

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

DCHA/MD-851 (03/04)

Page 1 of 2

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).

Tran Info: 430157	12744867-1	04/02/07
Chk#: 1182	Amt: \$20.00	
Tran Info: 430157	12744867-2	04/02/07
Chk#: 1182	Amt: \$65.00	
ID: [REDACTED]		
Board Use Only		
License Number	05990e	
C.S. License Number	430105	12744867-3 04/02/07
Chk#: 1182	Amt: \$85.00	
Date of License	[REDACTED]	S/1/10

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

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

631181

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 Audrey	Middle Name Ann	Last Name Lance
U.S. Social Security Number [REDACTED]	Date of Birth 1/1982	Previous MI License Number and Expiration Date, if applicable
Daytime Phone Number (734) [REDACTED]	All Previous Names and/or Birth Name Used (if applicable)	
Have you ever held a health professional license in Michigan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Name of Training Hospital The University of Michigan Health System		
Street Address of Training Hospital 1500 E. Medical Center Drive		
City Ann Arbor	State MI	ZIP Code 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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		Degree
	From	To	
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		Duties
	From	To	

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: 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

Page 1 of 2

CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL

Authority: Public Act 388 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 <i>Audrey</i>	Middle Name <i>Ann</i>	Last Name <i>Lance</i>
Social Security Number [REDACTED]	Date of Birth [REDACTED] / 82	
Street Address <i>F4808 Mott 15720 E. Medical Ctr. Dr.</i>		
City <i>Ann Arbor</i>	State <i>MI</i>	ZIP Code <i>48109-0264</i>
Daytime Telephone Number <i>734 - [REDACTED]</i>	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date
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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)

Page 2 of 2

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	University of Michigan Health System	
Street Address of Training Hospital	1500 E. Medical Center Drive Ann Arbor, MI 48109	- F4808 MOTT BOX 0264
City, State and ZIP Code		
I certify that	<u>Audrey Lance</u>	has been duly
appointed to a training program in the clinical area of	<u>Obstetrics & Gynecology</u>	
beginning	<u>6/15/2007</u>	and ending <u>6/30/2011</u>
	Month/Day/Year	Month/Day/Year
at	<u>University of Michigan</u>	
	Name of Training Hospital	
Is this program accredited by ACGME?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
Is this hospital or institution accredited by JCAH?	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
Signature of Director of Medical Education	<u>[Signature]</u>	Date of Signature
	<u>Lisa Colletti, MD</u>	<u>5/22/07</u>
Print or Type Name of Director of Medical Education		(SEAL)
		If hospital has no seal, please indicate.

APR 02 2007

GRADUATE MEDICAL EDUCATION

RECEIVED

APR -5 2007

DEPT. OF LEG

CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL


Authority: Public Act 368 of 1976, 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 Audrey	Middle Name Ann	Last Name Lance
Social Security Number [REDACTED]		Date of Birth [REDACTED] / 1982
Street Address [REDACTED]		
City Royal Oak	State MI	ZIP Code 48073
Daytime Telephone Number (734) [REDACTED]		All Previous Names and/or Birth Name Used (if applicable)

Signature of Applicant 	Date 3/25/07
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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.

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 <i>Audrey Ann Lance</i> has been duly	
appointed to a training program in the clinical area of <i>Obstetrics - Gynecology</i>	
beginning	and ending
<i>7-1-2007</i>	<i>06-30-07</i>
Month/Day/Year	Month/Day/Year
at <u>The University of Michigan Health System</u>	
Name of Training Hospital	
Is this program accredited by ACGME? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Is this hospital or institution accredited by JCAH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
<i>Claudia L. Kottick for</i>	<i>4-3-07</i>
Signature of Director of Medical Education	Date of Signature
(SEAL)	
<u>for Lisa Colletti, MD</u>	If hospital has no seal, please indicate
Print or Type Name of Director of Medical Education	

Michigan Department of Community Health
Board of Medicine
 P.O. Box 30192
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**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**

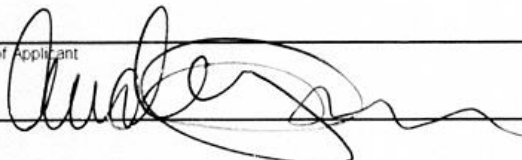
Authority: Public Act 368 of 1978, as amended
 If this form is not completed, a license will not be issued

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 Audrey	Middle Name Ann	Last Name Lance
Social Security Number [REDACTED]	Date of Birth [REDACTED]/1982	
Street Address [REDACTED]		
City Royal Oak	State MI	ZIP Code 48073
Daytime Telephone Number (734) [REDACTED]	All Previous Names and/or Birth Name Used (if applicable)	
Date of Admission		Date of Graduation 05/20/2007

Signature of Applicant 	Date 3/25/2007
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**APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR
 MEDICAL SCHOOL FOR COMPLETION OF SECTION II.**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, mental 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

