APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. SEE **REFERENCE SHEET, CHART I, OR INSTRUCTIONS** PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Physician	036	Endorsement	$300.00

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [x] This is the first time I have made application for this profession in Illinois.
- [ ] I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- [ ] Other: ____________________
- [ ] My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- [ ] I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
Berry Stanley Michael	M.D.	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

[redacted]

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

[redacted]

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)

7. MOTHER'S MAIDEN NAME [redacted]

8. PLACE OF BIRTH CITY STATE/COUNTRY [redacted]

9. DATE OF BIRTH [redacted] Month Day Year

10. AGE 58 [ ] Female [x] Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: [redacted] Home: [redacted]

Fax: [redacted] Fax: [redacted]

(Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) [If available] [redacted]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 (12) Graduated High School? [X] Yes [ ] No Received OR G.E.D.? [ ] Yes [ ] No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
Sterling School	Craftsbury Common, VT	06 / 1971 (Month / Year)

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 (8) Graduated? [X] Yes [ ] No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	TO Month/Year	TYPE OF DEGREE EARNED
Kenyon College	Gambier, OH	1971	1972	N/A
Macalester College	St. Paul, MN	1972	1978	N/A
Creighton University	Omaha, NE	1978	1979	N/A
Mayo Medical School	Rochester, MN	1979	1984	M.D.

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM Month/Year	TO Month/Year	Did You Complete Training?
St. Louis Univ. Hospitals	St. Louis, MO	1984	1988	[X] Yes [ ] No
Wayne State Univ. Hutzel Hospital	Detroit, MI	1988	1990	[X] Yes [ ] No
Kings College Hospital	London, England	1990	1990	[X] Yes [ ] No
				[ ] Yes [ ] No
				[ ] Yes [ ] No

NAME (Last, First, MI): Berry, Stanley M.

SS#:

Profession: Physician

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure: Missouri	Physician	MDR8E28	1984	Expired
State of Current Licensure where you most recently have been practicing: Michigan	Physician	4301052533	1988	Active
Other States of Licensure				
Michigan	Physician	4301052533	1988	Active
Georgia	Physician	051433	N/A	Active

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)
NBME - Part 1		10/82	Passed
NBME - Part 2			Passed
NBME - Part 3			Passed

(If additional space is needed, attach a separate sheet.)

NAME (Last, First, MI): Berry, Stanley M

SS#: [redacted]

Profession: Physician

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		X
2. Have you been convicted of a felony?		X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		X
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		X
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		X

NAME (Last, First, MI): Berry, Stanley M

PART VII: Examination Coding Information ***(This part is for examination applicants only)***

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes.

b) CHART III - Select the examination site you desire and enter Test Center Code:

c) CHART IV - Find your School of Graduation and enter school code:

d) Record the number of times you have taken this exam in Illinois or any other state:

SS#:

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☒
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☒

Profession: Physician

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant ________ Date 3/5/12

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed

HEALTH CARE WORKERS CHARGED WITH OR CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE

Berry Stanley Michael

3. PROFESSIONAL LICENSE NUMBER (if any)

___-_______

2. ADDRESS STREET, CITY, STATE, ZIP CODE

4. SOCIAL SECURITY NUMBER

[redacted]

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Advanced Practice Nurses
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Occupational Therapists
- ☐ Optometrists
- ☐ Pharmacists
- ☐ Podiatrists
- ☐ Physical Therapists
- ☐ Physician Assistants
- ☒ Physicians (036)
- ☐ Registered Nurses
- ☐ Speech Pathologists

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In order for your application to be evaluated, you must respond to each of the following questions:

	Question	Yes	No
1)	Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☒
2)	Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration?	☐	☒
3)	Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☒

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted]
Signature of Applicant

Date 5/7/2012

Michigan
777 Woodward Avenue, Suite 600
Detroit, MI 48226
313-324-3700
Provider Services: 888-773-2647
Member Services: 888-437-0606
www.mhplan.com

Meridian
Health Plan

May 9, 2013

Illinois Department of Financial and Professional Regulation
Attn: Medical Unit

Fax No. 217-524-2169

Re:
Name: Stanley Michael Berry, MD
Address: [redacted]
SS : [redacted]

Dear Sir/Madam:

I am requesting that you release information regarding my file/application to my assistant, Kathy McKendry. Please call me at 248-259-0671 if you have any questions.

Thank you.

