OHS/LOS-060 (6/99)

BOARD USE ONLY

License Number 044655

Date of Licensure 7.1.01

Michigan Department of Consumer & Industry Services
Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
TTY (517) 373-7489

APPLICATION FOR EDUCATIONAL LIMITED AND CONTROLLED SUBSTANCE LICENSES

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone (313) 234-4300)

I AM APPLYING FOR THE FOLLOWING:

☒ Educational limited and Controlled Substance Fee: $165.00

Daytime Phone Number: (517) 334-2195
Previous License Number:

(Last Name)	(First Name)	(Middle Name)
Smith	Jennifer	K.

All Previous Names and/or Birth Name Used (if applicable):

Date of Birth: [redacted]
U.S. Social Security Number: [redacted]

Business Address: 401 W. Greenlawn Ave.

City	State	ZIP Code
Lansing	MI	48910

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony? ☐ YES ☒ NO
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years? ☐ YES ☒ NO
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)? ☐ YES ☒ NO
4. Have you been treated for substance abuse in the past 2 years? ☐ YES ☒ NO
5. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ YES ☒ NO
6. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period? ☐ YES ☒ NO
7. Have you had one or more settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period? ☐ YES ☒ NO
8. Have you ever been denied the privilege of taking an examination by any state medical board? ☐ YES ☒ NO
9. Have you ever had a federal or state medical or controlled substance license revoked, suspended, or otherwise disciplined, been denied a license, or currently have disciplinary action pending against you? ☐ YES ☒ NO
10. Do you hold or have you ever held an osteopathic license in Michigan or any other state? If yes, list each state, the license number, the date issued, and the basis for licensure. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☐ YES ☒ NO

State	License Number	Date of Issue	Basis for Licensure

Provide a complete chronological record of your educational preparation. Attach additional sheets if necessary.

Name and address of Institution	Dates of Attendance From	To	Degree
ALBION COLLEGE ALBION, MI	08/91	05/95	Bachelor of Arts
MICHIGAN STATE UNIVERSITY / COLLEGE OF OSTEOPATHIC MEDICINE EAST LANSING, MI 48823	08/96	05/00	DOCTOR OF OSTEOPATHIC MEDICINE

Provide a description of your intern training experience. Attach additional sheets if necessary.

Name and address of Hospital	Dates of Practice From	To	Duties
Ingham Regional	7/1/2000	6/30/2001	
Medical Center			
401 W. Greenlawn Ave Lansing, MI 48910			
Residency In (Specify)			

CERTIFICATION

I understand that it is the policy of this agency to secure conviction criminal history as part of their pre-licensure screening process, and I authorize this agency to use the information provided in this application to obtain a conviction criminal history file search from the Central Records Division of the Michigan Department of State Police.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country

The statements in this application are true and correct. I have not withheld information which might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant: Jennifer K. Smith | Date: 02/06/00

THIS SIDE TO BE COMPLETED BY THE MEDICAL DIRECTOR OR SUPERINTENDENT

Please complete the following information. Return this completed certification directly to the Michigan Board of Osteopathic Medicine and Surgery at the address shown on the reverse side of this form.

SECTION II - CERTIFICATION OF TRAINING

AOA

Name of Hospital
Ingham Regional Medical center

Street Address of Hospital
401 W. Greenlawn Ave

City, State and ZIP Code
Lansing, MI 48910

I certify that Jennifer K. Smith
(Applicant's Name)

has been appointed to the position of Internship (Intern or Resident) in Traditional Track (Specialty) at

the hospital named above from July 1, 2000, and ending June 30, 2001.

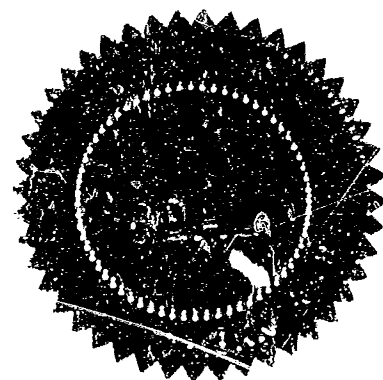
Is this training program approved by the AOA? ☒ Yes ☐ No

[signature]
Authorized Signature

6 1 00
Date of Signature

Gordon C. Spink, S.O.
Print or Type Name

Director of Medical Education
Title



If hospital has no seal, please indicate.

OHS/LOS-040 (10/98)

Michigan Departm[illegible]t of Consumer & Industry Services
Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
TDD (517) 373-7489

RECEIVED
MAY [illegible] 200[illegible]
BUREAU OF HEALTH SERVICES
LICENSING [illegible]VISION

Pm

CERTIFICATION OF APPOINTMENT TO TRAINING PROGRAM

Authority: Public Act 368 of 1978 as amended
If this form is not completed, a license will not be issued

Instructions: Applicant complete Section I. Type or print your name exactly as it appears on your application. Send this form to the medical director or superintendent of the Michigan Training Hospital where you expect to commence training. The form should be completed and returned directly to this office by that individual.

