

STATE OF MICHIGAN



JAMES J. BLANCHARD, Governor

MICHIGAN BOARD OF MEDICINE

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

DEPARTMENT OF LICENSING AND REGULATION

RAYMOND W. HOOD, SR., Director

February 24, 1986

Clarence Joseph Washington, III, M.D.

Atlanta, GA 30308

RE: MICHIGAN MEDICAL RELICENSURE

Dear Doctor:

This is to advise you that your application for relicensure in Michigan has been approved effective to January 31, 1987.

Your Michigan license number remains # 35289, and the effective date of your relicensure is 2/20/86.

Your relicensure certificate will be issued and forwarded to you in three to four weeks.

Sincerely yours,

MICHIGAN BOARD OF MEDICINE

*Genevieve A. Dionise*

Genevieve A. Dionise  
Administrative Assistant

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

MICH. LIC. # 35289

Rev/Ren 1/31/85

(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR RELICENSURE

TO January 31, 1987

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

TH WASHINGTON CLARENCE Joseph  
NAME OF APPLICANT (last) (first) (middle)

ADDRESS (No., Street, City, State, Zip)

ATLANTA, GEORGIA 30308

DATE OF BIRTH

1/47

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.

NATIONAL BOARDS I-II-III

4. Do you hold a license to practice medicine in any state or states?

☒ Yes ☐ No

If "YES", give states.

GEORGIA

5. EDUCATIONAL RECORD

	NAME AND LOCATION OF INSTITUTION ATTENDED	DATES OF ATTENDANCE		Degrees Obtained
		Mo/Yr	Mo/Yr	
MEDICAL EDUCATION (Submit Dates for Each School Year)	<u>UNIVERSITY of Michigan</u>	<u>8/69</u>	<u>TO 6/74</u>	<u>M.D.</u>
	<u>School of Medicine</u>			
POST GRADUATE EDUCATION	<u>MARTIN L KING Hosp.</u>	<u>7/74</u>	<u>6/75</u>	<u>INTERN</u>
	<u>WAYNE STATE UNIV</u>	<u>7/75</u>	<u>6/78</u>	<u>OB/GYN Residency</u>

Note: Please attach complete summary of medical training and experience

6. AFFIDAVIT OF APPLICANT

STATE OF

GEORGIA

COUNTY OF

FULTON

DATE

2/17/87

being duly sworn, deposes and says that he 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.

C. J. Washington M.D.  
Signature of Applicant in Full

Subscribed and sworn to before me  
NOTARY PUBLIC

Richard S. Baldwin

MY COMMISSION EXPIRES

Notary Public, Georgia, State at Large  
My Commission Expires Nov. 15, 1987

Board Members:  
Donald L. Branyon, Jr., M.D.  
George M. Chastain, M.D.  
Albert M. Deal, M.D.  
R. nette Flowers, M.D.  
H. Hilt Hammett, Jr., M.D.  
Donald L. Kennedy, D.O.  
S. Charlotte Neuberg, M.D.

Andrew Watry  
Executive Director

MAX CLELAND  
Secretary of State



Board Members:  
Irving T. Staley, M.D.  
Robert E. Thompson, M.D.  
L. Newton Turk, III, M.D.  
Joseph L. Vinci, D.O.

Consumer Member:  
Beth Parker

James E. Anthony, Jr., M.D.  
Medical Coordinator

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS  
William G. Miller, Jr., Joint Secretary, State Examining Boards  
166 Pryor Street, S.W.  
Atlanta, Georgia 30303  
(404) 656-3913

TO WHOM IT MAY CONCERN:

This is to certify that the following physician was issued a Georgia medical license by the Composite State Board of Medical Examiners as indicated:

Name CLARENCE JOSEPH WASHINGTON, M.D.  
License No. 24879 Date Issued: 4-6-83  
By: ( ) Georgia State Board Exam  
( ) FLEX Exam  
(xx) Endorsement of National Board Scores  
( ) Endorsement of Osteopathic National Board Scores  
( ) Reciprocity with \_\_\_\_\_  
(STATE)

It is further certified that the physician's license is in good standing with this Board and is current through 12-31-87.

This 17th day of FEBRUARY 1986.

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

*Andrew Watry*  
Andrew Watry, Executive Director

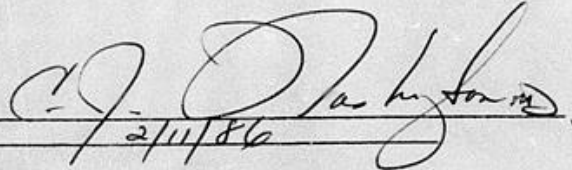
BOARD SEAL

RE: APPLICATION FOR RELICENSURE

1. Please attach complete summary of your education, training and experience since graduation from medical school.
2. Please list all of the states in which you hold or have held a medical license.  
① MICHIGAN ② GEORGIA
3. Please explain why you want to reinstate your Michigan medical license.  
① ACCEPTING HOSPITAL STAFF POSITION IN DETROIT (FULL TIME)  
② RETURNING TO PART TIME PRIVATE PRACTICE IN CONJUNCTION WITH ABOVE
4. Describe nature of your practice between time of forfeiture and the present.  
① PRIVATE PRACTICE  
② TEACHING - CLINICAL INST. Morehouse School of Medicine  
③ DEPARTMENT HEAD - Diagnostic ULTRASOUND / Gynecology (Atlanta Hosp.)
5. Please list Continuing Medical Education activities you have participated in since time of forfeiture and present.  
① CLINICAL TRAINING Medical ULTRASOUND  
② ADVANCED MICROSURGERY + INVITRO FERTILIZATION.  
③ TEACHING DUTIES as CLINICAL INSTRUCTOR.
6. Have you ever been convicted in any court of competent jurisdiction of a criminal offense under the provision of any state, provincial, territorial or federal law in the United States or any foreign country during the time between forfeiture of your license and the present? If the answer is "yes" please note in detail the offense and the location of the court. NO.
7. Have you had disciplinary action, or is there any disciplinary action pending against you in any state, province or country? If "yes" please explain.  
NO
8. What is your medical specialty? ① OBSTETRICS & Gynecology  
② MEDICAL ULTRASOUND
9. Have you been on active duty with the US Armed Forces since your license lapsed in Michigan? If "yes" please submit verification of this in the form of military orders, or letter from your Commanding Officer giving beginning and ending dates of your military service. NO

(SIGNATURE)

(DATE)

  
2/11/86



C. J. WASHINGTON MD & ASSOCIATES

2600 MARTIN LUTHER KING JR. DR.

SUITE 204 691-1439

ATLANTA, GA 30311

460

2/20 86 64.22  
19 610

PAY TO THE  
ORDER OF

STATE 9 Mich / Bondy Medicine \$ 165.00  
one hundred : sixty five dollars + 00/100

# 35289

 First Georgia Bank  
ATLANTA, GEORGIA

FOR

⑈000460⑈



CLARENCE J. WASHINGTON, M. D.