[redacted]

Stanley M. Berry, MD
Medical Director of Quality Improvement

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

Berry Stanley Michael

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☒ Permanent Physician License	036
☐ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

3. ADDRESS STREET, CITY, STATE, ZIP CODE

4. DATE OF BIRTH

5. SOCIAL SECURITY NUMBER

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION: Meridian Health Plan

JOB TITLE: Medical Director

ADDRESS STREET, CITY, STATE, ZIP CODE: 777 Woodward Detroit, MI 48226

DESCRIPTION OF DUTIES PERFORMED: Quality Improvement Reports to Chief Medical Officer

DATE OF EMPLOYMENT/ATTENDANCE: From 12/01/2011 (Month Day Year) To __/Present (Month Day Year)

HOURS WORKED PER WEEK: 40

TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month): 1/3

B. NAME OF BUSINESS / INSTITUTION: William Beaumont Hospitals

JOB TITLE: Corporate ~~Chairman~~ Chairman for the

ADDRESS STREET, CITY, STATE, ZIP CODE: 3601 West 13 mile Rd, Royal Oak, MI 48073

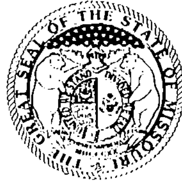
DESCRIPTION OF DUTIES PERFORMED: Department of Obstetrics and Gynecology

DATE OF EMPLOYMENT/ATTENDANCE: From 07/01/2004 (Month Day Year) To 07/01/2011 (Month Day Year)

HOURS WORKED PER WEEK: 40

TYPE OF EMPLOYMENT: ☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month): 8yrs/0 months



Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Jane A. Rackers, Division Director
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 Missouri Boulevard
P.O. Box 4
Jefferson City, MO 65102-0004
573-751-0098
866-289-5753 TOLL FREE
573-751-3166 FAX
800-735-2966 TTY
website: www.pr.mo.gov/healingarts.asp

Tina Steinman
Executive Director

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MAY 25 2012
IDFPR - MEDICAL UNIT

To:

Illinois Dept of Financial & Professional Regulation
Medical Board 320 W Washington St 3rd Flr
Springfield, IL 62786

This is to certify that the records of the Missouri Board of Healing Arts indicate the following information regarding Stanley M Berry, M.D..

LICENSE TYPE:	Medical Physician & Surgeon
DATE OF BIRTH:	
LICENSE NUMBER:	R8E28
DATE ISSUED:	7/1/1985
STATUS:	Lapsed
EXPIRATION DATE:	1/31/1994
LICENSE METHOD:	Natl Bd of Medical Examiners
MEDICAL SCHOOL:	Mayo Med Sch Rochester
DISCIPLINARY ACTION:	None

Donna Ellis
Verifications Clerk

05/18/2012
Date

This is the only form that will be used by the Missouri State Board of Registration for the Healing Arts for the purpose of license verification.

SD

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES

RICK SNYDER
GOVERNOR

STEVE ARWOOD
DIRECTOR

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF May 24, 2013

NAME: Stanley Michael Berry

BIRTHDATE: [redacted]

ADDRESS: [redacted]

TYPE: Medical Doctor

ORIGINAL DATE: 03/23/1988

LICENSE NUMBER: 4301052533 **STATUS:** Active

EXPIRATION DATE: 01/31/2016

OBTAINED BY: Endorsement

EXAM DATE **EXAM TYPE** **EXAM SCORE OR RESULT**

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

This license information was last updated on: 5/23/2013

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HEALTH PROFESSIONS DIVISION
611 W. OTTAWA ST. 1ST FL • P.O. BOX 30670 • LANSING, MICHIGAN 48909

MAY 17 2012 PM 3:40

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING**	SUPPORTING DOCUMENT **TN-MED** (DPR)

APPLICANT: ***Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Berry Stanley Michael	[redacted] Month Day Year	[redacted]
4. ADDRESS STREET, CITY, STATE, ZIP CODE [redacted]	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.	
6. MAIDEN OR GIVEN SURNAME	Physician (Profession Name) 036 (Profession Code)	
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)	8. ISSUANCE DATE	

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

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This is to certify that the above-named applicant satisfactorily completed 48 months of postgraduate clinical training in Obstetrics & Gynecology (Name of Specialty Program)

from 7/1/1984 (MM/DD/YYYY) to 6/30/1988 (MM/DD/YYYY) at the following hospital:

Hospital: Saint Louis University / St Mary's Health Ctr

Number and Street: 6420 Clayton Rd

City, State and Zip Code: St. Louis MO 63117

I further certify that at the time of such training the program was accredited by:

- [x] the ACGME
- [ ] the AOA
- [ ] the CFPC, RCPSC or FMLAC (Canadian Programs)
- [ ] not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: Mary T. McLennan, MD

Signature of Postgraduate Clinical Training Program Director: [redacted]

Date of this Certification: 5/14/12

Telephone No: (314) ~~97~~ 781-6031

University/Hospital
SEAL

(If no seal, attach letter on letterhead stating no seal exists.)