SECTION I - APPLICANT INFORMATION

Field	Value
Applicant's Name (Last, First, Middle)	Smith, Jennifer, K.
Street Address	c/o Ingham Regional Medical Center, 101 W. Greenlawn Ave
City	Lansing
State	Michigan
ZIP Code	48910
U.S. Social Security Number	[redacted]
Date of Birth	[redacted]

Field	Value
Program (Internship or Residency)	Internship
Name of Hospital	Ingham Regional Medical Center

Signature of Applicant	Date
Jennifer K. Smith	02/06/00

Applicant: Upon completion of Section I, send this form to the medical director or superintendent of the Michigan training hospital where you expect to commence training for completion of Section II on the reverse side of this form.

MICHIGAN STATE
UNIVERSITY

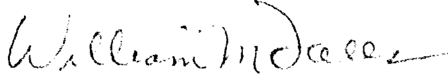
RECEIVED
FEB 2 2 2000
[illegible] OF HEALTH SERVICES

February 15, 2000

TO WHOM IT MAY CONCERN:

This is to verify that Jennifer K. Smith is a student in the College of Osteopathic Medicine at Michigan State University and is in good standing. Pending successful completion of all course requirements, it is anticipated that she will graduate with the Doctor of Osteopathic Medicine (D.O.) degree from this institution in May 5, 2000.

Very truly yours,



William M. Falls, Ph.D.
Associate Dean/Student Services

bjs

COLLEGE OF
OSTEOPATHIC MEDICINE

Office of Student Services

Michigan State University
C103 East Fee Hall
East Lansing, MI
48824-1316
517/353-7741
Toll Free 888/895-4680
Fax 517/432-1976

Office of Admissions

Michigan State University
C110 East Fee Hall
East Lansing, MI
48824-1316
517/353-7740
Fax 517/355-3296

MSU is an affirmative-action equal-opportunity institution

OHS/LOS-010 (10/01)

BOARD USE ONLY
License Number:
Date of Licensure:

Michigan Department of Consumer & Industry Services
Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
TTY (517) 373-7489

dup fee

Tran Info:510101 9147612-1 03/09/04
ChkH: 1268 Amt: $150.00
ID: [redacted]

APPLICATION FOR LICENSE

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone (800) 882-9539).

I AM APPLYING FOR THE FOLLOWING:

☑ License by Examination Fee: $150.00
☐ License by Endorsement (Must Currently be Licensed in Another State) Fee: $150.00

Daytime Phone Number: 517-862-9668
Previous License Number:

(Last Name) SMITH (First Name) JENNIFER (Middle Name) KRISTA

All Previous Names and/or Birth Name Used (if applicable): (NONE)

Date of Birth: [redacted]
U.S. Social Security Number: [redacted]

Street Address: 684 MOORLAND DR

City: EAST LANSING State: MI ZIP Code: 48823

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony? ☐ YES ☑ NO
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years? ☐ YES ☑ NO
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)? ☐ YES ☑ NO
4. Have you been treated for substance abuse in the past 2 years? ☐ YES ☑ NO
5. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ YES ☑ NO
6. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period? ☐ YES ☑ NO
7. Have you had one or more settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period? ☐ YES ☑ NO
8. Have you ever been denied the privilege of taking an examination by any state medical board? ☐ YES ☑ NO
9. Have you ever had a federal or state medical or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ☐ YES ☑ NO
10. Do you hold or have you ever held an osteopathic license in Michigan or any other state? If yes, list each state, the license number, the date issued, and the basis for licensure. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☑ YES ☐ NO

The Department of Consumer and Industry Services will not discriminate against any individual or group or race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

State	License Number	Date of Issue	Basis for Licensure
MICHIGAN	5101014655	7/1/03	~~Restricted~~ Limited Educational

Provide a complete chronological record of your educational preparation. Attach additional sheets if necessary.

Name and address of Institution	Dates of Attendance From	To	Degree
ALBION COLLEGE	8/91	5/95	BIOLOGY and SOCIOLOGY
611 E PORTER ST ALBION MI 49224			
MICHIGAN STATE UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE	8/96	5/00	DOCTOR OF OSTEOPATHIC MEDICINE
C110 EAST FEE HALL EAST LANSING, MI 48824-1316			

Provide a description of your intern training experience. Attach additional sheets if necessary.

