Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

DCH/LMD-851 (03/04) Page 1 of 2

5/8/07

Tran Info:430157 12931236-1 05/10/07
Chk#: 08646840467 Amt: $20.00
ID: [redacted]

# 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 controlledsubstance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

**Board Use Only**

| | |
|---|---|
| License Number | 090625 |
| C.S. License Number | 032443 |
| Date of Licensure | 6/22/07 |

**Type or Print Only**

**I AM APPLYING FOR THE FOLLOWING:**

☑ Educational Limited and Controlled Substance Fee: 170.00
71-43-01-375705

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 |
|---|---|---|
| Brenda | | Pereda |

| U.S. Social Security Number | Date of Birth | Previous MI License Number and Expiration Date, If applicable |
|---|---|---|
| [redacted] | [redacted]74 | |

| Daytime Phone Number | All Previous Names and/or Birth Name Used (if applicable) |
|---|---|
| 517 [redacted] | |

Tran Info:430137 12931236-2 05/10/07
Chk#: 08646840467 Amt: $65.00
ID: [redacted]

Have you ever held a health professional license in Michigan?

☐ Yes ☒ No

Tran Info:430145 12931236-3 05/10/07
Chk#: 08646840467 Amt: $85.00
ID: [redacted]

Name of Training Hospital: DETROIT MEDICAL CENTER GRADUATE MEDICAL EDUCATION

Street Address of Training Hospital: 4201 ST. ANTOINE, 9C / UHC DETROIT, MICHIGAN 48201

| City | State | ZIP Code |
|---|---|---|
| | | |

**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 had 3 or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period? | ☐ Yes ☒ No |
| 6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period? | ☐ Yes ☒ No |
| 7. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? | ☐ Yes ☒ No |

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 Americans with Disabilities Act, you may make your needs known to this agency.

www.michigan.gov/healthlicense

Name Brenda Pereda

8. 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

9. Do you hold or have you held a medical license in any state? If yes, list each state, the license or registration number, the date issued, and how the license was obtained DO NOT LIST TEMPORARY LICENSES. **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 | How obtained (Endorsement or examination) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**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 |
|---|---|---|---|
| Univ of California, Santa Cruz | 1992 | -1994<br>-1996-1998 | Bachelor of Science<br>Biochemistry and Molecular Biology |
| Univ of California Davis | 2000 | 2002 | Post baccalaureate |
| Michigan State University | 2002 | 2007 | Medical Degree |

**Provide a description of your professional medical experience.**
Attach additional sheets if necessary.

| Name and Address of Employer | Dates of Practice From | To | Duties |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of their pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement 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 that 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 |
|---|---|
| [signature] | 4/24/07 |

Education – Brenda Pereda

University of California Santa Cruz
1156 High Street
Santa Cruz, California
95064
From: 1992-1994, 1996-1998
Degree: Bachelor of Science -Biochemistry and Molecular Biology

University of California Davis
One Shield Ave
Davis, California 95616
From: 2000-2002
Degree: Post-baccalaureate

Michigan State University
College of Human Medicine
1200 E. Michigan Ave #640
Lansing, Michigan 48912
From 2002-2007
Degree: Medical Doctor

DCH/LMD-093 (03/04)

Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918



**RECEIVED**
MAY 11 2007
BUREAU OF HEALTH PROFESSIONS
LICENSING DIVISION - APPLICATION UNIT

# CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL

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

**INSTRUCTIONS TO APPLICANT:**

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by the Program Director of the Michigan hospital where you have been appointed. This certification must be submitted to the Board of Medicine by the hospital.

**SECTION I - APPLICANT INFORMATION**

| First Name | Middle Name | Last Name |
|---|---|---|
| Brenda | | Pereda |

| Social Security Number | Date of Birth |
|---|---|
| [redacted] | [redacted] 1974 |

| Street Address |
|---|
| [redacted] |

| City | State | ZIP Code |
|---|---|---|
| Lansing | MI | 48912 |

| Daytime Telephone Number | All Previous Names and/or Birth Name Used (if applicable) |
|---|---|
| 517 [redacted] | |

| Signature of Applicant | Date |
|---|---|
| Brenda Pereda | 4/24/07 |

**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR FOR COMPLETION OF SECTION II.**

Name Brenda Pereda

**THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR**

**INSTRUCTIONS FOR COMPLETING SECTION II:**

Please complete the following information. Return this completed certification directly to the Michigan Board Medicine at the address shown on page 1 of this form.

