STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF LICENSING AND REGULATION

ELIZABETH P HOWE, Director

Michigan Board of Medicine
P.O. Box 30018
Lansing, Michigan 48909
Telephone: (517) 373-0680

December 3, 1984

Leigh Ellen Watlington, M.D.
[redacted]
Detroit, Mich. 48201

Dear Doctor:

We are enclosing your copy of Michigan medical licensure # 48090 dated Nov. 29, 1984, and effective to Jan. 31, 1986.

This certificate will enable you to practice medicine and apply for your Controll Substances Registration, and hospital staff privileges.

The engraved certificate of medical licensure will be ordered and forwarded to you when it has been obtained from the engraver, and the proper seal and signatures affixed. This usually takes several months.

YOU ARE ADVISED TO KEEP THIS OFFICE INFORMED OF ANY CHANGE IN ADDRESS.

PLEASE NOTE ENCLOSURES:

1. Continuing Medical Education Rules
2. Rules - Standards of Practice Regarding Amphetamines
3. Informational material from the Michigan Department of Health

Sincerely yours,

MICHIGAN BOARD OF MEDICINE

Herman Fishman
Licensing Executive

Encls.

NOTE: Copy of the Michigan Public Health Code, Act 368, PA 1978, as amended may be obtained by forwarding a check for $2.00 for each booklet to: Receipts Accounting Section, Dept. of Licensing & Regulation, P.O. Box 30018, Lansing, MI 48909. Checks should be made payable to State of Michigan - P.H.S.R.P.

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATION
MICHIGAN BOARD OF MEDICINE
P.O. BOX 30018
Lansing, Michigan 48909

fee paid 165.00
#358 11-15-84

LMD-050 (10/82)

(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR LICENSURE BY EXAMINATION (NATIONAL BOARDS)

Approved by _____

FEE $165.00 — Make check or money order, in U.S. currency, payable to: STATE OF MICHIGAN — MEDICINE
(ALL FEES SUBMITTED ARE NOT REFUNDABLE)

INSTRUCTION TO APPLICANT

1. If additional space is necessary, use separate paper.
2. The application must be completely filled out.
3. The affidavit must be properly completed.
4. Before a license is issued, a personal appearance before the Board may be required.
5. Examination dates and locations will be determined by the Board.

WATLINGTON LEIGH ELLEN
NAME OF APPLICANT (last) (first) (middle)

[redacted]

ADDRESS (No., Street, City, State, Zip)
DETROIT, MI 48201

DATE OF BIRTH [redacted]/55

1. Have you ever been convicted of a felony or misdemeanor for which you could have been sent to jail? (You may exclude traffic violations not related to alcohol or substance abuse.)	☐ Yes ☒ No	If yes, do NOT give details at this time.
2. Have you ever had an adverse civil judgment (including malpractice)?	☐ Yes ☒ No	If yes, state subject of judgment.
3. Have you been examined by the National Board or any State Board of Medicine?	☒ Yes ☐ No	If "YES", give details. Parts I, II, III
4. Do you hold a license to practice medicine in any state or states?	☐ Yes ☒ No	If "YES", give states.

5. EDUCATIONAL RECORD

	NAME AND LOCATION OF INSTITUTION ATTENDED	DATES OF ATTENDANCE Mo/Yr	TO	Mo/Yr	Degrees Obtained
MEDICAL EDUCATION (Submit Dates for Each School Year)	HARVARD MEDICAL SCHOOL	9/77	TO	6/81	M.D.
POST GRADUATE EDUCATION					

Note: Please attach complete summary of medical training and experience

6. AFFIDAVIT OF APPLICANT

STATE OF Michigan COUNTY OF Wayne DATE November 6, 1984

Leigh Watlington, being duly sworn, deposes and says that she is the applicant named in the foregoing application for a Certificate to practice Medicine and Surgery in the State of Michigan; that he has read the foregoing application and knows the contents thereof and swears the same to be true.