Name and address of Hospital	Dates of Practice From	To	Duties
INGHAM HOSPITAL	7/00	6/01	General medical care for 12 months. Did
401 W. GREENLAWN LANSING, MI 48910			rotate on specialty services including Cardiology,
			Pulmonology, OB/GYN, Surgery. Care of patients in primary care
Residency In (Specify)			clinic
OBSTETRICS and GYNECOLOGY	7/01	Current	Obstetric and gynecologic care including hospital
SPARROW HOSPITAL 1212 E MICHIGAN AVE LANSING MI 48912			and clinic

CERTIFICATION

I understand that it is the policy of this agency to secure conviction criminal history as part of their pre-licensure screening process, and I authorize this agency to use the information provided in this application to obtain a conviction criminal history file search from the Central Records Division of the Michigan Department of State Policeor other law enfrcement or judicial record keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information which might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
	3/4/04

$170 ovrpmt ref. 9-24-04

OHS/LPH-090 (4/01)

BOARD USE ONLY

License Number: 5315 017088

Date of Licensure: 3-17-04

Michigan Department of Consumer & Industry Services
Board of Pharmacy
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
TTY (517) 373-7489

CONSUMER & INDUSTRY SERV
AMT. REC'D. 100
MAY 10 2002

Used $145 towards renewal of E & CS-1 per licensee request ICJ

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufactures, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, prescribe, or dispense controlled substances. If you are an M.D., D.O., D.P.M., D.D.S., or D.V.M. who prescribes at more than one location, a controlled substance license is required for each location. **Please submit a seperate application for each location.**

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the Federal licensing process.

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: Initial or relicensure -$85.00. If you already hold a professional license please see below.
2. M.D./D.O. Applicants: This application may not be used for physician methadone programs. **Please request an Application for Physician Methadone Program.**
3. Type or print your responses. Send the application and a check or money order drawn on a U.S. Financial institution and made payable to the "State of Michigan" to the address above. To speed up our processing, complete the payment slip at the bottom of the form. DO NOT DETACH IT.
4. Allow four to six weeks for your license to arrive.

TYPE OF PROFESSIONAL LICENSE (Please Check One):

	Regular		Educational Limited
☐ 43-01 M.D.	☐	or	☐
☑ 51-01 D.O.	☑	or	☐
☐ 29-01 D.D.S.	☐	or	☐
☐ 59-01 D.P.M.	☐	or	☐
☐ 69-01 D.V.M.	☐	or	☐
☐ 53-01 Pharmacy Store	☐		
☐ 53-02 R.Ph.	☐		
☐ 53-06 Manuf/Wholesaler	☐		

STATUS:

1. Have you ever had any license limited, suspended, revoked, denied, or surrendered?

   ☐ Yes ☑ No

   If Yes, please explain on a separate sheet.

2. Is your current license limited as a result of board disciplinary action?

   ☐ Yes ☑ No

Permanent Profession License Number (If Applicable): LIMITED 5101014656

Expiration Date of License: 6/30/02

Social Security Number: [redacted]

(Last Name, First Name, Middle Name): SMITH, JENNIFER, KRISTA

I hereby make application for a controlled substance license in Michigan and submit that the statements and information above are true.

Signature: Jennifer K Smith DO   Date: 5/1/01

THIS LICENSE VALID - ONLY - AT THE FOLLOWING LOCATION

Street		Telephone Number
City	State	ZIP Code

Do Not Detach

OHS/LOS-010 (10/01)

BOARD USE ONLY
License Number: 014655
Date of Licensure: 3-17-04

Michigan Department of Consumer & Industry Services
Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
TTY (517) 373-7489

$150.00 RCVD 5-13-02 P.M.

APPLICATION FOR LICENSE

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

MF ✓ WF ✓

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone (800) 882-9539).

I AM APPLYING FOR THE FOLLOWING:

- ☑ License by Examination Fee: $150.00
- ☐ License by Endorsement (Must Currently be Licensed in Another State) Fee: $150.00

Daytime Phone Number: 517·226·0832
Previous License Number: 5101014655

(Last Name) SMITH (First Name) JENNIFER (Middle Name) KRISTA

All Previous Names and/or Birth Name Used (if applicable): NA

Date of Birth: [redacted]
U.S. Social Security Number: [redacted]

Street Address: 684 MOORLAND DRIVE

City: EAST LANSING State: MI ZIP Code: 48823

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony? ☐ YES ☑ NO
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years? ☐ YES ☑ NO
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)? ☐ YES ☑ NO
4. Have you been treated for substance abuse in the past 2 years? ☐ YES ☑ NO
5. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ YES ☑ NO
6. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period? ☐ YES ☑ NO
7. Have you had one or more settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period? ☐ YES ☑ NO
8. Have you ever been denied the privilege of taking an examination by any state medical board? ☐ YES ☑ NO
9. Have you ever had a federal or state medical or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ☐ YES ☑ NO
10. Do you hold or have you ever held an osteopathic license in Michigan or any other state? If yes, list each state, the license number, the date issued, and the basis for licensure. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☑ YES ☐ NO

The Department of Consumer & Industry Services will not discriminate against any individual or group or race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writiing, hearing, etc., under the American Disabilities Act, you may make your needs known to this agency.