Atlanta, Georgia 30308

(404)

Age [REDACTED]  
Married  
2 Children

#### EDUCATION

High School:	Cass Technical 1965
College:	Northern Michigan 1969
Medical School:	University of Michigan School of Medicine 1974
Internship:	Martin L. King Hospital Los Angeles, California 1974-1975/Straight Internship
Residency:	Wayne State University Detroit, Michigan 1975-1978/Obstetrics and Gynecology  Chief Resident Hutzel Hospital Obstetrics Service 3 Months 1973  Chief Resident Hutzel Hospital Gynecology Service 3 Months 1974  Chief Resident Harper Hospital Gynecology Service 6 Months 1973-1974

#### MEDICAL TRAINING

Jr. Fellowship:	Michigan Heart Association 1970 Study of Population Differences of Hypertension; Between Ann Arbor, Michigan; Nashville, Tennessee
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MEDICAL TRAINING con't.

	Under direction of Dr. A. Zwiefler, Professor of Internal Medicine/ University of Michigan
Research Externship:	University of Michigan Prostaglandins For Induction of Labor, in Comparison with Pitocin Wayne County General Hospital/1971
Research Intern:	Martin L. King Hospital Prostaglandins For Induction of Labor/1974
Wayne State University:	Hutzel Hospital Study of Chemical Means of Deter- mining Fetal Lung Maturity/1973 L/S Ratio Versus TPP.
Presented Paper At:	International Meeting/University of Mexico; Mexico City, Mexico/1973
	National Medical Association/ Annual Meeting; Detroit, Michigan 1979

PRIVATE PRACTICE/Detroit, Michigan

Practice:	Obstetrics and Gynecology/1978-1983 70% Gynecology (15-24 cases per month and 30% Obstetrical
MicroSurgery:	Ralph K. Davies Institute of MicroSurgery; San Francisco, California/1978 50 hours with Certification/ Laboratory/Practical
	Ralph K. Davies Institute of MicroSurgery; San Francisco, California/1979 40 hours with Certification; Advanced Fallopian Tubal Surgery
	Presbyterian Hospital; Dallas, Texas/June 1985 30 hours Advance MicroSurgery/ Laser Laproscopy

PRIVATE PRACTICE/Detroit, Michigan con't.

Medical Sonics:	Use of Medical Ultrasound in Obstetrics and Gynecology in Private Practice, beginning 1978 Basic training under Dr. Wm. Steele, Professor of Radiology/ Hutzel Hospital/3 Months 1978
Post Graduate Training:	Bowman Gray School of Medicine 40 hours, May 1983/Medical Sonics Obstetrics and Gynecology with Certification of Satisfactory Completion  Bowman Gray School of Medicine 40 hours, February 1984/Medical Sonics Abdominal Ultrasound with Certification of Satisfactory Completion

PRIVATE PRACTICE/Atlanta, Georgia

Practice:	1983 to Present  85% of Practice Gynecology: 1) General Gynecology 2) Infertility Surgery/Microsurgical 3) Colposcopy/Cervical, Vulva Disease 4) Laser Surgery 5) Ultrasound  15% of Practice Obstetrical: 1) Referrals for Ultrasound, Developmental Defects, Growth Retardation, etc.
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MEDICAL ULTRASOUND

1983 to Present:	Director and Founder of Ultrasound Diagnostics; Atlanta, Georgia 100 to 175 Scans per month Type of Scans: Obstetrical, Gynecology, Abdominal
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Clarence J. Washington, M. D.  
Page 4

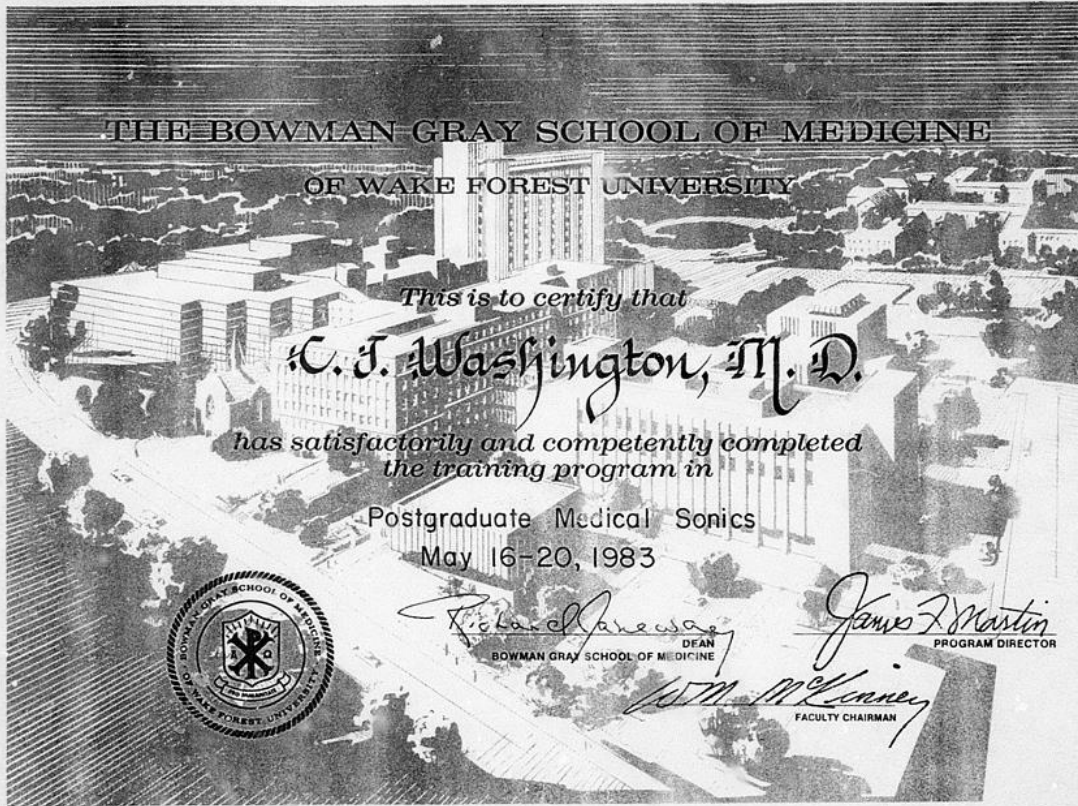
MEDICAL ULTRASOUND con't.