**SECTION II - CERTIFICATION OF RESIDENCY APPOINTMENT**

Name of Training Hospital

Wayne State University/Detroit Medical Center

Street Address of Training Hospital

4201 St. Antoine #9C

City, State and ZIP Code

Detroit, Michigan 48201

I certify that Brenda Pereda (Applicant's Name) has been duly appointed to a training program in the clinical area of Obstetrics + Gynecology

beginning July 1, 2007 (Month/Day/Year) and ending June 30, 2008 (Month/Day/Year)

at Wayne State University/Detroit Medical Center (Name of Training Hospital)

Is this program accredited by ACGME? ☒ YES ☐ NO

Is this hospital or institution accredited by JCAH? ☒ YES ☐ NO

Debi Kellogg

Signature of Director of Medical Education

5/08/07

Date of Signature

Debi Kellogg

Print or Type Name of Director of Medical Education

Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

**RECEIVED**
MAY - 8 2007
DEPT. OF LEG

# CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA

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

## INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of M the medical school.

## SECTION I - APPLICANT INFORMATION

| First Name | Middle Name | Last Name |
|---|---|---|
| Brenda | | Pereda |

| Social Security Number | Date of Birth | Daytime Telephone Number |
|---|---|---|
| [redacted] | [redacted]/1974 | 517 [redacted] |

| Street Address |
|---|
| [redacted] |

| City | State | ZIP Code |
|---|---|---|
| Lansing | MI | 48912 |

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

| Date of Admission | Date of Graduation |
|---|---|
| 8/2002 | 5/2007 |

| Signature of Applicant | Date |
|---|---|
| Brenda Pereda | 4/24/07 |

**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.**

Name
Pereda, Brenda

## TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

### INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

### SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School

Michigan State University, College of Human Medicine

Street Address of Medical School

A254 Life Sciences Building

City, State and ZIP Code

East Lansing, MI 48824-1317

I certify that Brenda Pereda (Applicant's Name) attended the medical school named above from 08/26/2002 (Month/Day/Year) to 05/04/2007 (Month/Day/Year) and was/will be granted the degree of Doctor of Medicine on 05/04/2007 (Month/Day/Year).

Michelle A. Nyquist

Signature of Dean or Registrar

05/03/2007

Date of Signature

(SE A L)

Michelle A. Nyquist, College Records Officer

Print or Type Name of Dean or Registrar

If school has no seal, please indicate

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
ONLINE APPLICATION FOR A MEDICAL DOCTOR
OBTAINED BY WEB BY EXAMINATION WITH CS

Amount Paid - $235.00
Date Paid - 05/12/2009

| | |
|---|---|
| License # | 0906?5 |
| License # | 043325 |
| Issue Date | 9/23/09 |

| FIRST NAME: | MIDDLE NAME: | LAST NAME: | SUFFIX: |
|---|---|---|---|
| Brenda | | Pereda | |

| SSN: | DATE OF BIRTH: | DAYTIME TELEPHONE NUMBER: |
|---|---|---|
| [redacted] | [redacted]1974 | 248[redacted] |

License Address - 2517 Ferncliff Ave
Royal Oak MI 48073
United States

Email Address - [redacted]@med.wayne.edu

## APPLICATION QUESTIONS

| | |
|---|---|
| Have you been convicted of a felony? | N |
| Have you been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years? | N |
| Have you been convicted of a misdemeanor involving the illegal delivery, possession or use of alcohol or a controlled substance (including motor vehicle violations)? | N |
| Have you been censured or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? | N |
| Have you been treated for substance abuse in the past 2 years? | N |
| Have you had 3 or more malpractice settlements, awards or judgments in any consecutive 5 year period? | N |
| Have you had one or more malpractice settlements, awards or judgments totaling $200,000 or more in any consecutive 5 year period? | N |
| Have you had a federal or state health professional or registration revoked, suspended or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? | N |
| Have you been denied the privilege of taking an examination by any state medical board? | N |
| If you have held a permanent license in another state, list the state's in which you hold or have held a medicine license. | no |
| If you ever held a health professional license in Michigan, please provide the Permanent ID Number (License Number) and Expiration date | no |
| List all previous names used. | n/a |