Leigh E. Watlington
Signature of Applicant in Full

Subscribed and sworn to before me
NOTARY PUBLIC Patricia S. Delia
PATRICIA S. DELIA
Notary Public, Wayne County, MI
MY COMMISSION EXPIRES

Note: This form required by PA368 of 1978, as amended. Must be completed for licensure

7. POST-GRADUATE TRAINING 1983-84

(This space should be left blank if the required residency has not been completed at the date the application is submitted)

I hereby certify that Dr. Leigh Watlington, satisfactorily served twelve months straight (Rotating or mixed or straight)

XX residency

____ internship in Wayne State University Affiliated Hospital from July 1, 1981 (DATE) to June 30, 1984 (DATE)

Verified 11-29-84 with W.S.U. per Patti A. Bonnie

(IF ABOVE)

3742

ADDRESS OF HOSPITAL
Wayne State University Affiliated Hospitals Graduate Medical Ed.
4201 St. Antoine #2C
Detroit, Michigan 48201

DATE	SIGNATURE OF MEDICAL DIRECTOR, SUPERINTENDENT OR CHIEF OF STAFF
11-7-84	Margaret F. Morrison

8. CERTIFICATE OF DEAN, SECRETARY OR REGISTRAR OF MEDICAL COLLEGE

I hereby certify that I have reviewed the answers in the above application. I certify that to the best of my knowledge all of the within answers or statements are true and are a matter of official record in this school, and that I am unaware of information that would suggest that said applicant is not of good moral and professional character.

I further certify that _____, M.D. matriculated in the _____ (Name and Address of Medical School)

on _____ (Date), and was graduated _____ (Date), at which time, he was granted the

degree of _____. If the degree, Bachelor of Medicine is conferred upon completion of four years of medical school, further state the conditions and time the degree, Doctor of Medicine will be granted

_____

_____

SEAL

NAME AND ADDRESS OF MEDICAL SCHOOL

DATE	SIGNATURE OF DEAN, SECRETARY OR REGISTRAR

9. NATIONAL BOARD CERTIFICATE OF RECORD: (copies are not acceptable)
Please submit your National Board Certificate of Records with this application: or you may ask the National Board to forward it directly to this office.

LMD-050 (10/82)

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATION
MICHIGAN BOARD OF MEDICINE
P.O. BOX 30018
Lansing, Michigan 48909

NOV 19 1 84695345 ***165.00
(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR LICENSURE BY EXAMINATION (NATIONAL BOARDS)

Approved by _____

FEE $165.00 — Make check or money order, in U.S. currency, payable to: STATE OF MICHIGAN — MEDICINE
(ALL FEES SUBMITTED ARE NOT REFUNDABLE)

INSTRUCTION TO APPLICANT
1. If additional space is necessary, use separate paper.
2. The application must be completely filled out.
3. The affidavit must be properly completed.
4. Before a license is issued, a personal appearance before the Board may be required.
5. Examination dates and locations will be determined by the Board.

WATLINGTON LEIGH ELLEN
NAME OF APPLICANT (last) (first) (middle)

[redacted]
ADDRESS (No., Street, City, State, Zip)

DETROIT, MI 48201

DATE OF BIRTH [redacted]/55

1. Have you ever been convicted of a felony or misdemeanor for which you could have been sent to jail? (You may exclude traffic violations not related to alcohol or substance abuse.)	☐ Yes ☒ No	If yes, do NOT give details at this time.
2. Have you ever had an adverse civil judgment (including malpractice)?	☐ Yes ☒ No	If yes, state subject of judgment.
3. Have you been examined by the National Board or any State Board of Medicine?	☒ Yes ☐ No	If "YES", give details. Parts I, II, III
4. Do you hold a license to practice medicine in any state or states?	☐ Yes ☒ No	If "YES", give states.