1985 to Present:

Director of Ultrasound Division/  
Atlanta Hospital; Atlanta, Georgia  
Supervisory of 2 Sonographers  
Interpretation of approximately  
100 to 150 Scans per month  
Type of Scans: Obstetrical,  
Gynecology

1984 to Present:

Assistant Clinical Professor  
Morehouse School of Medicine  
Atlanta, Georgia



THE BOWMAN GRAY SCHOOL OF MEDICINE  
OF WAKE FOREST UNIVERSITY

*This is to certify that*

*C. J. Washington, M. D.*

*has satisfactorily and competently completed  
the training program in*

Postgraduate Medical Sonics  
May 16-20, 1983



*Richard A. Neway*  
DEAN  
BOWMAN GRAY SCHOOL OF MEDICINE

*James F. Martin*  
PROGRAM DIRECTOR

*W. M. McKinney*  
FACULTY CHAIRMAN

*40 hours.*



THE BOWMAN GRAY SCHOOL OF MEDICINE  
of Wake Forest University

*Division of  
Continuing Education*

C. J. Washington, M.D. has attended the  
PG Medical Sonics at BGSM  
on (date) February 20-24, 1984 Category I (AMA) -35-

*Erving C. Miller MD*  
Associate Dean for Continuing Education

3500/hs

THE BOWMAN GRAY SCHOOL OF MEDICINE  
OF WAKE FOREST UNIVERSITY

*This is to certify that*

*C. J. Washington, M.D.*

*has satisfactorily and competently completed  
the training program in*

*Postgraduate Medical Series*

*February 20-24, 1984*



*Richard H. Hargrave*  
DEAN  
BOWMAN GRAY SCHOOL OF MEDICINE

*James F. Martin*  
PROGRAM DIRECTOR

*W. M. McKinney*  
FACULTY CHAIRMAN



has attended

*k*  
**ACOG Cognate Program**  
600 Maryland Avenue, SW, 300 East  
Washington, DC 20024

MASTERS IN GYN  
EMORY UNIV SCH MED  
APR 20 THRU 24 1985  
SEA ISLAND GA  
11 COGNATES

*C. J. WASHINGTON M.D. ATLANTA, GA.*

**THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS**

Non-Fellows retain both copies

*11 hours* **ACOG Copy**



**PRESBYTERIAN HOSPITAL OF DALLAS**

8200 WALNUT HILL LANE  
DALLAS, TEXAS 75231  
(214) 368-4111

Douglas D. Hawthorne, President

R. Reed Fraley, Executive Director

**MEMORANDUM**

**TO:** C. J. Washington, M.D.

**FROM:** Lela Breckenridge  
Director, Continuing Medical Education

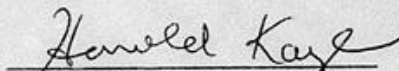
**RE:** WORKSHOPS IN FERTILITY SURGERY  
June 4 - 9, 1985

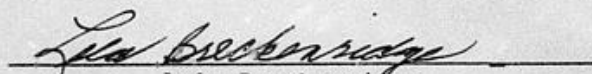
This certifies your attendance at WORKSHOPS IN FERTILITY SURGERY, Advance Course, June 6-9, 1985.

As an organization accredited for Continuing Medical Education, Presbyterian Hospital of Dallas designates this activity as meeting the criteria for 29 Hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

This activity has been approved for 29 Cognates of Formal Learning by the American College of Obstetricians and Gynecologists.

  
Brian M. Cohen M.B.Ch.B., M.D.  
Workshop Director

  
Harold L. Kaye, M.D.  
Arrangements Director

  
Lela Breckenridge  
Director, Continuing Medical Education  
Presbyterian Hospital of Dallas

29 hours

C. J. Washington, M.D.  
OBSTETRICS & GYNECOLOGY  
730 Peachtree St.  
Suite 920  
Atlanta, GA 30308  
(404)876-3585

## Continuing Medical Education

Category 1 - Included Copies 115 hours

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Also attended

Midwest OB Ultrasound  
CURRENT Theories/A medical  
Symposium

10 hours

Sunday & Monday April 24/25  
1983

Hgatt Regency, Flint Michigan

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Category 5 - Self Ass / Instruction

18 hours

- (1) American Journal OBSTETRICS & Gynecology
- (2) JAMA
- (3) OBSTETRICS & Gynecology (Green)
- (4) OB/GYN Clinics & North America
- (5) National Medical Ass. Journal
- (6) Journal & Clinical Ultrasound
- (7) Contemporary OB/Gyn

C. J. Washington, M.D.  
OBSTETRICS & GYNECOLOGY  
730 Peachtree St.  
Suite 920  
Atlanta, GA 30308  
(404)876-3585

## Continuing Medical Education.

### Category 5 (Cont.)

① Hospital STAFF: Atlanta Hospital  
701 Juniper St.  
Atlanta, GA.

6 hours

Surgical Committee - 1985

Review: Quality Assurance  
Surgical Complication  
Rules Guidelines, For OR,  
outpt. Surgery.  
Medical Records Review.

Category 3 Teaching Medical physicians.  
Morehouse School of Medicine.  
Family Practice Residents:  
1983, 1984.

Location: Southwest Community Hospital  
501 Fairburn Rd  
Atlanta, GA.

10 hours

1984- Teaching Rounds, lectures, Case presentation  
Grand Rounds. 4 hours per week, For  
one month.



C. J. Washington, M.D.  
OBSTETRICS & GYNECOLOGY  
730 Peachtree St.  
Suite 920  
Atlanta, GA 30308  
(404)876-3585

Continuing Medical Education  
Category 3 (Cont.)

1983 : 1984 : Teaching Rounds and patient  
Treatment protocols.

1983 — 5 hours
1984 — 5 hours

Southside Community Health Center  
1079 Ridge Ave  
Atlanta, GA.

6 hours per week For 6 months.