State	*License Number*	*Date of Issue*	*Basis for Licensure*
MICHIGAN	5101014655	7/00 - 6/30/02	INTERNSHIP RESIDENCY

Provide a complete chronological record of your educational preparation. Attach additional sheets if necessary.

Name and address of Institution	Dates of Attendance From	To	Degree
ALBION COLLEGE 611 E. PORTER ST ALBION, MI	8/91	5/95	BA
MICHIGAN STATE UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE EAST FEE, EAST LANSING MI	8/96	5/00	DOCTOR OF OSTEOPATHIC MEDICINE

Provide a description of your intern training experience. Attach additional sheets if necessary.

Name and address of Hospital	Dates of Practice From	To	Duties
INGHAM REGIONAL MED CENTER	7/00/00	6/30/01	ROTATING INTERN
Residency In (Specify)			
OBSTETRICS & GYNECOLOGY AT SPARROW HOSPITAL 1200 E MICHIGAN LANSING, MI	7/1/01	CURRENT	OBSTETRICS & GYNECOLOGY

CERTIFICATION

I understand that it is the policy of this agency to secure conviction criminal history as part of their pre-licensure screening process, and I authorize this agency to use the information provided in this application to obtain a conviction criminal history file search from the Central Records Division of the Michigan Department of State Police.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information which might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
Jennifer K Smith DO	5/1/02

National Board of Osteopathic Medical Examiners

8765 W. Higgins Road, Suite 200, Chicago, IL 60631 (773)714-0622 Fax (773)714-0631

RECEIVED

MAR 1 5 2004

DEPT OF CIS

Michigan Board of Osteopathic
P.O. Box 30670
611 W. Ottawa
Lansing , MI 48909-8170

NBOME OFFICIAL TRANSCRIPT

	Completion Date	Standard Score
COMLEX Level 1 Passed		
Total Score	**JUNE 1998**	[redacted]
Minimum Total Passing Standard Score is [redacted]		
COMLEX Level 2 Passed		
Total Score	**MARCH 2000**	[redacted]
Minimum Total Passing Standard Score is [redacted]		
COMLEX Level 3 Passed		
Total Score	**FEBRUARY 2001**	[redacted]
Minimum Total Passing Standard Score is [redacted]		

I, Joseph F. Smoley, Ph.D., Executive Director of the National Board of Osteopathic Medical Examiners, Inc., do hereby certify the above to be a true report of the record of

Jennifer K. Smith , D.O.

awarded Certificate of Completion No. 37185 on April 3, 2001

March 10, 2004
Date Prepared

Joseph F. Smoley, PhD.
Executive Director

MICHIGAN STATE UNIVERSITY
OFFICIAL ACADEMIC TRANSCRIPT

RECEIVED
MAR - 3 2004
DEPT. OF CIS-OMS

SMITH, JENNIFER KRISTA

STUDENT ID: A24315101

COURSE | TITLE | CRS | GRADE | SR | H

PREVIOUS/TRANSFER INSTITUTIONS

ALBION COLLEGE
ALBION MI
BACHELOR OF ARTS GRANTED : 1995

OSTEOPATHIC MEDICINE CREDIT

COURSE INFORMATION

FALL SEMESTER 1996 08/26/96 - 12/13/96

COURSE		TITLE
ANT	551	MEDICAL GROSS ANATOMY
BCH	521	MEDICAL BIOCHEMISTRY
FMP	515	HEALTH CARE UNDERSERVED AREAS
OST	501	CLINICAL SKILLS I
OST	504	DOCTOR/PATIENT RELATIONSHIP I
OST	541	INTEGRATIVE CLIN CORREL I
PSL	501	INTRO MEDICAL PHYSIOLOGY

CUM CREDITS : CUM GPA :

SPRING SEMESTER 1997 01/08/97 - 05/02/97

COURSE		TITLE
ANT	552	MEDICAL NEUROSCIENCE
ANT	562	MEDICAL HISTOLOGY
MIC	522	MEDICAL MICROBIO & IMMUNOLOGY
OST	502	CLINICAL SKILLS II
OST	505	DOCTOR/PATIENT RELATIONSHIP II
OST	542	INTEGRATIVE CLIN CORREL II
OST	590	SPECIAL PROBLEMS
PTH	542	BASIC PRINCIPLES OF PATHOLOGY
RAD	553	INTRODUCTION TO RADIOLOGY

CUM CREDITS : CUM GPA :

SUMMER SEMESTER 1997 05/12/97 - 08/14/97

COURSE		TITLE
OSS	512	BIOSTATISTICS AND EPIDEMIOLOGY
OST	511	SYS BIO NEUROMUSCULOSKLTL I
OST	543	INTEGRATIVE CLIN CORREL III
PHD	523	GENETICS FOR MEDICAL PRACTICE
PHM	563	MEDICAL PHARMACOLOGY