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Record of Scores

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Recipient: Illinois Div of Professional Regulation
320 West Washington Street, 3rd floor
Springfield, IL 62786

Date: 07/12/2012

Examinee ID: 3-303-610-4

Examinee: Berry, Stanley M

Date of Birth: [redacted]

This record shows a complete Part history for this examinee.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
09/08/1982	Pass	Three-Digit									
		Two-Digit									

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Med	Surg	ObGyn	Prev	Peds	Psych
04/03/1984	Pass	Three-Digit								
		Two-Digit								

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/06/1985	Pass	Three-Digit		
		Two-Digit		

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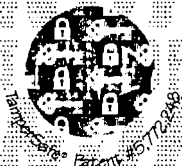
/64303

Patent 5636874



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SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE

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Authenticity of NBME Record of Scores

An original, certified NBME Record of Scores is printed using black ink on green safety paper and is produced only by the National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of the NBME Record of Scores may result in appropriate legal action or other action consistent with applicable policies.

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INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

Unless otherwise noted, the most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

NBME Part I and Part II Examinations June 1991 and Thereafter

Unless otherwise noted, the most recent total test score is reported. This score is on a scale with a mean of 200 and a standard deviation of 20, in increments of 1. Most scores fall between 145 and 260.

All NBME Part III Examinations

Unless otherwise noted, the most recent total test score is reported. This score is on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

Two-Digit NBME Scores

For all NBME scores, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

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

April 04, 2012

Attn: Jay Stewart
Illinois Dept of Financial and Professional Regulation
Jay Stewart
Springfield Office
320 W. Washington St, 3rd FL
Springfield, IL 62786

Re: Board Action Query Dated: April 04, 2012
Your Reference Number:
FSMB Batch Number: BQ2054946

The following is a report of the search results from the Board Action Data Bank as of April 04, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of April 04, 2012

Item	Name	DOB	School	Yr/Grad	Request ID
1	Berry, Stanley	[redacted]		1984	[redacted]
		LICENSE HISTORY State Board GEORGIA MICHIGAN			
2	Finn, Katherine	[redacted]		2009	
		LICENSE HISTORY State Board No License Information Available			
4	Miller, Gregory	[redacted]		1976	
		LICENSE HISTORY State Board INDIANA NEBRASKA UTAH WISCONSIN			
5	Tariq, Sarah	[redacted]		2000	
		LICENSE HISTORY State Board No License Information Available			

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.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for

Name: **Stanley Michael Berry**

Social Security: Number: [redacted]

Date of Birth: [redacted]

FID#: [redacted]

Recipient: **IL - Illinois Department of Financial and Professional Regulation**

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ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional 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.

NOTICE: All documents bearing an original Official FCVS seal are certified 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.

This FCVS medical professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other Intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

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FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis report for further details on the unresolved items

Medical Professional Name: **Stanley Michael Berry**
Date of Birth: [redacted]
Social Security Number: [redacted]
FID: [redacted]

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

Mayo Medical School
1. Medical Education Form
2. Medical Education L2
3. Medical Education Dean's Letter
4. Medical Education Transcript
X 5. Medical Education Diploma

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

Saint Louis University School of Medicine
1. GME Form
2. GME Completion Certificate

VI. Licensure Examination History

A. NBME Record of scores

End of report for: Stanley Michael Berry

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Section I

FCVS Reports

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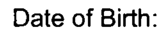
Identity

Medical Professional Name: **Stanley Michael Berry**

Documentation: Certified Birth Certificate

Gender: Male



Date of Birth:

Place of Birth:

Social Security Number:

FID:

Physical Description:

Height:	6 ft. 5 in.
Weight:	294 lbs.
Eye Color:	Brown
Hair Color:	Brown

Contact Information

Mailing Address:

Permanent Address:

Telephone Numbers: Primary:

Secondary:

Fax:

Other:

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Premedical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **Kenyon College**
Address: Gambier, OH 43022-9623
UNITED STATES
Dates of Attendance: 09/--/1971 To 05/--/1972
Degree Conferred/Issued: Applicant did not graduate

(Provided by Applicant. Not verified with the primary source.)

