

62169

DO NOT WRITE ON THIS FOLD

No. 36-62169APPLICATION FOR REGISTRATION AS
PHYSICIAN AND SURGEON

REGISTRATION

DO NOT WRITE ON THIS FOLD

EXAMINATION RECORD

Practical Test

Practical Test	Third Examination	Fourth Examination

Applicant Must Complete the
Following Blanks in Own Handwriting
Is this your first application for a license
in Illinois? yes

If licensed in other states, give facts below:

State Illinois Date 9/31/78

City _____
Street and number _____
County _____

Preliminary education
approved _____ 19 _____

Medical education
approved _____ 19 _____

Diploma verified _____ 19 _____

Diploma returned _____ 19 _____

By _____
Mail Express

Application fee \$150.00
received _____ 19 _____

Certificate issued S-26-81 19 _____

Certificate forwarded 6-1- 19 81

Application declined _____ 19 _____

Clinical Competence

Clinical Competence	Third Examination	Fourth Examination

Date of first examination _____ 19 _____

Date of second examination _____ 19 _____

Date of third examination _____ 19 _____

Date of fourth examination _____ 19 _____

Signature of Applicant

PERSONAL INFORMATION

1. (a) Have you ever been notified to appear before any Medical Society in regard to charges or complaints filed against you? no (b) Have you ever been rejected by a Medical Society? no If answer is Yes to either of the foregoing, explain fully in sworn affidavit stating name of society and reasons.
2. (a) Have you ever been denied a certificate by, or the privilege of taking an examination before any State Medical Board? no (b) Have you ever been notified or requested to appear before any State Medical Board in regard to charges filed against you? no (c) Has any State Medical Board suspended or revoked a license it had granted to you? no If answer is Yes to any of the foregoing, explain fully in sworn affidavit.
3. Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or habit-forming drugs? no If answer is Yes, explain fully in sworn affidavit.
4. (a) Are you now, or have you ever been emotionally or mentally ill? no (b) Have you ever been a patient (voluntarily or otherwise) in any institution for the treatment of mental or emotional illness, drug addiction, or inebriety? no (c) Have you ever been treated, but not hospitalized for mental or emotional illness, drug addiction, or inebriety? no If answer is Yes to any of the foregoing, give details, dates, and names and addresses of physicians who treated you.
5. Have you ever been charged with or convicted of any crime? no If answer is Yes, explain fully in sworn affidavit.
6. Have you ever been arrested, or summoned into court as a defendant, indicted, convicted, fined, imprisoned, or placed on probation, or has any case against you been filed, or have you ever forfeited collateral for breach or violation of any law or police regulation or ordinance whatsoever? no If answer is Yes, explain fully in sworn affidavit.
7. (a) Have you ever applied for and been denied a Narcotic Tax Stamp? no (b) Have you ever been called before or warned by the Federal and/or State Bureau of Narcotics and Dangerous Drugs? no (c) Have you ever surrendered your Narcotic Tax Stamp? no If answer is Yes to any of the foregoing, explain fully in sworn affidavit.
8. Have you ever been charged with or been convicted of violation of the Federal and/or State Narcotic and Dangerous Drug Laws, or of a crime of the grade of felony or misdemeanor under a State or Federal Law? no If answer is Yes, explain fully in sworn affidavit.
9. Have you ever been denied hospital staff privileges? no If answer is Yes, please give Hospital.

State of California)
County of Los Angeles) SS

Suzanne Ruth Trupin m.
being duly sworn, says that he is the person referred to in this application and that the statements therein contained are true.

(Signature of Applicant)

Subscribed and sworn to before me this 11 day of February A.D. 19 81.



(Notary Public Seal)
THERESA GONZALES
NOTARY PUBLIC - CALIFORNIA
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY

My Commission Expires April 24, 1984

CERTIFICATE OF DEAN, SECRETARY OR REGISTRAR OF MEDICAL COLLEGE GRANTING DEGREE

I hereby certify that Suzanne Ruth Trupin

matriculated in the New York Medical College Medical College on the 24 day of June, 19 74 and attended three courses of instruction, graduating with the degree of M.D. on the 7 day of June, 19 77.

