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

Tran Info:430157 12744867-1 04/02/07
Chk#: 1182 Amt: $20.00
Tran [redacted] 12744867-2 04/02/07
Chk#: 1182 Amt: $65.00
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 controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539)

Type or Print Only

Board Use Only
License Number 089906
C.S. License Number Tran Info:430105 12744867-3 04/02/07
Chk#: 1182 Amt: $85.00
Date of Lic Issu [redacted]
5/4/07

I AM APPLYING FOR THE FOLLOWING: G31181

☒ **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
Audrey	Ann	Lance

U.S. Social Security Number	Date of Birth	Previous MI License Number and Expiration Date, If applicable
[redacted]	[redacted]/1982	

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

Have you ever held a health professional license in Michigan?
☐ Yes ☒ No

Name of Training Hospital
The University of Michigan Health System

Street Address of Training Hospital
1500 E. Medical Center Drive

City	State	ZIP Code
Ann Arbor	MI	48109

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: Audrey Ann Lance

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
Michigan State University E. Lansing, MI	08/99	08/2000	No degree earned
University of Michigan Ann Arbor, MI	08/2000	04/2003	Bachelor of Arts - Women's Studies
George Washington University School of Medicine, 2300 I St. Washington, D.C. 20037	08/2003	05/2007	MD expected May, 2007.

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: [signature] Date: 3/25/07

DCH/LMD-093 (03/04)

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

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
Audrey	Ann	Lance

Social Security Number	Date of Birth
[redacted]	[redacted]/82

Street Address		
FA808 Mott 1520 E. Medical Ctr. Dr.		
City	State	ZIP Code
Ann Arbor	MI	48109-0264
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
734 - [redacted]		

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR FOR COMPLETION OF SECTION II ON PAGE 2 OF THIS FORM.

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

DCH/LMD-093 (03/04)

Name

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

Street Address of Training Hospital: University of Michigan Health System, 1500 E. Medical Center Drive, Ann Arbor, MI 48109 — F4808 MOTT BOX 0264

City, State and ZIP Code

I certify that Audrey Lance has been duly appointed to a training program in the clinical area of Obstetrics & Gynecology

beginning 6/15/2007 (Month/Day/Year) and ending 6/30/2011 (Month/Day/Year)

at University of Michigan (Name of Training Hospital)

Is this program accredited by ACGME? ☑ YES ☐ NO

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

Lynn Donnelly for — Signature of Director of Medical Education

5/22/07 — Date of Signature

Lisa Colletti, MD — Print or Type Name of Director of Medical Education

(SEAL)

If hospital has no seal, please indicate.

DCH/LMD-093 (03/04)

RECEIVED
APR -5 2007
DEPT. OF LEG

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

RECEIVED
APR 02 2007
GRADUATE MEDICAL EDUCATION

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
Audrey	Ann	Lance

Social Security Number	Date of Birth
[redacted]	[redacted]/1982

Street Address
[redacted]

City	State	ZIP Code
Royal Oak	MI	48073

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

Signature of Applicant	Date
[signature]	3/25/07

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR FOR COMPLETION OF SECTION II ON PAGE 2 OF THIS FORM.

Name
Audrey A. LANCE

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
The University of Michigan Health System

Street Address of Training Hospital
1500 E. Medical Center Drive

City, State and ZIP Code
Ann Arbor, MI 48109

I certify that Audrey Ann Lance has been duly

appointed to a training program in the clinical area of Obstetrics - Gynecology

beginning 7-1-2007 (Month/Day/Year) and ending 06-30-07 (Month/Day/Year)

at The University of Michigan Health System
Name of Training Hospital

Is this program accredited by ACGME? ☒ YES ☐ NO

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

Claudia L. Kontek for — 4-3-07

Signature of Director of Medical Education — Date of Signature

(SEAL)

for Lisa Colletti, MD

Print or Type Name of Director of Medical Education

If hospital has no seal, please indicate

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 completion of Section II, send this form to 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
Audrey	Ann	Lance
Social Security Number	**Date of Birth**	
[redacted]	[redacted]/1982	
Street Address		
[redacted]		
City	**State**	**ZIP Code**
Royal Oak	MI	48073
Daytime Telephone Number	**All Previous Names and/or Birth Name Used (if applicable)**	
(734) [redacted]		
Date of Admission		**Date of Graduation**
		05/20/2007

Signature of Applicant	Date
[signature]	3/25/2007

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

Name

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	OFFICE OF THE DEAN THE GEORGE WASHINGTON UNIVERSITY SCHOOL
Street Address of Medical School	OF MEDICINE & HEALTH SCIENCES ROSS HALL 713 - WEST 2300 I STREET, N.W.
City, State and ZIP Code	WASHINGTON, D.C. 20037

I certify that Audrey A. Lance **attended the**
(Applicant's Name)

medical school named above from 08/25/03 **, to** 5/06/07 .
Month/Day/Year Month/Day/Year

and was/will be granted the degree of MD **on**

5/20/07 .
Month/Day/Year

Signature of Dean or Registrar

MAR 30 2007
Date of Signature

Kyle Dirkes
Exec. Coordinator for Student Services & Registrar
The George Washington University
School of Medicine and Health Sciences
Print or Type Name of Dean or Registrar