Institution: **Macalester College**
Address: St Paul, MN 55105
UNITED STATES
Dates of Attendance: 10/--/1972 To 06/--/1978
Degree Conferred/Issued: Applicant did not graduate

(Provided by Applicant. Not verified with the primary source.)

Institution: **Creighton University**
Address: Omaha, NE 68178
UNITED STATES
Dates of Attendance: 09/--/1978 To 05/--/1979
Degree Conferred/Issued: None

ECFMG

There are none identified or not applicable.

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Medical Education

Medical School:	**Mayo Medical School**
Address:	200 First Street SW Rochester, MN 55905 UNITED STATES
Dates of Attendance:	09/04/1979 to 05/18/1984
Date Certificate Issued:	05/19/1984
Degree Conferred/Issued:	Doctor of Medicine
Unusual Circumstances	
Leave of Absence/Extension:	**Yes**
Dates:	**09/1980 To 07/1981**
Comments:	**Academic remediation Approved** **Student repeated year I curriculum**
Probation:	**No**
Disciplined:	**No**
Negative Reports:	**No**
Limitations:	**No**

Fifth Pathway

There are none identified or not applicable.

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Graduate Medical Education

Institution: **Saint Louis University School of Medicine**
Address: 3635 Vista At Grand
PO Box 15250
St Louis, MO 63110-0250
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/1984 To 06/30/1985
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2 - 4
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/1985 To 06/30/1988
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

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Licensure Examinations

NBME - National Board of Medical Examiners NBME Part I	Date: 09/1982	Passed the Exam
NBME - National Board of Medical Examiners NBME Part II	Date: 04/1984	Passed the Exam
NBME - National Board of Medical Examiners NBME Part III	Date: 03/1985	Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

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

End of report for Stanley Michael Berry

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Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the 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.

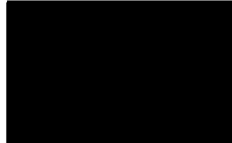
Medical Professional Identification

Medical Professional Name: **Stanley Michael Berry**

Date of Birth:

Social Security Number:

FID:



Omissions

There are no omissions identified.

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Discrepancies

Discrepancy 1:

Section of Profile: **Medical Education**

Discrepancy: **FCVS has identified discrepant information relating to the medical education graduation date for the Mayo Medical School**

Verification of Medical Education Form - 05/19/1984
Medical School Diploma - 05/19/1984
Applicant - 05/01/1984

Action Taken: **FCVS has defined "graduation date" as the date the diploma was issued to the applicant by the medical school.**

Discrepancy 2:

Section of Profile: **Medical Education**

Discrepancy: **FCVS has identified inconsistent information relating to the Unusual Circumstances section of the Medical Education Form for Mayo Medical School.**

Probation

Action Taken: **FCVS does not follow up with the applicant or the institution with inconsistent information on Unusual Circumstances questions. Any supporting information provided by the applicant and/or institution is included in the Medical Professional Information Profile.**

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Stanley Michael Berry

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Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Stanley Michael Berry**
Date of Birth: **May 20, 1953**
Social Security Number: **XXX-XX-3771**
FID#: **209829258**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
9/1979	05/1984	Medical Education Record	Mayo Medical School,200 First Street SW Rochester, MN 55905 UNITED STATES		
6/1984	06/1988	GME Record	Saint Louis University School of Medicine,3635 Vista At Grand St Louis, MO 63110-0250 UNITED STATES		
7/1988	06/1990	GME Record	Saint Louis University School of Medicine,3635 Vista At Grand St Louis, MO 63110-0250 UNITED STATES		

End of report for Stanley Michael Berry

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Section II

FSMB and Other Reports

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July 27, 2012

Attn: Tracy Bevers
FCVS
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: July 27, 2012
FSMB Batch Number: BQ2116346

The following is a report of the search results from the Board Action Data Bank as of July 27, 2012 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of July 27, 2012

Name	DOB	School	Yr/Grad	Provider ID
Stanley Michael Berry	[redacted]	024010	1984	232801

License History

Licensing Entity
GEORGIA
MICHIGAN

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.