I further certify that the above photograph is the likeness of the said Suzanne Ruth Trupin

and the identical person to whom the said diploma was originally issued.

(Seal of College)

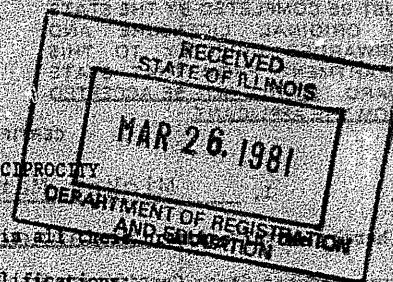
(Signature of Dean, Secretary or Registrar)

County Code

107

GRAD 6-7-77

STATE OF ILLINOIS
DEPARTMENT OF REGISTRATION AND EDUCATION
SPRINGFIELD



APPLICATION FOR A LICENSE TO PRACTICE MEDICINE ON THE BASIS OF RECIPROCITY

I hereby make application for a license to practice Medicine and Surgery in the State of Illinois

State of Illinois, and submit the following statements regarding my educational qualifications:

Full name Suzanne Ruth Trudin MD

Present address

Intended residence

Place of birth

Date of birth

Age

Assuming you are successful, please PRINT your name exactly as you desire it to appear on your certificate.

Please designate your Social Security Number: * NOTE: Designation of your Social Security Number is not mandatory -- used ONLY to insure identification, accessibility, and accuracy of your application.

COLLEGE OR UNIVERSITY EDUCATION

Name and location of institution attended

Period of attendance

1st year

Stanford University

Fall 70 - Spring 71

2nd year

3rd year

4th year

I have credit for

4 years

of college work. I received the degree of

AB

from

Stanford University

on the

16

day of

June

19

74

MEDICAL EDUCATION

I attended

3 years of

full courses of medical lectures as follows:

at

New York Medical College

from the

20

day of

June

19

74

to the

6

day of

June

19

77

from the

day of

19

to the

day of

19

from the

day of

19

to the

day of

19

Rotating internship served at

from

to

I was granted a diploma as a Doctor of Medicine by

New York Medical College

located at

Valhalla

State of

New York

on the

27

day of

June

19

77

and the Diploma presented with this application is the genuine Diploma of said institution.

RECEIVED
STATE OF ILLINOIS

MAR 3 1981

(MD 40a)

DEPARTMENT OF REGISTRATION
AND EDUCATION
PHYSICIANS ASSISTANT

THIS PORTION OF THE APPLICATION
MUST BE COMPLETED BY THE STATE
OF ORIGINAL LICENSURE AND
FORWARDED DIRECTLY TO THIS
DEPARTMENT FROM THAT STATE
BOARD. IT WILL NOT BE ACCEPTED
FROM THE APPLICANT.

CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE

I, Mickey Matsumoto, ~~XXXXXX~~ (Acting) Bureau Chief of Medical Statistics
XXXXXX California State Board of Medical
Quality Assurance (Official name of Board)

hereby certify that Suzanne Ruth Trupin
was granted State Certificate No. G 37711 to practice medicine in the State of California
on the 31 day of July 19 78, on the basis of National Board Credentials

I further certify that n/a in his written examination (including
n/a questions) before this Board, obtained a general average of n/a in the following branches:

NATIONAL BOARD CREDENTIALS NO FURTHER EXAMINATION WAS REQUIRED

(Please give grades in each subject)

I further certify that the preliminary and professional education as outlined on Page 1 of this
application was verified by this Board prior to the examination of the applicant.

Acting in behalf of the California State Board of Medical Quality Assurance
(Official name of Board)

I hereby certify to the reputability of Dr. Suzanne Ruth Trupin as appears on records of this
office, and recommend him to the Department of Registration and Education of the State of Illinois as a fit and
proper person to receive a license. The State of California * hereby agrees to reciprocate
the action of the Department of Registration and Education. *In so far as California Law allows

I also certify that the photograph as appears in this application is the likeness of the said
Dr. Suzanne Ruth Trupin and the person named in the above endorsement.