## EDUCATION

| School Name | DATE FROM | DATE TO |
|---|---|---|
| Michigan State Univ College of Human Medicine | 08/26/2002 | 05/04/2007 |

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZE
DIRECTOR

Name : Brenda Pereda
License Number : Pending
Tracking Number : 1700917
Profession : Medicine
License Type : Medical Doctor
Process : Apply for Initial License process

Certification:

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

Sign on the signature line and mail this page along with any required attachments to:

Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

Print Page

Close Window

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

# SIGNATURE CERTIFICATION

| First Name | Middle Name | Last Name |
|---|---|---|
| Brenda | | Pereda. |
| U.S. Social Security Number [redacted] | Date of Birth [redacted] 74 | Daytime Phone Number |
| Profession: Medical Doctor | License Type: Permanent Medical license | |

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organizations. 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 that 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 |
|---|---|
| [signature] | 7/10/09 |

Sign in the signature block and mail this page to:

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing MI 48909

# United States Medical Licensing Examination™ (USMLE™)
## Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

**Date :** 07/20/2009

**Recipient:**

Michigan Board of Medicine
ATTN: Carole Hakala Engle, Licensing Director
611 W Ottawa
1st Floor
Lansing, MI 48933

**Examinee:** Pereda, Brenda
**Alt Name(s):**

**Examinee ID#:** [redacted]-205-4
**Date of Birth:** [redacted]1974

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

### USMLE STEP 1

| | Test Date | Pass/Fail | Three-Digit Score Total | Three-Digit Score MP | Two-Digit Score Total | Two-Digit Score MP | Comments |
|---|---|---|---|---|---|---|---|
| | 06/29/2005 | Pass | [redacted] | | | | |

### USMLE STEP 2

**Clinical Knowledge (CK)**

| | Test Date | Pass/Fail | Three-Digit Score Total | Three-Digit Score MP | Two-Digit Score Total | Two-Digit Score MP | Comments |
|---|---|---|---|---|---|---|---|
| | 01/25/2007 | Pass | [redacted] | | | | |

**Clinical Skills (CS)***

| | Test Date | Pass/Fail | Three-Digit Score Total | Three-Digit Score MP | Two-Digit Score Total | Two-Digit Score MP | Comments |
|---|---|---|---|---|---|---|---|
| | 01/30/2007 | Pass | | | | | |

### USMLE STEP 3

| | Test Date | Pass/Fail | Three-Digit Score Total | Three-Digit Score MP | Two-Digit Score Total | Two-Digit Score MP | Comments |
|---|---|---|---|---|---|---|---|
| MICHIGAN | 07/05/2008 | Pass | [redacted] | | | | |

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

# CERTIFICATION OF POSTGRADUATE TRAINING

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

## INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.

## SECTION I - APPLICANT INFORMATION

| First Name | Middle Name | Last Name |
|---|---|---|
| Brenda | | Pereda. |

| Social Security Number | Date of Birth |
|---|---|
| [redacted] | [redacted]/74 |

| Street Address |
|---|
| 2517 Fernclif AVE |

| City | State | ZIP Code |
|---|---|---|
| Royal Oak | Michigan | 48073. |

| Daytime Telephone Number | All Previous Names and/or Birth Name Used (if applicable) |
|---|---|
| 248 [redacted] | N/A |

**RECEIVED**

JUL 31 2009

BUREAU OF HEALTH PROFESSIONS
LICENSING DIVISION

| Signature of Applicant | Date |
|---|---|
| [signature] | 7/6/09 |

**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.**

Name: Brenda Pereda

## TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

### INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

### SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital: Detroit Medical Center- Wayne State University

Street Address of Hospital: 4201 St. Antoine

City: Det | State: MI | Zip Code: 48201

I certify that Brenda Pereda (Applicant's Name) a graduate of the Michigan State University medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 7-1-07 (Month/Day/Year), to 6-30-09 (Month/Day/Year), in the clinical area of obstetrics-Gynecology.

Is this training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? ☒ Yes ☐ No

Debi Kellogg
Signature of Director of Medical Education

7-27-09
Date of Signature

Debi Kellogg
Print or Type Name of Director of Medical Education

NOTE: Certification of Postgraduate Training will not be accepted if signed and s... actual completion.