5. EDUCATIONAL RECORD

	NAME AND LOCATION OF INSTITUTION ATTENDED	DATES OF ATTENDANCE Mo/Yr	TO	Mo/Yr	Degrees Obtained
MEDICAL EDUCATION (Submit Dates for Each School Year)	HARVARD MEDICAL SCHOOL	9/77	TO	6/81	M.D.
POST GRADUATE EDUCATION					

Note: Please attach complete summary of medical training and experience

6. AFFIDAVIT OF APPLICANT

STATE OF Michigan COUNTY OF Wayne DATE November 6, 1984

Leigh Watlington being duly sworn, deposes and says that she is the applicant named in the foregoing application for a Certificate to practice Medicine and Surgery in the State of Michigan; that he has read the foregoing application and knows the contents thereof and swears the same to be true.

Leigh E. Watlington
Signature of Applicant in Full

PATRICIA S. DELIA
Notary Public, Wayne County, MI
Subscribed and sworn to before me
NOTARY PUBLIC Patricia S. Delia
MY COMMISSION EXPIRES

Note: This form required by PA368 of 1978, as amended. Must be completed for licensure

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Leigh E. Watlington, 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 WILLIAM B. HOLDEN, M.D.
Chairman of the Board

SEAL EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa.
07/01/82

Certificate # 245862

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from HARVARD MEDICAL SCHOOL in JUNE ,1981 and whose birth date is [redacted]/1955 This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/79		
Anatomy, incl. histology and embryology		
Physiology		
Biochemistry		
Pathology		
Microbiology, incl. immunology		
Pharmacology and Materia Medica		
Behavioral Sciences		
TOTAL TEST (Minimum Passing Score 380/75)		
Part II passed 09/80		
Internal medicine and the medical specialties		
Surgery and the surgical specialties		
Obstetrics and Gynecology		
Public Health and Preventive Medicine		
Pediatrics		
Psychiatry		
TOTAL TEST (Minimum Passing Score 290/75)		
PART III passed 03/82		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)		
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		

[redacted]

Reviewed 11-29-84 G Diomede

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Ann K. Heverling
Secretary for Certification

SEAL

06/21/84
Date

State of Michigan – Dept. of Licensing and Regulation

MICHIGAN BOARD OF MEDICINE

P.O. Box 30018, Lansing, MI 48909

EDUCATIONAL/TRAINING LIMITED LICENSE RENEWAL APPLICATION

LMD-230 (11/83)

XL-3 19 8450114 ****20.00
XL-3 19 8450104 ****30.00

(Do Not Write in This Space)

MAKE CHECK OR MONEY ORDER PAYABLE TO: STATE OF MICHIGAN – MEDICINE

YOUR LIMITED LICENSE EXPIRES ON	JUNE 30, 1984.
RENEWAL FEE IF PAID BEFORE 6-30-84	$30.00
ADDITIONAL LATE FEE DUE AFTER 6-30-84	$20.00
TOTAL FEES DUE NOW	**$30.00**

Renewal Instructions:

Postgraduate Trainee Completes All Appropriate Items Below and on Reverse Side. The Director of Medical Education Must Complete all Items on the Right Portion of Reverse Side. Postgraduate Trainee is Responsible for Returning Completed Application in the Envelope Provided.

WATLINGTON, LEIGH E 43-41
WAYNE ST UNIV AFFIL HSPS 002449
GRADUATE MED ED ADM 2-C
4201 ST ANTOINE 82
DETROIT MI 48201

If you are in a different program than you were last year, give new program name below.

OB/GYN

Enter any personal name changes or corrections below.

Enter any hospital name changes below.

Enter any hospital address changes or corrections below.