(Seal)

Date March 16, 1981

~~XXXXXX~~ (Acting) Bureau Chief of Medical Statistics

NOTE: To save time--forward a certifying fee to above board when sending this for certification.

RECOMMENDATION OF PRESIDENT AND SECRETARY OF COUNTY, DISTRICT OR STATE MEDICAL SOCIETY

_____, Secretary, and
_____, President of the

Medical Society, certify that _____ is personally
(Full name of applicant)
known to us, and that he is an ethical practitioner and is of good moral and professional character.

We further certify that said Dr. _____ engaged in the
reputable practice of medicine in the State of _____ for _____ years,
from _____ 19 _____ to _____ 19 _____. We have carefully reviewed all the
statements made by the applicant herein and believe them to be true in every respect.

We also certify that the photograph, which appears on Page 2, is the likeness of said Dr. _____
We hereby recommend the said applicant to the Department of Registration and Education for a license to
practice medicine in Illinois.

(Seal of the Society)

Secretary

President

NOTE: If Society has no seal, the signature must be acknowledged before a Notary Public.

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Suzanne Puth Trupin, M.D.
having satisfied all the requirements and having successfully passed the examinations is
hereby declared a Diplomate of the National Board of Medical Examiners

Attest **JOHN S. MILLIS**
(Chairman of the Board)

SEAL
Cert # **186018**

EDITH J. LEVIT
President of the Board

Philadelphia, Pa.
[Redacted]

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of **NEW YORK MEDICAL COLLEGE** in **JULY 1977** whose birth date is [Redacted] following successful completion of all examinations required for Certification by the National Board of Medical Examiners.

The grades obtained are as follows:

	Standard* Score	Scale Score
<u>PART I passed</u> [Redacted]		
Anatomy incl histology and embryology		
Physiology		
Biochemistry		
Pathology		
Microbiology incl immunology		
Pharmacology and Materia Medica		
Behavioral Sciences		
(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**		
<u>Part II passed</u> [Redacted]		
Internal medicine and the medical specialties		
Surgery and the surgical specialties		
Obstetrics and Gynecology		
Public Health and Preventive Medicine		
Pediatrics		
Psychiatry		
(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**		
<u>PART III passed</u> [Redacted]		
A General Test of Clinical Competence		
(Minimum Passing Grade 290/75)		
<u>GENERAL AVERAGE (Parts I, II, and III)</u>		

AVERAGE

(Scale Score)

*Examinations taken since June 1971 are reported with both Standard and Scale Score Equivalents

**Since 1966 National Board criteria for certification are based upon candidate's Total Grade in Part I, Part II, and Part III, and not scores of individual subjects within each Part.

Secretary for Certification

02/17/81

SEAL

Date

RECOMMENDATION

DATE 20 Jan 19 81

This certifies that I am personally acquainted with

Suzanne Ruth Truitt
that I know her to be of good moral and professional character and entirely worthy of
confidence. I hereby recommend her to the Department of Registration and Education to
be licensed to practice Medicine in the State of Illinois.

SIGNATURE: 

P.O. Address  IL

Endorser is a Graduate of

N.Y. Med College in the year 55
Name of Professional School

Illinois License No.

36-37130

Date issued

1961

RECOMMENDATION

DATE

Jan. 15, 19 81

This certifies that I am personally acquainted with

Suzanne Ruth Trupin

that I know h_u to be of good moral and professional character and entirely worthy of confidence. I hereby recommend h_u to the Department of Registration and Education to be licensed to practice Medicine in the State of Illinois.

SIGNATURE: 

Street Address 

P.O. Address 

Endorser is a Graduate of

Tufts University

in the year 46

Name of Professional School

Illinois License No.

36-028968

Date issued

1948

(GO 52)

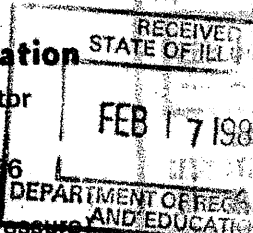
STATE OF ILLINOIS

Enter all applicable information.