CUM CREDITS : CUM GPA :

FALL SEMESTER 1997 08/25/97 - 12/12/97

COURSE		TITLE
FCM	590	SPEC PROB IN FAMILY MEDICINE
FCM	640	PRIN OF FAMILY MEDICINE I
IM	618	CLINICAL TROPICAL MEDICINE
OST	512	SYS BIO NEUROMUSCULOSKLTL II
OST	516	SYSTEMS BIOLOGY: BEHAVIOR I
OST	521	SYS BIO HEMATOPOIETIC
OST	522	SYS BIO GASTROINTESTINAL
OST	529	SYS BIO ENDOCRINOLOGY
OST	544	INTEGRATIVE CLIN CORREL IV

CUM CREDITS : CUM GPA :

SPRING SEMESTER 1998 01/14/98 - 05/08/98

COURSE		TITLE
FCM	590	SPEC PROB IN FAMILY MEDICINE
FCM	650	PRIN OF FAMILY MEDICINE II
OST	513	SYS BIO NEUROMUSCULOSKLTL III
OST	517	SYSTEMS BIOLOGY: BEHAVIOR II
OST	519	ETHICS, POLICY & JURISPRUDENCE
OST	524	SYS BIO CARDIOVASCULAR
OST	525	SYSTEMS BIOLOGY: RESPIRATORY
OST	545	INTEGRATIVE CLIN CORREL V

CUM CREDITS : CUM GPA :

----------------------END OF COLUMN----------------------

SUMMER SEMESTER 1998 05/18/98 - 08/19/98

COURSE		TITLE
OST	523	SYS BIO GENITOURINARY
OST	526	SYS BIO INTEGUMENTARY
OST	527	SYS BIOLOGY: FEMALE REPRO
OST	528	SYS BIO: GROWTH & DEV
OST	535	PRIN GERONTOLOGY FOR MED PRACT
OST	546	INTEGRATIVE CLIN CORREL VI

CUM CREDITS : CUM GPA :

FALL SEMESTER 1998 08/31/98 - 12/18/98

COURSE		TITLE
OST	602	PRIMARY CARE AMBULATORY CLKSHP
OST	602	PRIMARY CARE AMBULATORY CLKSHP
OST	602	PRIMARY CARE AMBULATORY CLKSHP
OST	602	PRIMARY CARE AMBULATORY CLKSHP
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OST	602	PRIMARY CARE AMBULATORY CLKSHP
OST	602	PRIMARY CARE AMBULATORY CLKSHP

CUM CREDITS : CUM GPA :

SPRING SEMESTER 1999 01/11/99 - 05/07/99

COURSE		TITLE
IM	650	MEDICINE CLERKSHIP
OST	602	PRIMARY CARE AMBULATORY CLKSHP
OST	602	PRIMARY CARE AMBULATORY CLKSHP
OST	602	PRIMARY CARE AMBULATORY CLKSHP
OST	602	PRIMARY CARE AMBULATORY CLKSHP
PED	600	PEDIATRICS CLERKSHIP

CUM CREDITS : CUM GPA :

SUMMER SEMESTER 1999 05/17/99 - 08/19/99

COURSE		TITLE
IM	650	MEDICINE CLERKSHIP
OSS	651	OBSTETRICS & GYNECOLOGY CLKSHP
OSS	653	SURGERY CLERKSHIP
PSC	608	PSYCHIATRY & BEHAV SCIEN CKSHP

CUM CREDITS : CUM GPA :

FALL SEMESTER 1999 08/30/99 - 12/17/99

COURSE		TITLE
IM	651	CARDIOLOGY CLERKSHIP
IM	657	EMERGENCY MEDICINE CLERKSHIP
OSS	620	DIRECTED STUDIES
OSS	654	ANESTHESIOLOGY CLERKSHIP
RAD	609	RADIOLOGY CLERKSHIP

CUM CREDITS : CUM GPA :

SPRING SEMESTER 2000 01/10/00 - 05/05/00

COURSE		TITLE
IM	653	ONCOLOGY & HEMATOLOGY CLKSHP
OMM	601	OSTEO MANIPUL MEDICINE CLKSHP
OSS	620	DIRECTED STUDIES
OSS	655	ORTHOPEDIC CLERKSHIP

CUM CREDITS : CUM GPA :

DOCTOR OF OSTEOPATHIC MEDICINE GRANTED: 05/05/00
MAJOR: OSTEOPATHIC MEDICINE
COLLEGE: OSTEOPATHIC MEDICINE

----------------NO ENTRIES BELOW THIS LINE----------------

PROVIDED SOLELY FOR: (1)
MICHIGAN DEPT OF CONSUMER &
INDUSTRY SERVICES
BOARD OF OSTEOPATHIC MEDICINE &
SURGERY
PO BOX 30670
LANSING MI 48909

Linda O. Stanford
Linda O. Stanford
University Registrar

THE FACE OF THIS TRANSCRIPT IS PRINTED WITH BLACK INK ON PAPER WITH GREEN BACKGROUND.

