06/2000		

Unusual Circumstances

Leaves/Extensions	N
Probation	N
Disciplined	N
Negative Reports	N
Limits	N

[illegible]
North Carolina Hospitals

and the School of Medicine of the
University of North Carolina at Chapel Hill

This is to certify that

Virgil C. Reid III, M.D.

has successfully completed training as a

Resident in Obstetrics and Gynecology

In Witness Whereof, this certificate is awarded at Chapel Hill,
North Carolina this 30th day of June, 2000.

Program Director

Dean, School of Medicine

President & CEO

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

PAT QUINN
Governor

BRENT E. ADAMS
Secretary

DONALD W. SEASOCK
Acting Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

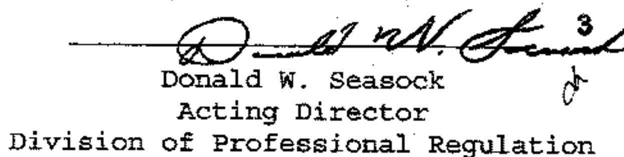
April 8, 2010

PROFESSIONAL LICENSING AGENCY
402 W WASHINGTON ST ROOM W072
INDIANAPOLIS, IN 46204

Licensee:	VIRGIL CAYTON REID III MD
License Number:	036.102311
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	04/10/2000
Expiration Date:	07/31/2011
License Status:	ACTIVE
License Method:	ACCEPT EXAM - USMLE
Disciplinary History:	Has not been disciplined

RECEIVED
APR 12 2010
Indiana Professional Licensing Agency

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



Donald W. Seasock
Acting Director
Division of Professional Regulation

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

NORTH CAROLINA MEDICAL BOARD

Donald E. Jablonski, DO
President

Janice E. Huff, MD
President-Elect

William A. Walker, MD
Secretary/Treasurer

Indiana Professional Licensing Agency
402 W. Washington Street RM WO72
Indianapolis, IN 46204

LICENSE VERIFICATION FORM

DATE: **March 19, 2010**

TO WHOM IT MAY CONCERN:

This is to verify that the practitioner noted below was issued a North Carolina License. A review of the files indicate the following information:

Name: Virgil Cayton Reid
Address: UNC HOSPITALS
101 MANNING DRIVE
Chapel Hill, NC 27599-

Annual Renewal Date:
Public Action: No

License Number	License Type	Issue Date	Current Status	Expire Date
	Resident Training	07/17/1996	Inactive	04/10/2001

RECEIVED

MAR 22 2010

Indiana Professional
Licensing Agency

Sincerely,

R David Henderson

R. David Henderson
Executive Director

R. David Henderson
Executive Director

1203 Front Street
Raleigh, North Carolina 27609-7533

Mailing:
P.O. Box 20007
Raleigh, North Carolina 27619-0007

Telephone: (919) 326-1100
Fax: (919) 326-1131
Email: info@ncmedboard.org
Web: www.ncmedboard.org

04/16/2011

INDIANA PROFESSIONAL LICENSING AGENCY
Internet Renewal Questions

Name: **Reid, Virgil Cayton, III** LICENSE#: **01068292A**
Care Of:
Address: redacted
City/St/Zip: **New Buffalo, MI 49117**

Birth Date **01/23/1970**

Date/Time Completed: 6/16/2011 12:57:56PM

Question	Answer
1.) Since you last renewed, has any professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending in any state?	**N**
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state?	**N**
3.) Since you last renewed, have you been convicted of or pled guilty to a violation of a federal or state law or are criminal charges pending?	**N**
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	**N**
5.) Since you last renewed, have you been denied staff membership or privileges in any hospital or health care facility or have staff membership or privileges been revoked, suspended, or subject to any restriction, probation, or other type of discipline - or have you resigned in lieu of discipline or termination?	**N**
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	**N**
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	**N**

Person Info

Name: Virgil Cayton Reid, III

Address Info

Street Address: 14432 Ridgeview Dr
Fax:
City: New Buffalo
State: MI
Zipcode: 49117
Country: United States
County: Cook

Email: redacted@gmail.com
Phone: redacted085

Survey Response Summary

Question	Answer

Question Response Summary

Question	Answer
1.) Since you last renewed, has any professional license, certificate, registration, or permit you hold or have held been disciplined or are formal charges pending in any state?	N
2.) Since you last renewed, have you been denied a license, certificate, registration, or permit in any state?	N
3.) Since you last renewed, have you ever been arrested or convicted for a crime that has not been expunged by an Indiana court?	N
4.) Since you last renewed, have you had a malpractice judgment against you or settled any malpractice action?	N
5.) Since you last renewed, have you been denied staff membership or privileges in any hospital or health care facility or have staff membership or privileges been revoked, suspended, or subject to any restriction, probation, or other type of discipline - or have you resigned in lieu of discipline or termination?	N
6.) Since you last renewed, have you been excluded from being a Medicare or Medicaid provider?	N
7.) Since you last renewed, have you surrendered your DEA registration at any time or had any limitations or discipline placed on your DEA registration?	N