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

ABMS Verification of Certification

Federation of STATE MEDICAL BOARDS

As of: **07/27/2012**
Medical Professional Name: **Stanley Michael Berry**
Date of Birth: [redacted]
Year of Graduation: **(Doctor of Medicine)**
Social Security Number: [redacted]
ABMSUID#:: [redacted]

Certification

Certification:

Board: Obstetrics and Gynecology
Specialty: Obstetrics and Gynecology
Status: IACT
Initial Certification: 12/06/1991

Certification:

Board: Obstetrics and Gynecology
Specialty: Maternal-Fetal Medicine
Status: IACT
Initial Certification: 12/01/1992

End of report for Stanley Michael Berry

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.

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Section III

Identity

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Affidavit and Release

Federation of STATE MEDICAL BOARDS

Notary:
The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I, the undersigned, 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 me 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 Federation Credentials Verification Service 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 Federation Credentials Verification Service 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 Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

While the FSMB will only use collected personal information for the purposes described on our website and in the FCVS application materials, the FSMB has no control over the entities to which an applicant authorizes the release of FCVS materials. Such entities may include state medical boards, state osteopathic boards, and other entities that may be subject to state and federal public information or open records laws, which might require the release of certain FCVS packet information to the public upon request.

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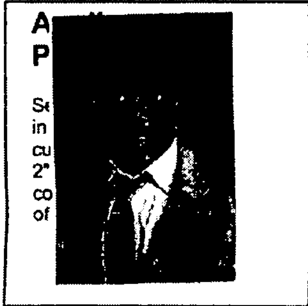

Applicant's Signature (must be signed in the presence of a notary)

Berry, Stanley
Michael

Applicant's Printed Last Name

03/21/2012

Date of Signature (must correspond to date of notarization)

State of Michigan, County of Wayne,
I certify that on the date set forth below 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. The statements on this document are subscribed and sworn to before me by the applicant on this 21st day of March, 2012.

TRACY NOVAK
NOTARY PUBLIC, STATE OF MI
COUNTY OF MACOMB
MY COMMISSION EXPIRES Aug 6, 2016
ACTING IN COUNTY OF Wayne

Notary Public Signature:

My Notary Commission Expires: August 6, 2016

232801 232801 209829258

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Section IV

Medical Education

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

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 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).

Institution Name: Mayo Medical School

Address Line 1:
Office of Associate Dean/Student Affairs

Address Line 2:
200 First Street SW

City: Rochester **State/Province:** MN **Zip Code (Postal Code):** 55905
Country: US

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
Credential/degree presented by the applicant for admission to your medical school: B.A., Macalester College

Enrollment and Participation: Our records indicate that Berry, Stanley Michael
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 198 weeks of medical education on the following dates: **From:** 9,4,79 (Month Day Year) **To:** 5,18,84 (Month Day Year)

This individual
Was awarded the degree of Doctor of Medicine on 5,19,84 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.

SEAL VERIFIED

Name: David L. Dahlen
Signature:
Title: Registrar
Date of Signature: 5,11,12 Phone: (507) 284-3627
Fax: (507) 266-5298 Email:

232801 953 209829258

232801 953

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Unusual Circumstances

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

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved:

Reason	From (Mo/Yr)	To (Mo/Yr)	Approved	Unapproved
Personal/Family	___/___	___/___	___	___
Academic remediation	9/80	7/81	✓	___
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: Student repeated year I curriculum

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

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

Reason	From (Mo/Yr)	To (Mo/Yr)
Academic Probation	___/___	___/___
Probation for unprofessional conduct/behavioral	___/___	___/___
Probation for other reason	___/___	___/___

Please specify a 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? ___ 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? ___ 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? ___ YES ✓ NO

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

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Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: **Stanley Michael Berry**
Mayo Medical School

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education? **Yes** No

Dates: 05/1983 to 05/1984
Comments: One extra year

Were you ever placed on probation? **Yes** No

Comments: Academic difficulties

Were you ever disciplined or placed under investigation? Yes **No**

Were any negative reports for behavioral reasons ever filed by instructors? Yes **No**

Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason? Yes **No**

End of report for Stanley Michael Berry

PROVIDED BY APPLICANT

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Section V

Graduate Medical Education

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Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-4292

Verification of Graduate Medical Education

Institution: Saint Louis University School of Medicine

Attention: OBSTETRICS AND GYNECOLOGY

Specialty: Obstetrics and Gynecology

Address: St Louis, MO

Verification For:

Name: Berry, Stanley

DOB: [redacted]

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: 1 (e.g., 1, 2, 3, etc.)
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: Obstetrics and Gynecology
From: 7/1/84 **To:** 6/30/85
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: 2-4 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: Obstetrics and Gynecology
From: 7/1/85 **To:** 6/30/88
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: ______ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: ______
From: / / **To:** / /
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.