OHS/LCS-044 (10/01)

Michigan Department of Consumer & Industry Services
Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
TTY (517) 373-7489

RECEIVED
MAR 1 1 2004
DEPT OF CIS

CERTIFICATION OF INTERNSHIP

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Instructions Applicant complete Section I. Type or print your name exactly as it appears on your application. Send this form to be completed and mailed directly to this office by the medical director or superintendent of the Training Hospital where you served your internship.

SECTION I - APPLICANT INFORMATION

Applicant's Name (Last, First, Middle)	
SMITH JENNIFER KRISTA	
Street Address	
684 MOORLAND DR	
City	
EAST LANSING	
State	ZIP Code
MI	48823
Social Security Number	Date of Birth
[redacted]	[redacted]

Name of Hospital
INGHAM REGIONAL MEDICAL CENTER

Signature of Applicant	Date
Jennifer K Smith DO	~~4/9/03~~ 3/1/04

Applicant: Upon completion of Section I, send this form to the medical director or superintendent of the training hospital where you served your internship.

THIS SIDE TO BE COMPLETED BY THE MEDICAL DIRECTOR OR SUPERINTENDENT

Please complete the following information. Return this completed certification directly to the Michigan Board of Osteopathic Medicine and Surgery at the address shown on the reverse side of this form.

SECTION II - CERTIFICATION OF INTERNSHIP

Name of Hospital

Ingham Regional Medical Center

Street Address of Hospital

401 W. Greenlawn Avenue

City, State and ZIP Code

Lansing, MI 48910

I certify that Jennifer Krista Smith, DO
(Applicant's Name)

☑ has completed one year of internship at the above named hospital beginning

7/1/00 (Month/Day/Year) and ending 6/30/01 (Month/Day/Year).

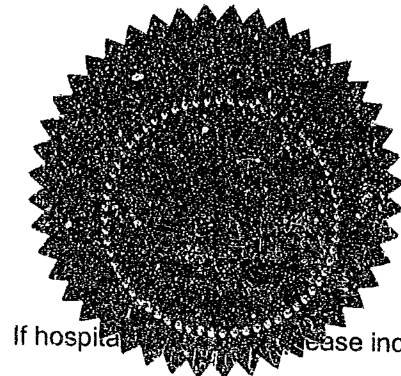
I certify that this internship is one year in duration; of a rotating type, with services in the organized departments of Medicine, Surgery, Obstetrics or Obstetrics and Gynecology; and that this Hospital is currently approved for the training of interns by the American Osteopathic Association. I further certify that the above named physician has served an apportioned time in each of the named services and has satisfactorily performed his/her duties.

Gordon C. Spink DO
Authorized Signature

3.9.04
Date of Signature

Gordon C Spink, DO
Print or Type Name

Director, Internship Program
Title



If hospita[l] ... [pl]ease indicate.

IMPORTANT: **This certification <u>may not</u> be dated and submitted more than fifteen (15) days prior to the completion of a full year's internship.**

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-070 (04/05)

Tran Info:510138 11921708-1 06/12/06
Chk#: 15062 Amt: $65.00
ID: 5101014655

Date of Licensure 7-20-06

License Number 5315028476

DRUG CONTROL LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A drug control license must be obtained by all licensed medical doctors, doctors of osteopathic medicine, podiatric medicine and dentists WHO ROUTINELY DISPENSE DRUGS from their principal place of practice. A drug control license is not necessary if the dispensing involves only the issuance of complimentary starter dose drugs. A separate drug control license is required for each business location from which you routinely dispense drugs. YOUR DRUG CONTROL LICENSE WILL EXPIRE ON THE SAME DATE AS YOUR PROFESSIONAL LICENSE.

Type or Print Only

INSTRUCTIONS

1. ADDRESS CHANGES: If your name and/or address changes please notify the Board in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. Your Drug Control license will expire with your current professional license. If your professional license expires in:

   0-12 months the fee is $45.00 13-24 months the fee is $65.00 25-36 months the fee is $85.00

3. Allow up to six weeks for your paper license to arrive.

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

- ☐ 43 - 01 M.D. 71-4301-38
- ☒ 51 - 01 D.O. 71-5101-38
- ☐ 29 - 01 D.D.S. 71-2901-38
- ☐ 59 - 01 D.P.M. 71-5901-38

STATUS:

1. Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?
   ☐ Yes ☒ No

   If Yes, please explain on separate sheet.

2. Is your current professional license limited as a result of Board disciplinary action?
   ☐ Yes ☒ No

Michigan Permanent I.D. Number	Expiration Date of License	Social Security Number
5101014655	12/31/07	[redacted]

First Name	Middle Name	Last Name
Jennifer	Krista	Smith

I hereby make application for a drug control license in Michigan and submit that the statements and information above are true.