TOTALS	Category 1	115 hours
	Category 5	18 hours
	Category 5	6 hours
	Category 3	20 hours.
		<hr/> 159 hours
	+ 10 Cat. 1	
	(Flint, Mich. - Cannot	
	Find Slip)	<hr/> 10
		169 hours

C. J. Washington M.D.

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

MICH. LIC. # 35289

Rev/Ren 1/31/85

FEB 21 1 86521543 \*\*\*165.00

(DO NOT WRITE IN THIS SPACE)

RECEIVED

APPLICATION FOR RELICENSURE

TO January 31, 1987

Approved by \_\_\_\_\_

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.

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

TIT WASHINGTON CLARENCE Joseph

NAME OF APPLICANT (last)

(first)

(middle)

ADDRESS (No., Street, City, State, Zip)

ATLANTA, GEORGIA 30308

DATE OF BIRTH

1/47

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.

NATIONAL BOARDS I-II-III

4. Do you hold a license to practice medicine in any state or states?

☒ Yes ☐ No

If "YES", give states.

GEORGIA

5. EDUCATIONAL RECORD

	NAME AND LOCATION OF INSTITUTION ATTENDED	DATES OF ATTENDANCE		Degrees Obtained
		Mo/Yr	Mo/Yr	
MEDICAL EDUCATION (Submit Dates for Each School Year)	<u>UNIVERSITY of Michigan</u>	<u>8/69</u>	<u>TO 6/74</u>	<u>M.D.</u>
	<u>School of Medicine</u>			
POST GRADUATE EDUCATION	<u>MARTIN L KING Hosp.</u>	<u>7/74</u>	<u>6/75</u>	<u>INTERN</u>
	<u>WAYNE STATE UNIV</u>	<u>7/75</u>	<u>6/78</u>	<u>OB/GYN Residency</u>

Note: Please attach complete summary of medical training and experience

6. AFFIDAVIT OF APPLICANT

STATE OF

GEORGIA

COUNTY OF

FULTON

DATE

2/17/87

being duly sworn, deposes and says that he 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.

C. J. Washington M.D.

Signature of Applicant in Full

Subscribed and sworn to before me

NOTARY PUBLIC

Richard S. Bridgman

MY COMMISSION EXPIRES

Public, Georgia, State of Large  
Commission Expires Nov. 15, 1987



WILLIAM G. MILLIKEN, Governor  
BEVERLY J. CLARK, Director

STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATION

MEDICAL PRACTICE BOARD

1033 SOUTH WASHINGTON AVENUE, LANSING, MICHIGAN 48926

Telephone Area Code 517 373-0680

MD-09 11/79

BOARD MEMBERS

C. Allen Payne, M.D., President  
Frederick W. VanDuyne, M.D., Vice President  
Irvin J. Kurtz, M.D.  
H. Clay Tellman, M.D.  
Donato F. Sarapo, M.D.  
Donald T. Anderson, M.D.  
Joseph J. Berke, M.D.  
John R. Wilson, M.D.  
John W. Moses, M.D.  
Florence A. Pillote, M.D.  
Mrs. Margaret J. Thoms

51 35289 82  
WASHINGTON III, CLARENCE J  
HUTZEL HOSP  
432 E HANCOCK  
DETROIT MI 48201

Dear Doctor:

We are enclosing herewith your engraved Certificate of Michigan Medical Licensure which is to be framed and conspicuously displayed in your business office or consultation room.

Sincerely yours,

MICHIGAN MEDICAL PRACTICE BOARD

C. Allen Payne, M.D.  
President

Encl.





WILLIAM G. MILLIKEN, Governor  
BEVERLY J. CLARK, Director

STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATION

MEDICAL PRACTICE BOARD

1033 SOUTH WASHINGTON AVENUE, LANSING, MICHIGAN 48926

Telephone Area Code 517 373-0680

July 11, 1975

Clarence Joseph Washington, III, M.D.

Detroit, MI 48206

BOARD MEMBERS

C. Allen Payne, M.D., President  
Frederick W. VanDuyne, M.D., Vice President  
Irvin J. Kurtz, M.D.  
H. Clay Tellman, M.D.  
Donato F. Sarapo, M.D.  
Donald T. Anderson, M.D.  
Joseph J. Berke, M.D.  
John R. Wilson, M.D.  
John W. Moses, M.D.  
Florence A. Pilote, M.D.  
Mrs. Margaret J. Thoms

Dear Doctor:

We are enclosing a certified copy of your Michigan medical registration  
# 35289 dated July 11, 1975

This certificate will enable you to practice legally and apply for your  
Controlled Substances Registrations, membership in your county medical  
society, and hospital staff privileges.

The engraved certificate of Michigan medical licensure, which is to be  
framed and conspicuously displayed in your business office or  
consultation room, will be ordered and forwarded as soon as it can  
be hand inscribed and the seal and signatures affixed. This usually  
takes about four to six months.

PLEASE NOTIFY THIS BOARD IF YOU WISH THIS CERTIFICATE MAILED TO AN  
ADDRESS OTHER THAN THE ONE USED ABOVE.

PLEASE NOTE ENCLOSURES:

1. Re: Annual Re-registration of your medical license  
in Michigan
2. Re: Registration for controlled substances in Michigan

Sincerely yours,

MICHIGAN MEDICAL PRACTICE BOARD

*B. J. Brennan*  
B. J. Brennan  
Executive Director

Encls.







WILLIAM G. MILLIKEN, Governor  
BEVERLY J. CLARK, Director

3 5289  
STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATION

MEDICAL PRACTICE BOARD

1033 SOUTH WASHINGTON AVENUE, LANSING, MICHIGAN 48926

Telephone Area Code 517 373-0680

July 11, 1975

Clarence J. Washington, III, M.D.

Detroit, MI 48206

Dear Doctor:

This is to acknowledge receipt of:

- ☒ Endorsement application
- ☒ \$100.00 fee
- ☒ Blue reference slips
- ☒ National Board Certification of Record

☒ At any time that you comply with the requirement of a personal appearance in this office, for identification of self and signature, we will issue your Michigan medical license. No special appointment is required, bearing in mind that this office is open Monday through Friday, from 8:00 A.M. to 12 noon and 1:00 P.M. to 5:00 P.M.