# UNITED STATES MEDICAL LICENSING EXAMINATION

## STEP 3 SCORE REPORT
## 7/30/2008

**FILE COPY**

NAME: Pereda, Brenda

USMLE ID: 51332054

SSN: [redacted]

TEST DATE: 7/5/2008

REPEAT (Y/N) N

The **USMLE Step 3** is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions.

Examinee scores on the three-digit scale score are based upon the number of questions answered correctly on the entire examination. For recent administrations, the mean and standard deviation for first-time takers from U.S. and Canadian medical schools were 207 and 18, respectively, with most of the scores falling between 140 and 260.

**Pass**

This result is based on the minimum passing score recommended by USMLE for Step3.

[redacted]

This score is determined by your overall performance on Step 3. A score of 182 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM) for this scale is approximately five points.

[redacted]

This score is also determined by overall performance on the examination. A score of 75 on this scale is equivalent to a score of 182 on the scale described above; this is the score set by USMLE to pass Step 3. Based upon recent administrations, the SEM for the two-digit score scale is approximately one and a half points.

Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918

DCH/LMD-050 (09/04)

Board Use Only

Tran Info: 430137 13838692-1 05/21/08
Chk#: 1012 Amt: $50.00
ID: 4301090675

## APPLICATION FOR USMLE STEP 3 EXAMINATION

Authority: Public Act 368 of 1978, as amended

**Type or Print Only**

**I AM APPLYING FOR THE FOLLOWING:**

☑ USMLE Step 3 Examination Fee: $50.00 71-4301-25

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 |
|---|---|---|
| Brenda | | Pereda |
| U.S. Social Security Number [redacted] | Date of Birth [redacted]74 | Michigan Permanent I.D. Number and Expiration Date 4301090675 6/30/08. |
| Street Address 2517 ferncliff Ave | | |
| City Royal Oak | State MI | ZIP Code 48073. |
| Daytime Telephone Number 517 [redacted] | All Previous Names and/or Birth Name Used (if applicable) | |

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

| | | |
|---|---|---|
| 1. Have you previously taken USMLE Step 3 in Michigan? | ☐ Yes | ☑ No |
| 2. Have you previously taken USMLE Step 3 in another State? If yes, Please list state(s) and date of exam. | ☐ Yes | ☑ No |
| 3. Do you now or have you ever held an educational limited license in the State of Michigan? If yes, please give license number below. 4301090675 6/30/08 | ☑ Yes | ☐ No |

### ELIGIBILITY

**To be eligible to take USMLE step 3, you must establish BOTH of the following:**

a) That you have passed USMLE Step 1 and USMLE Step 2 and

b) That you have completed not less than six months of postgraduate clinical training in a program approved by board.

### INSTRUCTIONS TO APPLICANT

**It is your responsibility to assure that the following two documents are provided to this office directly from their sources:**

1) USMLE Step 1 and USMLE Step 2 examination scores from the Federation of State Medical Boards and

2) Certification of completion of at least six months postgraduate clinical training on the enclosed form from your Program Director

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 Americans with Disabilities Act, you may make your needs known to this agency.

DCH/LMD-091 (03/04)



Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918



# CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA

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

## INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by the Dean of the medical school you attended. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

## SECTION I - APPLICANT INFORMATION

| First Name | Middle Name | Last Name |
|---|---|---|
| Brenda | | Pereda |

| Social Security Number | Date of Birth | Daytime Telephone Number |
|---|---|---|
| [redacted] | [redacted]/74 | 248 [redacted] |

| Street Address |
|---|
| 2517 fernclift Ave |

| City | State | ZIP Code |
|---|---|---|
| Royal Oak | MI | 48073 |

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

| Date of Admission | Date of Graduation |
|---|---|
| 2002 | 2007 |

| Signature of Applicant | Date |
|---|---|
| [signature] | 8/15/09 |

**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.**

Name
Pereda, Brenda

## TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

**INSTRUCTIONS FOR COMPLETING SECTION II:**
Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.

**SECTION II - CERTIFICATION OF MEDICAL EDUCATION**

Name of Medical School
Michigan State University College of Human Medicine

Street Address of Medical School
A234 Life Sciences Building

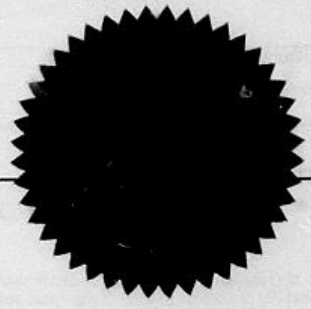
City, State and ZIP Code
East Lansing, MI 48824

I certify that Brenda Pereda (Applicant's Name) attended the medical school named above from 8/26/2002 (Month/Day/Year) to 8/16/2007 (Month/Day/Year) and was/will be granted the degree of Doctor of Medicine on 8/16/2007 (Month/Day/Year).