Signature: [signature] Date: 6/7/06

Please indicate below an address and telephone number where you can be reached concerning this application

Street		Telephone Number
37300 Dequindre Ste. 102		5862681700
City	**State**	**ZIP Code**
Sterling Heights	MI.	48310

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-070 (04/05)

Tran Info:510138 11962168-1 07/03/06
Chk#: 19185 Amt: $65.00
ID: 5101014655

DRUG CONTROL LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A drug control license must be obtained by all licensed medical doctors, doctors of osteopathic medicine, podiatric medicine and dentists WHO ROUTINELY DISPENSE DRUGS from their principal place of practice. A drug control license is not necessary if the dispensing involves only the issuance of complimentary starter dose drugs. A separate drug control license is required for each business location from which you routinely dispense drugs. YOUR DRUG CONTROL LICENSE WILL EXPIRE ON THE SAME DATE AS YOUR PROFESSIONAL LICENSE.

Board Use Only

Date of Licensure 7-20-06

License Number 5315028474

Type or Print Only

INSTRUCTIONS

1. ADDRESS CHANGES: If your name and/or address changes please notify the Board in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. Your Drug Control license will expire with your current professional license. If your professional license expires in:

   0-12 months the fee is $45.00 13-24 months the fee is $65.00 25-36 months the fee is $85.00
3. Allow up to six weeks for your paper license to arrive.

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

- ☐ 43 - 01 M.D. 71-4301-38
- ☒ 51 - 01 D.O. 71-5101-38
- ☐ 29 - 01 D.D.S. 71-2901-38
- ☐ 59 - 01 D.P.M. 71-5901-38

STATUS:

1. Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?
   ☐ Yes ☑ No
   If Yes, please explain on separate sheet.
2. Is your current professional license limited as a result of Board disciplinary action?
   ☐ Yes ☑ No

Michigan Permanent I.D. Number	Expiration Date of License	Social Security Number
5101014655	12/31/07	[redacted]

First Name	Middle Name	Last Name
Jennifer	Krista	Smith

I hereby make application for a drug control license in Michigan and submit that the statements and information above are true.

[signature] Signature 6/29/06 Date

Please indicate the location address of the business where you will be dispensing drugs concerning this application

Street	Telephone Number
35000 Ford Rd. Ste. 3	734 721 4700

City	State	ZIP Code
Westland	MI	48185

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-070 (04/05)

Tran Info:510138 11921711-1 06/12/06
Chk#: 31157 Amt: $65.00
ID: 5101014655

DRUG CONTROL LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A drug control license must be obtained by all licensed medical doctors, doctors of osteopathic medicine, podiatric medicine and dentists WHO ROUTINELY DISPENSE DRUGS from their principal place of practice. A drug control license is not necessary if the dispensing involves only the issuance of complimentary starter dose drugs. A separate drug control license is required for each business location from which you routinely dispense drugs. YOUR DRUG CONTROL LICENSE WILL EXPIRE ON THE SAME DATE AS YOUR PROFESSIONAL LICENSE.

Board Use Only

Date of Licensure: 7-20-06

License Number: 5315028475

Type or Print Only

INSTRUCTIONS

1. ADDRESS CHANGES: If your name and/or address changes please notify the Board in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.
2. Your Drug Control license will expire with your current professional license. If your professional license expires in:

   0-12 months the fee is $45.00 13-24 months the fee is $65.00 25-36 months the fee is $85.00
3. Allow up to six weeks for your paper license to arrive.

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

- ☐ 43 - 01 M.D. 71-4301-38
- ☒ 51 - 01 D.O. 71-5101-38
- ☐ 29 - 01 D.D.S. 71-2901-38
- ☐ 59 - 01 D.P.M. 71-5901-38

STATUS:

1. Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?
   ☐ Yes ☒ No
   If Yes, please explain on separate sheet.
2. Is your current professional license limited as a result of Board disciplinary action?
   ☐ Yes ☒ No

Michigan Permanent I.D. Number	Expiration Date of License	Social Security Number
5101014655	12/31/07	[redacted]

First Name	Middle Name	Last Name
Jennifer	Krista	Smith

I hereby make application for a drug control license in Michigan and submit that the statements and information above are true.

Signature: [signature] Date: 6/7/06

Please indicate below an address and telephone number where you can be reached concerning this application.