We will await receipt of:

- ☐ Endorsement Application
- ☐ \$100.00 fee
- ☐ Blue Reference Slips (completed by licensed physicians with whom you are or have been associated)
- ☐ Complete resume of training and experience since medical school graduation
- ☐ National Board Certification of Record. (This may be obtained directly from the NBME. Copy of official certificate not acceptable)
- ☐ Certification of Internship (form enclosed)
- ☐ Letter directed to this Board from each state in which you hold a license concerning your licensure status.



MICHIGAN MEDICAL PRACTICE BOARD

Bert C. Brennan, Executive Director

BOARD MEMBERS

C. Allen Payne, M.D., President  
Frederick W. VanDuyne, M.D., Vice President  
Irvin J. Kurtz, M.D.  
H. Clay Tellman, M.D.  
Donato F. Sarapo, M.D.  
Donald T. Anderson, M.D.  
Joseph J. Berke, M.D.  
John R. Wilson, M.D.  
John W. Moss, M.D.  
Florence A. Pillote, M.D.  
Mrs. Margaret J. Thoms

JUL -8 17 75615043\*\*\*100.00

Clarence J.  
Washington

Endorsement  
\$100<sup>00</sup>

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATION  
MEDICAL PRACTICE BOARD  
1033 S. Washington Avenue, Lansing, Michigan 48926

**ENDORSEMENT APPLICATION**

FEE \$100.00 — Make check or money order, in U.S. currency,  
payable to STATE OF MICHIGAN — MEDICINE

35289  
7-11-75

LMD-94 (4/74)

(DO NOT WRITE IN THIS SPACE)

Approved by \_\_\_\_\_

I hereby apply for endorsement of my certificate of registration No. \_\_\_\_\_

Issued by \_\_\_\_\_

STATE BOARD OR NATIONAL BOARD

on the \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_

NAME OF APPLICANT (last) (first) (middle)

WIL WASHINGTON CLARENCE Joseph

ADDRESS (NO. STREET CITY STATE ZIP)

DETROIT MICHIGAN 48206

PLACE OF BIRTH

DETROIT

DATE OF BIRTH

1/47

INTENDED RESIDENCE (CITY)

DETROIT

**INSTRUCTIONS TO APPLICANT**

1. If additional space is necessary, use back of application or attach additional sheets.
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.

1. Are you a citizen of the United States?

YES

NO



If "NO", Check one of following which is applicable:

2. If a naturalized citizen please give date of naturalization:

a. Hold official Declaration

of Intention No. \_\_\_\_\_ Dated \_\_\_\_\_

b. Hold Permanent Visa No. \_\_\_\_\_

Date of Issue \_\_\_\_\_

c. Other (Please Explain)

2. Have you ever practiced any other branch of the Healing Arts?



If "YES", what branch and where?

3. Have you ever been notified by any medical board or society of any complaint against you relative to the practice of medicine?



If "YES", explain.

4. Have you ever been convicted of any crime in any state?



If "YES", explain.

5. Have you been a member of any branch of the Armed Forces?



If "YES", give dates of service and branch.

6. Have you ever been connected, directly or indirectly with any concern, company, institution or any individual medical advertising corporation?



If "YES", give details.

7. In what states do you hold a medical license? (Each state must submit letter to this Board concerning licensure status)

NONE

8. In what states have you practiced medicine?

NONE

EDUCATIONAL RECORD	NAME AND LOCATION OF INSTITUTION ATTENDED	DATES OF ATTENDANCE		DEGREES OBTAINED
		MONTH/YEAR	MONTH/YEAR	
PREMEDICAL EDUCATION	DETROIT INSTITUTE OF TECHNOLOGY	9/67	TO 12/67	
	NORTHERN MICH UNIV	9/1965	6/67	
		1/68	6/69	
MEDICAL EDUCATION	UNIVERSITY of MICHIGAN	8/69	6/74	M.D.
POST GRADUATE EDUCATION	MARTIN L KING HOSPITAL	6/30/74	6/30/75	

Note: Please attach complete summary of medical training and experience

INTERNSHIP	TYPE <input type="checkbox"/> ROTATING <input type="checkbox"/> MIXED <input checked="" type="checkbox"/> STRAIGHT	NAME OF HOSPITAL <u>MARTIN L KING Hospital</u>
ADDRESS OF HOSPITAL <u>12021 S. Wilmington Ave.</u>		DATES OF INTERNSHIP FROM: <u>JULY 1 74</u> TO: <u>JUNE 30, 1975</u>
DEGREE OF DOCTOR OF MEDICINE RECEIVED FROM		NAME OF MEDICAL SCHOOL <u>UNIVERSITY of MICHIGAN</u>
		DATE RECEIVED <u>JUNE 7, 1974</u>

10. AFFIDAVIT OF APPLICANT

STATE OF <u>California</u>	COUNTY OF <u>Los Angeles</u>	DATE <u>7-1-75</u>
-------------------------------	---------------------------------	-----------------------

Clarence Joseph Washington III MD, being duly sworn, deposes and says that he is the applicant named in the foregoing application for a Reciprocity 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.

PAPERCLIP PHOTOGRAPH (3" x 3") OF APPLICANT HERE. PHOTO MUST HAVE BEEN TAKEN WITHIN THE LAST 60 DAYS. ENCASE PHOTO ACROSS THE FRONT WITH YOUR SIGNATURE.

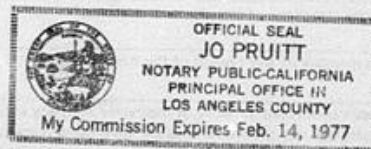
Clarence Joseph Washington III MD  
Signature of Applicant in Full

Subscribed and sworn to before me

NOTARY PUBLIC

Jo Pruitt

2-14-77  
MY COMMISSION EXPIRES



11. 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 CLARENCE WASHINGTON, M.D. matriculated in the UNIVERSITY OF MICHIGAN MEDICAL SCHOOL  
(NAME AND ADDRESS OF MEDICAL SCHOOL)  
on August 25, 1969 (DATE), and was graduated May 31, 1974 (DATE), at which time, he was granted the

degree of Doctor of Medicine. 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 OF MEDICAL SCHOOL <u>THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL</u>	
DATE <u>JUN 23 1975</u>	SIGNATURE OF <u>CLARENCE WASHINGTON</u> REGISTRAR <u>Frances D French</u> Frances D. French, Registrar

Note: No application will be accepted without proper completion of this portion ( Sec. 11)



12. HOSPITAL INTERNSHIP / OR FIRST YEAR RESIDENCY

I hereby certify that Dr. Clarence Washington satisfactorily served twelve months OBSTETRICS AND GYNECOLOGY  
 \_\_\_\_\_ residency (ROTATING OR MIXED OR STRAIGHT)  
X internship in Martin Luther King, Jr. Gen. Hospital from 7/1/74 to 6/30/75  
 (CHECK ONE OF ABOVE) (DATE) (DATE)

ADDRESS OF HOSPITAL

12021 S. Wilmington Avenue, Los Angeles, California 90059

DATE

July 1, 1975

SIGNATURE OF MEDICAL DIRECTOR, SUPERINTENDENT  
OR CHIEF OF STAFF

J. G. Wrean, M.D.

13. CERTIFICATION OF SECRETARY OF STATE BOARD WHICH ISSUED LICENSE USED AS THE BASIS FOR THIS APPLICATION  
 (NOTE: If you are a representative of the National Boards, please submit National Board Certificate of Record in lieu of completion of this Section.)