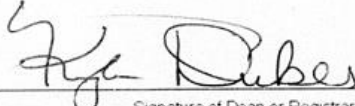
Name

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 OF MEDICINE & HEALTH SCIENCES	
Street Address of Medical School	
ROSS HALL 713 - WEST 2300 I STREET, N.W. WASHINGTON, D.C. 20037	
City, State and ZIP Code	
I certify that <u>Audrey A. Lance</u> attended the	
(Applicant's Name)	
medical school named above from	to
<u>08/25/03</u>	<u>5/06/07</u>
Month/Day/Year	Month/Day/Year
and was/will be granted the degree of <u>M.D.</u> on	
<u>5/20/07</u>	
Month/Day/Year	
	MAR 30 2007
Signature of Dean or Registrar	Date of Signature
Kyle Dirkes Exec. Coordinator for Student Services & Registrar The George Washington University School of Medicine and Health Sciences	(SEAL)
Print or Type Name of Dean or Registrar	If school has no seal, please indicate

Michigan Department of Community Health

Board of Medicine

P.O. Box 30192

Lansing, MI 48909

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www.michigan.gov/healthlicense

DCH/LMD-040 (04/10)

Page 1 of 2

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)

Tran Info:	430101	16831113-1	04/25/11
Chk#:	177	Amt:	\$150.00
ID:	[REDACTED]		
Tran Info:	531337	16831113-2	04/25/11
Chk#:	177	Amt:	\$20.00
ID:	[REDACTED]		
Tran Info:	531337	16831113-3	04/25/11
Chk#:	177	Amt:	\$65.00
ID:	[REDACTED]		

Board Use Only
License Number
Controlled Substance License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- License by Examination Fee: \$150.00 71-4301-01
- 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
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Have you been treated for substance abuse in the past 2 years?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 2200 I St. N.W., 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 			Date 4/18/2011

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 1976, 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 Audrey	Middle Name Ann	Last Name Lance
Social Security Number [REDACTED]	Date of Birth [REDACTED] / 1982	
Street Address 2133 N. Circle Dr.		
City Ann Arbor	State MI	ZIP Code 48103
Daytime Telephone Number (734) [REDACTED]	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant 	Date 4/13/2011
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DIRECTOR OF MEDICAL EDUCATION FOR COMPLETION OF SECTION II.

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

TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION

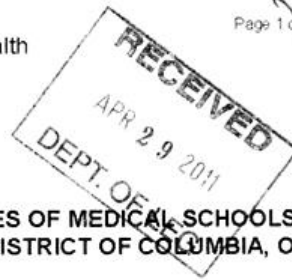
INSTRUCTIONS FOR COMPLETING SECTION II:

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 1500 E. Medical Center Drive
City, State and ZIP Code	Ann Arbor, MI 48109
<p>I certify that <u>Audrey Lance</u> a graduate of the <small>(Applicant's Name)</small></p> <p><u>Georgetown University</u> medical school, has successfully completed postgraduate <small>(Month/Day/Year)</small> clinical training offered by the hospital named above from <u>6/15/07</u> to <u>Present</u> <small>(Month/Day/Year)</small></p> <p>In the clinical area of <u>Obstetrics & Gynecology</u></p> <p>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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Lynn Donnelly</u> Signature of Director of Medical Education <u>4/22/11</u> Date of Signature</p> <p><u>for Lisa Colletti, MD</u> Print or Type Name of Director of Medical Education (SEAL) <small>If hospital has no seal, please indicate</small></p> <p>NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.</p>	

Michigan Department of Community Health
Board of Medicine
 P.O. Box 30192
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**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 <i>Audrey</i>	Middle Name <i>Ann</i>	Last Name <i>Lance</i>
Social Security Number [REDACTED]	Date of Birth [REDACTED] / 1982	Daytime Telephone Number (734) [REDACTED]
Street Address <i>2133 N. Circle Dr.</i>		
City <i>Ann Arbor</i>	State <i>MI</i>	ZIP Code <i>48103</i>
All Previous Names and/or Birth Name Used (if applicable)		
Date of Admission <i>08/25/2003</i>		Date of Graduation <i>05/20/2007</i>

Signature of Applicant 	Date <i>4/13/2011</i>
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APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE DEAN OF YOUR MEDICAL SCHOOL FOR COMPLETION OF SECTION II.

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.

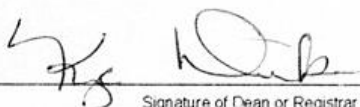
Name Audrey Ann Lance.

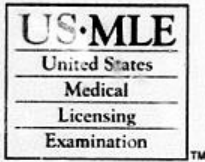
TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE MEDICAL SCHOOL

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	
Street Address of Medical School	The George Washington University School of Medicine & Health Sciences	
City, State and ZIP Code	Ross Hall 713 West 2300 I Street N.W. Washington, D.C. 20037	
I certify that <u>Audrey A. Lance</u> attended the		
	(Applicant's Name)	
medical school named above from	<u>08-25-2003</u>	to <u>05-06-2007</u>
	(Month/Day/Year)	(Month/Day/Year)
and was/will be granted the degree of	<u>MD</u>	on
		<u>05-20-2007</u>
		(Month/Day/Year)
	APR 26 2011	
Signature of Dean or Registrar	Date of Signature	
Kyle Dirkes Exec. Coordinator for Student Services & Registrar The George Washington University School of Medicine and Health Sciences	(SEAL)	
Print or Type Name of Dean or Registrar	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		Two-Digit Score		Comments
		Total	MP	Total	MP	
06/21/2005	Pass	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
07/20/2006	Pass	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
12/20/2006	Pass	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

USMLE STEP 3

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
CONNECTICUT 04/21/2009	Pass	[REDACTED]	[REDACTED]	[REDACTED]	[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.