Street	Telephone Number
20755 Greenfield Ste. 1104	2485590590

City	State	ZIP Code
Southfield	MI	48075

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-090 (12/05)

Tran Info:510137 11921704-1 06/12/06
Chk#: 31156 Amt: $120.00
ID: 5101014655
Tran Info:510157 11921704-2 06/12/06
Chk#: 31156 Amt: $40.00
ID: 5101014655

Board Use Only

Date of Licensure	7-19-06
License Number	5315028434

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you just prescribe controlled substances at more than one location, you only need one controlled substance license.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

Type or Print Only

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: Initial (first time) professional license or relicensure of your professional license - $85.00.
   If you already hold a professional license and your professional license expires in:

   0-12 months the fee is $85.00 (13757) 13-24 months the fee is $160.00 (23757) 25-36 months the fee is $235.00 (33757)

2. M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.
3. Allow up to six weeks for your paper license to arrive.

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
Jennifer	Krista	Smith

Street Address	Telephone Number
20755 Greenfield #1104	2485590590

City	State	ZIP Code
Southfield	MI.	48075

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

	Regular		Educational Limited
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐
☐ 43 - 01 M.D. 71-5315	☐	or	☐
☒ 51 - 01 D.O. 71-5315	☒	or	☐
☐ 49 - 01 O.D. 71-5330	☐		
☐ 53 - 01 Pharmacy Store 71-5301	☐		
☐ 53 - 02 R.Ph. 71-5302	☐		
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐		

STATUS:

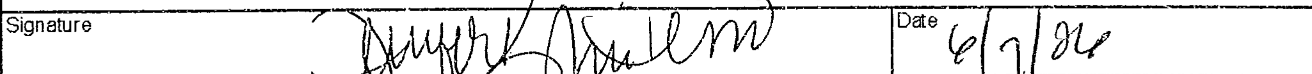
1. Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?
   ☐ Yes ☒ No
   If Yes, please explain on separate sheet.
2. Is your current professional license limited as a result of Board disciplinary action?
   ☐ Yes ☒ No

Michigan Permanent I.D. Number (as shown on your pocket card): 5101014655

Expiration Date of License: 12/31/07

Social Security Number: [redacted]

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.



Signature	Date
[signature]	6/7/06

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Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-090 (12/05)

Tran Info:510157 11921700-1 06/12/06
Chk#: 15061 Amt: $40.00
ID: 5101014655

Tran Info:510137 11921700-2 06/12/06
Chk#: 15061 Amt: $120.00
ID: 5101014655

Board Use Only

Date of Licensure 7-19-06

License Number 5315028436

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

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Type or Print Only

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: Initial (first time) professional license or relicensure of your professional license - $85.00.
   If you already hold a professional license and your professional license expires in:

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2. M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.
3. Allow up to six weeks for your paper license to arrive.

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First Name	Middle Name	Last Name
Jennifer	Krista	Smith

Street Address	Telephone Number
37300 Dequindre Ste. 102	586 268 1700

City	State	ZIP Code
Sterling Heights	MI	48310

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

	Regular		Educational Limited
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐
☐ 43 - 01 M.D. 71-5315	☐	or	☐
☒ 51 - 01 D.O. 71-5315	☒	or	☐
☐ 49 - 01 O.D. 71-5330	☐		
☐ 53 - 01 Pharmacy Store 71-5301	☐		
☐ 53 - 02 R.Ph. 71-5302	☐		
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐		

STATUS:

1. Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?
   ☐ Yes ☑ No
   If Yes, please explain on separate sheet.
2. Is your current professional license limited as a result of Board disciplinary action?
   ☐ Yes ☑ No

Michigan Permanent I.D. Number (as shown on your pocket card): 5101014655

Expiration Date of License: 12/31/07

Social Security Number: [redacted]

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.

Signature: [signature] Date: 6/7/06

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Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-090 (12/05)

Tran Info:510137 11921695-2 06/12/06
Chk#: 19184 Amt: $120.00
ID: 5101014655

Tran Info:510157 11921695-1 06/12/06
Chk#: 19184 Amt: $40.00
ID: 5101014655

Date of Licensure 7-19-06

License Number 5315028437

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

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Type or Print Only

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: Initial (first time) professional license or relicensure of your professional license - $85.00.
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2. M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.
3. Allow up to six weeks for your paper license to arrive.

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First Name	Middle Name	Last Name
Jennifer	Krista	Smith

Street Address	Telephone Number
35000 Ford Rd. Ste. 3	734 721 4700

City	State	ZIP Code
Westland	MI	48185

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

	Regular		Educational Limited
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐
☐ 43 - 01 M.D. 71-5315	☐	or	☐
☒ 51 - 01 D.O. 71-5315	☒	or	☐
☐ 49 - 01 O.D. 71-5330	☐		
☐ 53 - 01 Pharmacy Store 71-5301	☐		
☐ 53 - 02 R.Ph. 71-5302	☐		
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐		

STATUS:

1. Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?
   ☐ Yes ☒ No

   If Yes, please explain on separate sheet.

2. Is your current professional license limited as a result of Board disciplinary action?
   ☐ Yes ☒ No

Michigan Permanent I.D. Number (as shown on your pocket card): 5101014655

Expiration Date of License: 12/31/07

Social Security Number: [redacted]

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.

Signature	Date
[signature]	6/7/06

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