As Secretary of the below named agency, I certify that License No. \_\_\_\_\_ to practice Medicine and Surgery was  
 issued to Dr. \_\_\_\_\_ on \_\_\_\_\_ (DATE)

The issuance of this license was based on:

☐ FLEX  
Examination

☐ Credentials

☐ Board  
Examination

This license has never been revoked. If licensure was based on examination, I further certify that the aforementioned Doctor passed  
 the regular written examination given by this Board on \_\_\_\_\_ and scored a general average of \_\_\_\_\_  
 percent of the following subjects:

DAY I-BASIC SCIENCES AV. \_\_\_\_\_

DAY II-CLINICAL SCIENCES AV. \_\_\_\_\_

Anatomy

Medicine

Physiology

Surgery

Biological Chemistry

Obstetrics & Gynecology

Pathology

Preventive Medicine & Public Health

Microbiology

Pediatrics

Pharmacology

Psychiatry

DAY III-CLINICAL COMPETENCE \_\_\_\_\_

I believe the above applicant to be a fit and proper person to receive a Reciprocity Certificate.

SEAL

BOARD OR DEPARTMENT

DATE

SIGNATURE OF SECRETARY



#### 14. REFERENCES

Names and addresses of three registered practitioners of medicine in good standing to whom reference may be made if necessary, relative to applicant's moral and professional character:

NAME		ADDRESS
1. Charles Vincent	M.D.	2424 Puritan, Detroit, Michigan
2. J.S. Williams	M.D.	5050 Joy Rd. Detroit, Michigan
3. George Morley	M.D.	Womens Hospital, Ann Arbor, Mich.

#### 15. SOCIETY RECOMMENDATION

As secretary of the below named Medical Society, I certify that Dr. \_\_\_\_\_ is personally known to me, and that he is an ethical practitioner and of good moral character. I have examined the statements made by the applicant and believe them to be true.

SEAL

NAME AND ADDRESS OF SOCIETY
DATE
SIGNATURE OF SECRETARY



WILLIAM G. MILLIKEN, Governor  
BEVERLY J. CLARK, Director

STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATION

MEDICAL PRACTICE BOARD

1033 SOUTH WASHINGTON AVENUE, LANSING, MICHIGAN 48926

Telephone Area Code 517 373-0680

July 8, 1975

Clarence Joseph Washington, III, M.D.

Detroit, MI 48206

Dear Doctor:

This is to acknowledge receipt of: ☒ Endorsement application

☒ \$100.00 fee

☐ Blue reference slips

☒ National Board Certification of Record

BOARD MEMBERS

C. Allen Payne, M.D., President  
Frederick W. VanDuyn, M.D., Vice President  
Irvin J. Kurtz, M.D.  
H. Clay Teliman, M.D.  
Donato F. Sarapo, M.D.  
Donald T. Anderson, M.D.  
Joseph J. Berke, M.D.  
John R. Wilson, M.D.  
John W. Moses, M.D.  
Florence A. Pillote, M.D.  
Mrs. Margaret J. Thoms

At any time that you comply with the requirement of a personal appearance in this office, for identification of self and signature, we will issue your Michigan medical license. No special appointment is required, bearing in mind that this office is open Monday through Friday, from 8:00 A.M. to 12 noon and 1:00 P.M. to 5:00 P.M.

We will await receipt of:

☐ Endorsement Application

☐ \$100.00 fee

☒ Blue Reference Slips (completed by licensed physicians with whom you are or have been associated)

☐ Complete resume of training and experience since medical school graduation

☐ National Board Certification of Record. (This may be obtained directly from the NBME. Copy of official certificate not acceptable)

☐ Certification of Internship (form enclosed)

☐ Letter directed to this Board from each state in which you hold a license concerning your licensure status.



MICHIGAN MEDICAL PRACTICE BOARD

Bert C. Brennan, Executive Director

You will note that the date entered for certification is later than the current date in order to coincide with satisfactory completion of one year internship.

# 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  
**Clarence Joseph Washington III, 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: JOHN S. MILLIS  
Chairman of the Board

SEAL

Philadelphia, Pa.  
July 1, 1975

Cert. # 142960

ROBERT A. CHASE  
President of the Board

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of University of Michigan Medical School on 05/23/1974, whose birth date is 01/11/1947, following successful completion of all examinations required for Certification by the National Board of Medical Examiners. The grades obtained are as follows:

### PART I passed 06/14/1972

	Standard* Score	Scale Score
Anatomy, incl. histology and embryology .....		
Physiology .....		
Biochemistry .....		
Pathology .....		
Microbiology, incl. immunology .....		
Pharmacology and Materia Medica .....		
Behavioral Sciences .....		
(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**		

### PART II passed 04/11/1973

Internal medicine and the medical specialties .....		
Surgery and the surgical specialties .....		
Gynecology and Obstetrics .....		
Public Health and Preventive Medicine .....		
Pediatrics .....		
Psychiatry .....		
(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**		

### PART III passed 03/05/1975

A General Test of Clinical Competence .....		
(Minimum Passing Grade 290/75) AVERAGE		

GENERAL AVERAGE (Parts I, II, and III) .....

(Scale Score)

\*Examinations taken since June 1971 are reported with both Standard and Scale Score Equivalents.

\*\*Since 1966 National Board criteria for certification are based upon candidate's Total passing grade in Part I, Part II, and Part III, and not scores of individual subjects within each Part.

SEAL

*Ann K. Haverling*  
Secretary for Certification

June 27, 1975

Date

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATION  
MEDICAL PRACTICE BOARD

RECEIVED

Dr.