(SEAL)
If school has no seal, please indicate

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LMD-040 (04/10) Page 1 of 2

Tran Info:430101 16831113-1 04/25/11
Chk#: 177 Amt: $150.00
ID: [redacted]
Tran Info:531537 16831113-2 04/25/11
Chk#: 177 Amt: $20.00
ID: [redacted]
Tran Info:531537 16831113-3 04/25/11
Chk#: 177 Amt: $65.00
ID: [redacted]

APPLICATION FOR MEDICAL DOCTOR 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 1-800-882-9539)

Board Use Only

License Number 089906

Controlled Substance License Number 050714

Date of Licensure 6/2/11

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- [X] **License by Examination Fee: $150.00 71-4301-01**
- [X] **Controlled Substance Fee: $85.00 43-01 71-5315**

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
Audrey	Ann	Lance

U.S. Social Security Number	Date of Birth	Daytime Phone Number
[redacted]	[redacted]/1982	(734) [redacted]

Street Address	E-Mail Address
2133 N Circle Dr.	alance@med.umich.edu

City	State	ZIP Code
Ann Arbor	MI	48103

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

Have you ever held a health professional license in Michigan?	Michigan Permanent I.D. Number and Expiration Date
☐ Yes [X] No	4301089906 6/30/2011

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	[X] No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	☐ Yes	[X] 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	[X] No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes	[X] No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	☐ Yes	[X] 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	[X] No
7. Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes	[X] No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	☐ Yes	[X] 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.

Name: Audrey Ann Lance

9. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privilege involuntarily modified? ☐ Yes ☒ No

10. Do you hold or have you ever held a permanent medical license in any state, U.S. Territory or Canadian Province? If yes, list the state(s) U.S. Territory or Province in which you hold or have held a medicine license, the license or registration number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. **You must have each licensing agency verify licensure directly to this board office. (Attach additional sheets, if necessary)** ☐ Yes ☒ No

State, U.S. Territory or Province	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
University of Michigan - Ann Arbor, MI	08/2000	05/2003	B.A. - Women's Studies
George Washington University 2300 I St. NW, Wash D.C. 20037	08/2003	05/2007	M.D.

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

Name and Address of Employer	Dates of Practice From	To	Duties
University of Michigan Hospital	07/2007	Present (graduate 06/2011)	House Officer - OB&Gyn

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 of Applicant: [signature] Date: 4/18/2011

DCH/LMD-200 (03/06)

RECEIVED
APR 27 2011
DEPT. OF LEG

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

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 applic[illegible]. 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
Audrey	Ann	Lance
Social Security Number	**Date of Birth**	
[redacted]	[redacted]/ 1982	
Street Address		
2133 N. Circle Dr.		
City	**State**	**ZIP Code**
Ann Arbor	MI	48103
Daytime Telephone Number	**All Previous Names and/or Birth Name Used (if applicable)**	
(734) [redacted]		

Signature of Applicant	Date
[signature]	4/13/2011

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

Name Audrey Ann Lance

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

Street Address of Hospital: University of Michigan Health System

City, State and ZIP Code: 1500 E. Medical Center Drive, Ann Arbor, MI 48109

I certify that Audrey Lance (Applicant's Name) a graduate of the Georgetown University medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 6/15/07 (Month/Day/Year), to Present (Month/Day/Year).

In the clinical area of Obstetrics & Gynecology.

Is this an active 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

Lynn Donnelly
Signature of Director of Medical Education

4/22/11
Date of Signature

for Lisa Colletti, MD
Print or Type Name of Director of Medical Education

(SEAL)
If hospital has no seal, please indicate

NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.

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
Audrey	Ann	Lance
Social Security Number	**Date of Birth**	**Daytime Telephone Number**
[redacted]	[redacted]/1982	(734) [redacted]
Street Address		
2133 N. Circle Dr.		
City	**State**	**ZIP Code**
Ann Arbor	MI	48103
All Previous Names and/or Birth Name Used (if applicable)		
Date of Admission		**Date of Graduation**
08/25/2003		05/20/2007

Signature of Applicant	Date
[signature]	4/13/2011

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

Name Audrey Ann Lance.

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	
Street Address of Medical School	**Office of the Dean** **The George Washington University School of Medicine & Health Sciences** **Ross Hall 713 West** **2300 I Street N.W.**
City, State and ZIP Code	**Washington, D.C. 20037**

I certify that Audrey A. Lance (Applicant's Name) attended the medical school named above from 08-25-2003 (Month/Day/Year) to 05-06-2007 (Month/Day/Year) and was/will be granted the degree of MD on 05-20-2007 (Month/Day/Year).

Signature of Dean or Registrar

Kyle Dirkes
Exec. Coordinator for Student Services & Registrar
The George Washington University
School of Medicine and Health Sciences

Print or Type Name of Dean or Registrar

APR 26 2011

Date of Signature

(SEAL)

If school has no seal, please indicate

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 : 04/21/2011

Recipient:

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

Examinee: Lance, Audrey
Alt Name(s): Lance, Audrey Ann

Examinee ID#: 5-158-822-6
Date of Birth: [redacted]1982

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
	06/21/2005	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
	07/20/2006	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
	12/20/2006	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
CONNECTICUT	04/21/2009	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.