City State ZIP County

LICENSEE AND MEDICAL EDUCATION DIRECTOR COMPLETE REVERSE SIDE

THIS SIDE TO BE COMPLETED BY POSTGRADUATE TRAINEE

Check One Box Below Which Describes Your Renewal Status:

Renewal Status:

- [X] I am continuing my training beyond June 30 at the same location shown in the label on the reverse side. Correct any errors that appear on the label in the area provided on the reverse side.
- [ ] I am continuing my training beyond June 30, but will transfer to a new hospital and/or program. Enter new program name, new hospital name and address in area provided on reverse side.
- [ ] I will not continue my training in Michigan beyond June 30.

Termination Date _____

Forwarding Address: _____

THIS SIDE MUST BE COMPLETED, SIGNED AND SEALED BY THE DIRECTOR OF MEDICAL EDUCATION

CERTIFICATION OF TRAINING APPOINTMENT

This Certifies That Leigh Watlington, MD. Has Been
Print Name of Postgraduate Trainee

Appointed to the Position of (Check one box below and enter Program Name).

- [ ] Categorical First Year In _____
- [ ] Categorical Year In _____
- [ ] Fi _____
- [X] ne) Year Resident In Obstetrics & Gynecology

W.S.U. Affiliated Hospitals G.M.E.
Hospital Name

Signature of Director of Medical Education

Margaret F. Morrison - Coordinator
Printed Name of Director of Medical Education

June 29, 1984
Date Completed (Month, Day, Year)

WATLINGTON, LEIGH E 43-41
WAYNE ST UNIV AFFIL HSPS 002449
GRADUATE MED ED ADM 2-C
4201 ST ANTOINE 82
DETROIT MI 48201

WAYNE STATE UNIVERSITY -
GRADUATE MEDICAL EDUCATION PROGRAM

APPLICATION FOR GRADUATE CLINICAL TRAINING

INSTRUCTIONS: Please type (preferred) or print. This form will be used for purposes of stipend payment as well as determining your academic and professional qualifications.

FOR OFFICE USE ONLY
(Do not write in this space)

Date Rec'd. _____

Hosp. Sent _____

Date Sent _____

Application date March 30 1981 (Month Day Year) To begin training July 1 1981 (Month Day Year) Social Security Number 204469827

M.D. D.O. D.D.S.

WATLINGTON (Last Name) IEICH (First Name) EILEN (Middle Name)

Sex: M F Maiden Name (if married female) _____

Marital Status: Single Divorced Widowed Separated. If married, name of spouse: _____ wife husband (circle)

Present address and telephone number

[redacted] (Number Street City) Boston Ma. (State) 02120 (Zip Code) (617) [redacted] (Country (if not U.S.) Telephone)

Address and telephone number where you can be reached during the day (Hospital, office):

[redacted] (Number Street) Boston Ma. (City State) 02120 (Zip Code) (617) [redacted] (Country (if not U.S.) Telephone)

Citizenship: [X] U.S. [ ] Other (Specify) _____ Date of Birth [redacted] (Month Day Year) Place of Birth [redacted] (City State Country)

State group, racial or ethnic minority Black American

Previous Education:

Philadelphia High School For Girls (Preparatory or High School)	Philadelphia, Pa. (Location)	9/69-6/73 (From - To (dates))	Diplom (Degree)
Massachusetts Institute of Technology (College or University)	Cambridge, Ma. (Location)	6/73-6/77 (From - To (dates))	SB Nutr. SB Manag (Degree)
Harvard Medical School (Medical or Dental School)	Boston, Ma. (Location)	9/77-6/81 (From - To (dates))	MD (Degree)

Year of Training Preferred Postgraduate Year I Specialty Department Obstetrics and Gynecology

Do you intend to enter NRMP matching program? [ ]Yes [ ]No

Previous post – M.D./D.O./D.D.S. training: (show type or specialty).