JUL 10 1975

Dear Doctor:

Dr. Charles Washington at present  
residing at [REDACTED] Detroit, Mich applying for a cer-  
tificate of registration from this Board. Will you kindly assist us by answering the following  
questions and returning to us at once?

1. How long and how intimately have you known the applicant? 5 years
2. How long has the applicant been in practice, and where, since graduation? Just completed Internship
3. What are the applicant's habits as regards the use of intoxicating liquors? Has the applicant ever used them to excess or ever taken any "cures" for inebriety? Not to any excess by my knowledge
4. Is the applicant or has the applicant ever been addicted to the drug habit? No
5. Has the applicant ever been known as an "advertising doctor?" No
6. Is the applicant's ethical and professional character beyond suspicion? yes
7. Has the applicant ever been charged of a crime or of a misdemeanor in law? None to my knowledge
8. Can you without reservation recommend the applicant as a citizen entirely worthy to receive a license to practice medicine? without any reservations what so ever

Date 6/1/75

Charles Vincent M. D.  
3040 E 7 Mile Rd  
Detroit, Mich

Yours very truly,  
Bert C. Brennan,  
Executive Director  
1033 So. Washington Ave.  
Lansing, Michigan 48926



J. S. WILLIAMS, M. D.

5050 JOY ROAD  
DETROIT, MICHIGAN - 48204

TEXAS 4-4347

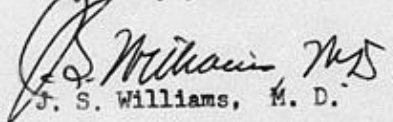
July 8, 1975

TO: Medical Practice Board

RE: Clarence J. Washington III, M. D.

Please accept this as my endorsement of the above  
named physician for licensure by the State of Michigan.  
I have known Dr. Washington all of his life and know him  
to be of excellent character, ethical, responsible, mature,  
and responsive to regulations imposed upon physicians.

Very truly yours,

  
J. S. Williams, M. D.

JSW/dye

*D. G. Williams, Jr., M.D.*

PHYSICIAN — SURGEON  
MEDICAL PROFESSIONAL BLDG.  
SUITE 205 - 5050 JOY ROAD  
DETROIT 4, MICHIGAN

July 8, 1975

TO: Medical Practice Board

RE: Clarence J. Washington III, M. D.

Please accept this as my endorsement of the above-named physician for licensure by the State of Michigan. I have known Dr. Washington for fifteen years and know him to be of excellent character, ethical, responsible, mature, and responsive to regulations imposed upon physicians.

Very truly yours,

*D. G. Williams Jr., M.D.*  
D. G. Williams Jr., M.D.

DGW/dye

6/8/75.

Please find enclosed, three recommendation letters.

As per our conversation of 6/7/75, these had not been received.

One physician still had possession of the blue form letter, which I enclosed.

Two physicians, who no longer had the forms, (previously mailed?) I requested write letters, per your suggestion to save time. Both physicians, with their letters stated that they are available for any further question, not answered in their letters.

C. J. Washington MD.

3 - CUSTOMER

MICHIGAN DEPARTMENT OF LICENSING AND REGULATION

Rec'd  
Of

*Clarence Joseph*

Date

*7-8*

19

*71*

Address

*Washington*

*Condemnment.*

*100.00*

How Paid:

CHECK



CASH

TOTAL



*100.00*

NOTICE: The amount above stated has been received on your account, subject to audit. If found to be incorrect proper adjustment must be made.

DETROIT

No. 16830

Received  
Payment

*Am.*

CASHIER

THE HAMILTON AUTOGRAPHIC REGISTER CO., HAMILTON, OHIO



WILLIAM G. MILLIKEN, Governor  
BEVERLY J. CLARK, Director

STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATION

MEDICAL PRACTICE BOARD

1033 SOUTH WASHINGTON AVENUE, LANSING, MICHIGAN 48926

Telephone Area Code 517 373-0680

June 11, 1975

Clarence J. Washington III, M.D.

Torrance, California 90502

BOARD MEMBERS

C. Allen Payne, M.D., President  
Frederick W. VanDuyne, M.D., Vice President  
Irvin J. Kurtz, M.D.  
H. Clay Tellman, M.D.  
Donato F. Sarapo, M.D.  
Donald T. Anderson, M.D.  
Joseph J. Berke, M.D.  
John R. Wilson, M.D.  
John W. Moses, M.D.  
Florence A. Pillote, M.D.  
Mrs. Margaret J. Thoms

Dear Doctor:

This is in reply to your recent inquiry concerning requirements for Michigan medical licensure by endorsement of another state.

This Board will consider your application for licensure by endorsement if you hold a permanent medical license in any state in the United States, District of Columbia and Territory of Puerto Rico, on the basis of the complete FLEX Examination (FWA 75.0% or above); OR if your license in another state was obtained on the basis of an examination other than the FLEX Examination your application will be considered by the Board only if the examination in that state was written prior to June 1970.

Diplomates of the National Board of Medical Examiners are also accepted for licensure by endorsement.

Our endorsement application, three blue reference forms, which are to be completed in full and submitted to this office with the required fee of \$100.00, are enclosed herewith. The reference forms must be completed by licensed physicians with whom you are or have been associated.

Upon receipt of the completed forms and fee we will begin the processing of them for your Michigan medical license. If your application is approved you will be advised and your license will be issued on the day you make a personal appearance in this office, for identification of self and signature.

Sincerely yours,

MICHIGAN MEDICAL PRACTICE BOARD

Bert C. Brennan  
Executive Director

Encls.





CLARENCE Washington  
# 35289

Lot # 352

Box # 3

34-9-11

STATE OF MICHIGAN



JAMES J. BLANCHARD, Governor

DEPARTMENT OF LICENSING AND REGULATION

RAYMOND W. HOOD, SR., Director

MICHIGAN BOARD OF MEDICINE  
P.O. Box 30018  
Lansing, Michigan 48909  
Telephone: (517) 373-0680

December 10, 1987

Clarence J. Washington, III, M.D.  
[REDACTED]  
Detroit, MI 48238

RE: MICHIGAN MEDICAL RELICENSURE

Dear Doctor:

This is to advise you that your application for relicensure in Michigan has been approved effective to January 31, 1991.

Your Michigan license number remains # 035289, and the effective date of your relicensure is December 10, 1987.