Department of Registration and Education

Joan G. Anderson, Director
320 West Washington
Springfield, Illinois 62786

(Use typewriter or print with pressure)



E.C.F.M.G. No. _____
Vise Type and No. _____
DBI No. _____
Full name before marriage same
Social Security No. _____

NOTE: Designation of your Social Security Number is not mandatory. It is used ONLY to ensure identification, accessibility and accuracy of your application.

NAME: TRUPIN SUZANNE RUTH
All other names (spell out completely) _____
Street Address: _____
City: _____ State: _____ Postal code: _____
Country: USA Place of birth: _____ City: _____ Province: _____ Country: _____

DATE OF BIRTH: _____ Sex: Male _____ Female X
CITIZENSHIP: At birth: USA Now: USA
MEDICAL DEGREE: Title of degree (M.D., M.B.-B.S., D.O., other) MD Date conferred 6/7/77

MEDICAL SCHOOL: (School(s) attended) (Location) (Dates) (No. of school yrs.)
(Precise name) NEW YORK MEDICAL COLLEGE VALHALLA NY 6/74-6/77 3

SECONDARY SCHOOL, COLLEGE, UNIVERSITY UNIVERSITY HIGH SCHOOL, URBANA ILL. / STANFORD UNIVERSITY

HOSPITAL TRAINING: Hospital(s) Location Position(s) Dates
LAC/USC WOMEN'S HOSP PGY1-PGY4 6/79-6/81
1240 N MISSION RD CA

Are you a Diplomate of the National Board of Medical Examiners? Yes ✓ No _____
Are you certified by an American Specialty Board? Yes _____ No ✓
Board(s) with date(s): _____

Licensure: Name the state or states in which you have received an unrestricted license to practice medicine and state whether by examination or endorsement. (Give License No(s).) CALIF 6037711

Have you ever taken an E.C.F.M.G. examination? Yes _____ No ✓ Date(s) _____ ☐ Passed ☐ Failed
Have you ever taken a FLEX examination? Yes _____ No ✓ Date(s) _____ ☐ Passed ☐ Failed
Have you ever been refused admission to a recognized medical or osteopathic organization, or has any disciplinary action been taken against you by such an organization or by any licensing or registering authority? _____

I hereby certify that the information given in this application is true and accurate to the best of my knowledge and belief. I hereby authorize the State of Illinois or its licensing or registering authority to transmit to any person, governmental authority or legal entity information contained in this application or information which otherwise may become known or available to any State Board of Medical Examiners, any Medical Examining Committee appointed or otherwise constituted pursuant to statute and the Federation of State Medical Boards of the United States, Inc., or any of them, when written request is made to such State or such authority for such information and such writing states that such information is to be used exclusively in connection with licensure to practice medicine or any problem (describing it) related thereto.

I, [Signature], a Notary Public, DO

HEREBY CERTIFY, that [Signature] appeared before me this day in person and acknowledged that he signed the above instrument as a free and voluntary act, for the uses and purposes therein set forth.

Given under my hand and official seal, this 11

day of February 1981
THERESA GONZALES
NOTARY PUBLIC - CALIFORNIA
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
My Commission Expires April 24, 1984



NOTE: Accompanying this preliminary application must be two photographs taken within the past six months. They should be at least passport size (2 1/2 x 2 1/2) and be signed on the reverse by the applicant.

THERESA GONZALES
NOTARY PUBLIC - CALIFORNIA
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
Signature of Applicant
Date 2/11/81

PLEASE RETURN ALL COPIES OF THIS PRELIMINARY APPLICATION UPON COMPLETION.
FLEX EXAM () NATL BD ENDORSEMENT () FLEX ENDORSEMENT () REPROFIT ()
ECC (X) TYPE OF FORMAL APPLICATION DESIRED.