1) Intern

From - To (dates) | Name of Institution | Location | Training Supervisor

2) Resident

From - To (dates) | Name of Institution | Location | Training Supervisor

3) Resident or Fellow

From - To (dates) | Name of Institution | Location | Training Supervisor

4) Resident or Fellow

From - To (dates) | Name of Institution | Location | Training Supervisor

True Copy
Margaret Monroe
Notary Public, Wayne County, Mich.
My Commission Expires Oct. 24, 1982

State of Michigan — Dept. of Licensing and Regulation
MICHIGAN BOARD OF MEDICINE
P.O. Box 30018, 905 Southland Ave., Lansing, MI 48909

LMD-230 (3/82)

JUN 18 82 82332143 ****30.00

LIMITED LICENSE RENEWAL APPLICATION — POSTGRADUATE TRAINING
Your Limited License Expires **June 30, 1982**

Make Check or Money Order Payable To:
STATE OF MICHIGAN — MEDICINE

Renewal Fee Due Now Is	$30.00	Renewal Fee Due After 6-30-82 Is	$50.00

License ID Number: 43-41-00

WATLINGTON, LEIGH E 43-41
WAYNE ST UNIV AFFIL HSPS 002449
GRADUATE MED ED ADM -2e c/a 82
4201 ST ANTOINE
DETROIT MI 48201

Licensee And Medical Ed. Director Complete Other Side

Renewal Instructions:
Postgraduate Trainee Completes All Appropriate Items Below and on Reverse Side. The Director of Medical Education Must Complete all Items on the Right Portion of Reverse Side. Postgraduate Trainee is Responsible for Returning Completed Application in the Envelope Provided.

Our Records Indicate You Are In the Program Given Below
Cat. 1st yr - OB/GYN

If You Are In A Different Program, Give Name Below
and yr - OB/GYN

Enter Any Personal Name Changes Or Corrections Below

Enter Hospital Name Changes Or Corrections Below

Enter Hospital Address Changes Or Corrections Below

City | State | ZIP | County

THIS SIDE TO BE COMPLETED BY POSTGRADUATE TRAINEE

Check One Box Below Which Describes Your Renewal Status:

- [x] I am continuing my training beyond June 30 at the same location shown in the label on the reverse side. Correct any errors that appear on the label in the area provided on the reverse side.
- [ ] I am continuing my training beyond June 30, but will transfer to a new hospital and/or program. Enter new program name, new hospital name and address in area provided on reverse side.
- [ ] I will not continue my training in Michigan beyond June 30.

Termination Date _____
Forwarding Address: _____

THIS SIDE MUST BE COMPLETED, SIGNED AND SEALED BY THE DIRECTOR OF MEDICAL EDUCATION

CERTIFICATION OF TRAINING APPOINTMENT

This Certifies That Leigh E. Watlington, M.D. Has Been
Print Name of Postgraduate Trainee

Appointed to the Position of (Check one box below and enter Program Name).

- [ ] Categorical First Year In _____
- [ ] Categorical First Year In _____
- [ ] Flex _____
- [x] (Check One) Year Resident In GYN/OB - 2nd yr.

Hospital Name WSU Affiliated Hospitals Graduate Medical Education

Signature of Director of Medical Education

Printed Name of Director of Medical Education
G. N. Grimes, Coordinator, GME

Date Completed (Month, Day, Year) 06-14-82

State of Michigan
Department of Licensing and Regulation
MICHIGAN BOARD OF MEDICINE

P.O. Box 30018
905 Southland
Lansing, Michigan 48909

LMD-060 (2/80)

(DO NOT WRITE IN THIS SPACE)

MAY 29 8 8198403 ****30.00

APPLICATION FOR LIMITED LICENSE FOR POST GRADUATE TRAINING IN AN APPROVED TRAINING HOSPITAL

FEE $30.00 Make check or money order, in U.S. currency payable to:
STATE OF MICHIGAN — MEDICINE
Do Not Send Cash

I hereby apply for a Certificate of Registration under Section 16182(1)(a) & Section 17012(2) of Act 368, P.A. 1978, and Acts amendatory thereto:

SWORN STATEMENT:

1. Name WATLINGTON (last) LEIGH (first) ELLEN (middle)
2. Place of birth [redacted] Date of birth [redacted]/52 Age [redacted]
3. Are you a citizen of the United States? YES
4. If not a citizen, what is your visa status in the United States?
5. Present mailing address [redacted] Detroit, Michigan 48201
6. Permanent residence [redacted] Philadelphia, Pa. 19119

   Name, address, of nearest relative Same as above
7. In what states do you hold a license to practice medicine? None
8. Have you ever been denied a license to practice medicine in any state? No
9. Military service: Date of Entry ..... Date of Discharge ..... Branch of service and particulars .....

   Rank .....
10. What was your premedical education?

Name and location of institution attended	Period and date of study
University of Pennsylvania	Spring 1972
Massachusetts Institute of Technology	6/73-6/77

What literary degrees did you obtain, when and from what schools or colleges? .....

11. MEDICAL EDUCATION: (Submit dates for each school year)

Day	Month	Year		Day	Month	Year	Name and Address of Medical College
	9	77	to	4	6	81	Harvard Medical School, Boston, Ma.
			to				
			to				
			to				
			to				
			to				

12. POST GRADUATE EDUCATION: NOTE: Please attach *complete summary* of medical training and experience since medical school graduation.

Year		Year	School or Clinic	Degrees Obtained
	to			
	to			
	to			
	to			

13. Have you ever attended any other college or school teaching any of the healing arts? No

14. (1) Have you been certified by the Educational Council for Foreign Medical Graduates? .....
    Certificate Number .....
    (2) Have you been certified by the Visa Qualifying Examination? .....
    Certificate Number .....

15. Internship: Straight (Rotating, Mixed or Straight) at Hutzel Hospital, located at Wayne State University, from July 1, 1981 (Date) to June 30, 1982 (Date)

16. Received degree of Doctor of Medicine from Harvard Medical School, on 4 day of June, 1981

17. Have you carefully read Public Health Code, Act 368, P.A. 1978? .....

18. Have you ever been convicted of any crime in any state? NO

19. Do you unreservedly agree to comply with all the provisions in the laws governing the practice of medicine in Michigan? YES

20. Have you been examined by the National Board or any State Board of Medicine? NO

If so, are you licensed in any state? .....

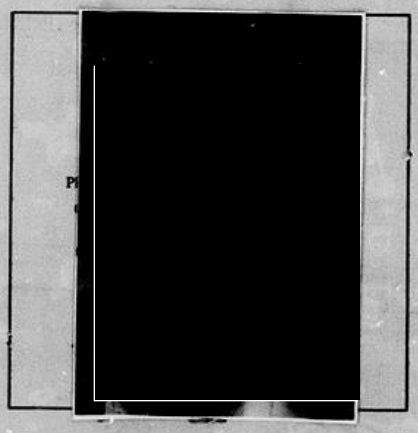
(Signed) .....

AFFIDAVIT OF APPLICANT

State of MASSACHUSETTS
County of SUFFOLK } ss.

LEIGH ELLEN WATLINGTON, being duly sworn, deposes and says that she is the applicant named in the foregoing application for a Certificate to practice Medicine and Surgery in the State of Michigan; that she has read the foregoing application and knows the contents thereof and swears the same to be true.

Leigh Ellen Watlington
Signature of applicant in full



I hereby certify that the photograph hereto attached is a genuine likeness of LEIGH ELLEN WATLINGTON

[redacted]
of BOSTON, MASS. 02115

Arthur H. Sparr
(SEAL)

Subscribed and sworn to before me, Arthur H. Sparr
a Notary Public, this 12th day of MAY, 1981
Address Boston, Mass.
My Commission expires NOV 13, 1981

NOTE: No application will be accepted without proper completion of this portion by your medical school (Sec. 21). This applies to all applicants.