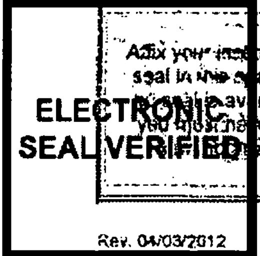
1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by 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).

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.



Name: Mary T. McLennan, MD

Signature: 5/2/12

Title of Signatory: Program Director

Date of Signature: [redacted]

Tel: 314-781-1031 Fax: 314-645-8771 E-Mail: mclennan@slu.edu

Rev. 04/03/2012

FCVS ID: 232801 FID: 209829258 FFF CODE: 110580

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name: Stanley Michael Berry
Saint Louis University School of Medicine
Obstetrics and Gynecology

Unusual Circumstances

Question		
Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for Stanley Michael Berry

PROVIDED BY APPLICANT

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Section VI

Licensure Examination History

(State Licensing Authorities Only)

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NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Record of Scores

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Recipient: To Whom It May Concern **Date:** 04/03/2012

Examinee ID:
Examinee: Berry, Stanley M **Date of Birth:**

This record shows a complete Part history for this examinee.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
09/08/1982	Pass	Three-Digit									
		Two-Digit									

NBME PART II

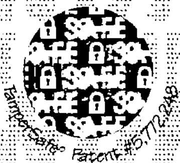
Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Med	Surg	ObGyn	Prev	Peds	Psych
04/03/1984	Pass	Three-Digit								
		Two-Digit								

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/06/1985	Pass	Three-Digit		
		Two-Digit		

 163686

Patent 5636874



232801

TouchSafe®

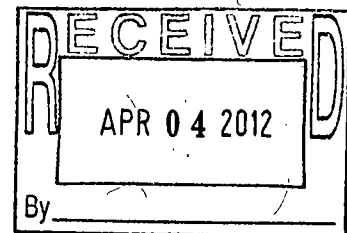
SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

Authenticity of NBME Record of Scores

An original, certified NBME Record of Scores is printed using black ink on green safety paper and is produced only by the National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of the NBME Record of Scores may result in appropriate legal action or other action consistent with applicable policies.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES



NBME Part I and Part II Examinations Prior to June 1991

Unless otherwise noted, the most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

NBME Part I and Part II Examinations June 1991 and Thereafter

Unless otherwise noted, the most recent total test score is reported. This score is on a scale with a mean of 200 and a standard deviation of 20, in increments of 1. Most scores fall between 145 and 260.

All NBME Part III Examinations

Unless otherwise noted, the most recent total test score is reported. This score is on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

Two-Digit NBME Scores

For all NBME scores, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

SCANNED #1
APR 05 2012

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 and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

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

Berry
Applicant's Printed Last Name

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

03/21/2012
Date of Signature

NOTARY

Dated 3/21/12 Signed Tracy Nemd

State of Michigan County of Wayne

SUBSCRIBED AND SWORN TO before me this 21st day of, March 2012.

My commission expires: August 6, 2016 (NOTARY PUBLIC SIGNATURE & SEAL)

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IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING**	SUPPORTING DOCUMENT **TN-MED** (DPR)

APPLICANT: ***Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH	3. SOCIAL SECURITY NUMBER
Berry Stanley Michael	Month Day Year	

4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
6	Physician — Profession Name; 0 3 6 — Profession Code
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)	8. ISSUANCE DATE

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed 24 months of postgraduate clinical training in Maternal-Fetal Medicine (Name of Specialty Program)

from 7/1/1988 (MM/DD/YYYY) to 6/30/1990 (MM/DD/YYYY) at the following hospital:

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Hospital: HUTZEL Hospital

Number and Street: 3990 John R. Str.

City, State and Zip Code: DETROIT, MI 48201

I further certify that at the time of such training the program was accredited by:

- [x] the ACGME ABOG, Inc.
- [ ] the AOA
- [ ] the CFPC, RCPSC or FMLAC (Canadian Programs)
- [ ] not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: SONIA S. Hassan, MD

Signature of Postgraduate Clinical Training Program Director:

Date of this Certification: 6/1/12

University/Hospital SEAL

Telephone No: 313-745-7619

(If no seal, attach letter on letterhead stating no seal exists.)

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