This is to certify that I, LEWIS TRUPIN am personally acquainted with SUZANNE RUTH TRUPIN, MD, who is applying for licensure to practice medicine in all of its branches in the State of Illinois; that I hereby attest to the educational background of Dr. SUZANNE RUTH TRUPIN, who graduated from NEW YORK MEDICAL COLLEGE and was issued the degree and diploma of Doctor of Medicine on the 7 day of JUNE, 19 77; and that Dr. SUZANNE RUTH TRUPIN is of good moral character and professional background. I further endorse D- SUZANNE RUTH TRUPIN's application for a license to practice medicine in all of its branches in the State of Illinois, attest that the hereto attached photograph is a true likeness of Dr. SUZANNE TRUPIN and that I personally viewed the original medical diploma of this applicant.

Signed

LEWIS TRUPIN, MD
PRINTED NAME

State of Illinois Medical Certificate No.

R 36-37130
PRINT NUMBER

State of Illinois in the County of Champaign

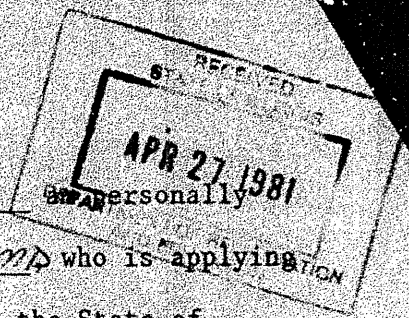
Subscribed and sworn to before me this 2nd day of April, 19 81

NOTARY PUBLIC

My Commission

expires. 4/3/85

This is to certify that I, JACK D. BRODSKY
acquainted with SUZANNE RUTH TRUPIN MD who is applying
for licensure to practice medicine in all of its branches in the State of
Illinois; that I hereby attest to the educational background of Dr. SUZANNE
RUTH TRUPIN, who graduated from NEW YORK MEDICAL COLLEGE
and was issued the degree and diploma of Doctor of Medicine on the 7 day of
JUNE, 19 77; and that Dr. SUZANNE RUTH TRUPIN
is of good moral character and professional background. I further endorse
Dr. SUZANNE RUTH TRUPIN's application for a license to
practice medicine in all of its branches in the State of Illinois, attest that the
hereto attached photograph is a true likeness of Dr. SUZANNE TRUPIN
and that I personally viewed the original medical diploma of this applicant.



Signed

JACK D. BRODSKY
PRINTED NAME

State of Illinois Medical Certificate No.

036-028968
PRINT NUMBER

State of Illinois in the County of Champaign

Subscribed and sworn to before me this 22nd day of April, 19 81

NOTARY PUBLIC

My Commission

expires: 4/3/85

RECEIVED
STATE OF ILLINOIS
the board in the state
MAR 20 1991

RECEIVED
STATE OF ILLINOIS

MAR 20 1964

DEPARTMENT OF REGISTRATION
AND EDUCATION
PHYSICIANS ASSISTANT

RECEIVED
REGISTRATION & EDUCATION
EDUCATION
1981 FEB 23 PM 10 46

CASH SECTION

This is to CERTIFY:

- (1) That SUZANNE RUTH TRUPIN
(full name of physician)
has satisfactorily completed 48 months in
a program of OBSTETRICS AND GYNECOLOGY graduate - specialty - residency
at UC/USC WOMEN'S HOSPITAL (strike out whichever is not applicable)
(name of hospital)
extending from JULY 1977 to JUNE 1981;
and
- (2) That the physician hereinabove named

(check and complete whichever is applicable)

presently holds Temporary Certificate of Registration No. T-
issued under the provisions of Section 11a of the Illinois Medical Practice Act.

_____ previously held Temporary Certificate of Registration No. T-
issued under the provisions of Section 11a of the Illinois Medical Practice Act

X does not hold a Temporary Certificate of Registration issued under the provisions of Section 11a of the Illinois Medical Practice Act insofar as can be determined from the records of this hospital.

SIGNED:

(Medical Director)

(Name of Hospital)

(Address)

SEAL OF HOSPITAL

DATED:

When completed, the hospital must forward this form directly to

Medical Section
Department of Registration and Education
320 Washington Street, 3rd Floor
Springfield, Illinois 62786