21. CERTIFICATE OF DEAN, SECRETARY OR REGISTRAR OF MEDICAL COLLEGE

In the application of Leigh Ellen Watlington, of Philadelphia, Pennsylvania, dated May 12, 1981,
I hereby certify that I have reviewed the answers of the above named applicant. I certify that to the best of my knowledge all of the within answers or statements are true and are a matter of official record in this school, and that said applicant is of good moral and professional character.

I further certify that Leigh Ellen Watlington, ~~M.D.~~

matriculated in the Harvard Medical School (Name of medical school)
September 7, 1977 (Date) will be / ~~was~~ graduated June 4, 1981 (Date), at which time she will be / ~~was~~

granted the degree, M.D.

If the degree, Bachelor of Medicine, is conferred upon completion of four years of medical school, further state the conditions and time the degree, Doctor of Medicine, willl be granted.

DATED AT Boston, Massachusetts

THIS 12th day of May, 1981

(SEAL)
Seal of college must be attached

Audrey Ann Kolb
Signature of ~~Dean~~ Secretary of Registrar

Harvard Medical School
Name of medical college

25 Shattuck Street, Boston, Mass.
Address of medical college

---

22. CERTIFICATION OF FIRST YEAR OF POSTGRADUATE TRAINING:

(This space should be left blank if this year of training has not been completed at the date the application is submitted)

I hereby certify that Dr. ..... satisfactorily served a rotating internship in ..... Hospital, from the ..... day of ....., 19 ....., to the ..... day of ....., 19 ..... .

(Signed) .....
(Medical Director or Superintendent)

Date .....

.....
(Name of hospital)

[SEAL]

.....
(Address of hospital)

---

23. CERTIFICATION OF
MEDICAL DIRECTOR OR SUPERINTENDENT OF MICHIGAN TRAINING HOSPITAL

This certifies that Leigh Ellen Watlington

has been appointed to the position of ☒ CATEGORICAL 1st yr. in GYN/OB

☐ CATEGORICAL* 1st yr. in .....

☐ FLEXIBLE 1st yr. in .....

RESIDENT .....

WSU Affiliated Hospitals (Name of Hospital) beginning July 1, 1981

and ending June 30, 1982 .

(SEAL)

Signature of Medical Director or Superintendent
G.N. Grimes

24. INSTRUCTIONS TO APPLICANTS:

1. This application will not be accepted unless properly signed and sworn to by the applicant and endorsed by the medical director or superintendent of the hospital in which service is requested.
2. This application must be completed and on file in the office of the Executive Director of the Michigan Board of Medicine on or before July 1 of the year in which permit is requested.
3. Material omissions covering questions in this application will bring the applicant under the provisions of Act 368, P.A. 1978, Section 16221 through Section 16241.
4. The annual registration fee of $30.00 must accompany the application, and should be transmitted by CHECK EXPRESS or MONEY ORDER. No responsibility will be assumed for fees transmitted in any other manner.
5. Before issuance of a license, a personal appearance with medical school diploma may be required.

If after a license has been issued on this application, it is ascertained that misrepresentation of facts, or fraudulent statements have been made, the license so issued will be immediately revoked by this Board and the applicant becomes subject to prosecution.

RECORD OF LIMITED LICENSES ISSUED

No. 1

6/10/81

Number T39376 for Wayne State Univ. Affiliated Hospital

Effective Date from July 1, 19 81 to June 30, 19 82

No. 2

6/22/82

Number 2449 for W.S.U. Affil Hospital

Effective Date from July 1, 19 82 to June 30, 19 83

No. 3

5-19-83

Number 2449 for W.S.U. Affil Hospital

Effective Date from July 1, 19 83 to June 30, 19 84

No. 4

7-3-84

Number 2449 for W.S.U. Affil Hospital

Effective Date from July 1, 19 84 to June 30, 19 85

No. 5

Number ..... for ..... Hospital

Effective Date from July 1, 19 ..... to June 30, 19 .....