Gina L Brooks
Signature of Dean or Registrar

September 10, 2009
Date of Signature

Gina L. Brooks, MA
Print or Type Name of Dean or Registrar



USMLE
United States
Medical
Licensing
Examination
TM

# United States Medical Licensing Examination™ (USMLE™)
## Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date : 03/19/2008

**Recipient:**

Michigan Board of Medicine
ATTN: Carole Hakala Engle, Licensing Director
P.O. Box 30670
Lansing, MI 48909

**Examinee:** Pereda, Brenda
**Alt Name(s):**

**Examinee ID#:** 5-133-205-4
**Date of Birth:** [redacted]974

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

### USMLE STEP 1

| Test Date | Pass/Fail | Three-Digit Score Total | Three-Digit Score MP | Two-Digit Score Total | Two-Digit Score MP | Comments |
|---|---|---|---|---|---|---|
| 04/29/2005 | Pass | [redacted] | | | | |

### USMLE STEP 2

**Clinical Knowledge (CK)**

| Test Date | Pass/Fail | Three-Digit Score Total | Three-Digit Score MP | Two-Digit Score Total | Two-Digit Score MP | Comments |
|---|---|---|---|---|---|---|
| 01/25/2007 | Pass | [redacted] | | | | |

**Clinical Skills (CS)***

| Test Date | Pass/Fail | Three-Digit Score Total | Three-Digit Score MP | Two-Digit Score Total | Two-Digit Score MP | Comments |
|---|---|---|---|---|---|---|
| 01/30/2007 | Pass | | | | | |

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

* Performance on the CS component of Step 2 is reported as pass or fail.

DCH/LMD-201 (09/04)

Michigan Department of Community Health
**Board of Medicine**
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918





# CERTIFICATION OF POSTGRADUATE TRAINING FOR USMLE EXAMINATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, you will be ineligible to sit for the exam

## INSTRUCTIONS TO APPLICANT:

**Complete Section I. Type or print your name exactly as it appears on your application. For Section II, send this form to be completed by the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the Director of Medical Education.**

## SECTION I - APPLICATION INFORMATION

| First Name | Middle Name | Last Name |
|---|---|---|
| Brenda | | Pereda |

| Social Security Number | Date of Birth |
|---|---|
| [redacted] | |

| Street Address |
|---|
| 2517 ferndiff Ave |

| City | State | ZIP Code |
|---|---|---|
| Royal Oak | MI | 49073 |

| Daytime Telephone Number | All Previous Names and/or Birth Name Used (if applicable) |
|---|---|
| 517-[redacted] | |

| Signature of Applicant | Date |
|---|---|
| [signature] | 3/19/08 |

**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.**

Name Brenda Pereda

**TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION**

**INSTRUCTIONS FOR COMPLETING SECTION II:**

**Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on Page 1 of this form.**

**SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING**

**Name of Hospital**
Hutzel Women's

**Street Address of Hospital**
3990 John R

**City, State and ZIP Code**
Detroit, MI 48201

**I certify that** Brenda Pereda (Applicant's Name) **a graduate of the** Michigan State **medical school, has successfully completed postgraduate clinical training offered by the hospital named above from** 7/1/07 (Month/Day/Year) **to** 3/31/08 (Month/Day/Year) **in the clinical area of** Obstetrics and Gynecology.

**Is this training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training programs of the Canadian Medical Association?**

☒ **Yes** ☐ **No**

T B Jones

Signature of Director of Medical Education

3·31·08

Date of Signature

Theodore B. Jones M.D.

Print or Type Name of Director of Medical Education

**(SEAL)**

If hospital has no seal, please indicate

**NOTE: This form may not be completed and submitted to the Board office prior to the completion of the required 6 months of post graduate training. In order to be made eligible for the USMLE examination, the required training must be completed and verified by the established deadline date.**