Your relicensure certificate will be issued and forwarded to you in three to four weeks.

Sincerely,

MICHIGAN BOARD OF MEDICINE

*Flo. Beasley*  
Florestine Beasley  
Board Secretary

State of Michigan  
Department of Licensing and Regulation  
BOARD OF MEDICINE  
P.O. Box 30018  
Lansing, Michigan 48909

COUNTER PAYMENT

DEC 10 1987

APPLICATION FOR REINSTATEMENT  
OF AN EXPIRED LICENSE

RECEIPT #

19065  
14002

NAME OF APPLICANT (last, first, middle)

III Washington, Clarence Joseph

ADDRESS (no., street, city, state, zip)

[REDACTED]

Detroit, Michigan 48238

DATE OF BIRTH

[REDACTED]

47

SOCIAL SECURITY NUMBER

[REDACTED]

CHECK THE APPROPRIATE ANSWER TO EACH OF THE FOLLOWING QUESTIONS.  
ATTACH DETAILED EXPLANATION FOR ANY YES ANSWER YOU CHECK.

Have you ever been convicted of a felony or misdemeanor?

YES

NO

DEC 10 1987

Have you ever had a malpractice settlement or award entered against you?

YES

NO

DEC 10 1987  
OF LIC. & REG.  
BOARD OF MEDICINE

Have you ever been denied a license in this or any other state?

YES

NO

List each state in which you hold or have ever held a license and the date the license was issued:

Georgia

Has any disciplinary action been taken or are any disciplinary proceedings pending against any license you hold or have held?

YES

NO

I certify that I have earned 150 hours of continuing medical education (CME) in the 3 years preceding this application, including a minimum of 75 hours in category 1. I understand that it is my responsibility to maintain evidence of my compliance with the CME requirements, that this evidence must be kept for a period of 4 years and that I am subject to an audit of all such evidence. I acknowledge that the Michigan Board of Medicine considers this part of my application for reinstatement of an expired medical license. I further certify that all my entries on this application are true and correct.

Signature

Clarence J. Washington

Date 12-10-87

Subscribed and sworn to before me this 10 day of Dec. 1987

Signature of Notary Public

Paula J. Stevens

County of

Clinton

My commission expires 2-9-88

PAULA J. STEVENS  
Notary Public, Clinton County, Mich.  
Acting In Ingham County, Michigan  
My Comm. Expires 2-9-88

**MAX CLELAND**  
Secretary of State



Board Members:  
Wilbur E. Baugh, M.D.  
Donald L. Branyon, Jr., M.D.  
Thomas J. Busey, Jr., M.D.  
George M. Chastain, M.D.  
Runette Flowers, M.D.  
W. Gordon Irwin, D.O.  
Jack A. Raines, M.D.

Andrew Watry  
Executive Director

Board Members:  
Eloise B. Sherman, M.D.  
Irving T. Staley, M.D.  
Robert E. Thompson, M.D.  
L. Newton Turk, III, M.D.  
Joseph L. Vinci, D.O.

Consumer Member:  
Marjorie (Marge) E. Lucas

James E. Anthony, Jr., M.D.  
Medical Coordinator

**COMPOSITE STATE BOARD OF MEDICAL EXAMINERS**

William G. Miller, Jr., Joint Secretary, State Examining Boards  
166 Pryor Street, S.W.  
Atlanta, Georgia 30303  
(404) 656-3913

December 8, 1987

Mr. Herman Fishman  
Michigan Board of Medicine  
611 W. Ottawa Street  
P O Box 30018  
Lansing, MI. 48909

Dear Mr. Fishman:

This is to certify that Clarence Joseph Washington, M.D. was issued Georgia Medical License No. 24879. It is further certified that the physician's license is current and in good standing through December 31, 1989.

Sincerely,

*Andrew Watry*  
Andrew Watry  
Executive Director

AW/ca

RECEIVED

DEC 10 1987

DEPT. OF LIC. & REG.  
BOARD OF MEDICINE

Board Members:  
Wilbur E. Baugh, M.D.  
Donald L. Branyon, Jr., M.D.  
Thomas J. Busey, Jr., M.D.  
George M. Chastain, M.D.  
Runette Flowers, M.D.  
W. Gordon Irwin, D.O.  
Jack A. Raines, M.D.

Andrew Watry  
Executive Director

**MAX CLELAND**  
Secretary of State



Board Members:  
Eloise B. Sherman, M.D.  
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Robert E. Thompson, M.D.  
L. Newton Turk, III, M.D.  
Joseph L. Vinci, D.O.

Consumer Member:  
Marjorie (Marge) F. Lucas

James E. Anthony, Jr., M.D.  
Medical Coordinator

**COMPOSITE STATE BOARD OF MEDICAL EXAMINERS**

William G. Miller, Jr., Joint Secretary, State Examining Boards  
166 Pryor Street, S.W.  
Atlanta, Georgia 30303  
(404) 656-3913

December 4, 1987

Mr. Herman Fishman, Licensing Executive  
Michigan Board of Medicine  
611 W. Ottawa Street  
P O Box 30018  
Lansing, MI. 48909

RE: Clarence Joseph Washington, M.D.  
GA. MED. LIC. #24879

Dear Mr. Fishman:

The above physician has contacted our office and asked for a Letter of Good Standing to be forwarded to the Michigan Board; however, this physician has presented us with a "Bad Check" for the 1986-87 renewal of his license. Therefore, until this matter has been cleared up, the Georgia Board cannot verify this physician's license.

If we can be of further assistance, please let us know.

Sincerely,

*AW*  
Andrew Watry  
Executive Director

AW/ca

**RECEIVED**

DEC 11 1987

DEPT of LICENSING & REG.

DEC 11 1987  
DEPT. OF LIC. & REG.  
BOARD OF MEDICINE



STATE OF MICHIGAN



JAMES J. BLANCHARD, Governor

DEPARTMENT OF LICENSING AND REGULATION

RAYMOND W. HOOD, SR., Director

December 21, 1987

MICHIGAN BOARD OF MEDICINE  
P.O. Box 30018  
Lansing, Michigan 48909  
Telephone: (517) 373-0680

Clarence J. Washington, III, M.D.

[REDACTED]  
Detroit, MI 48238

Dear Dr. Washington:

The Board of Medicine is in receipt of your application and fee for the reinstatement of your Michigan Medical License. However, as we discussed previously on the telephone, we can not issue your license until we receive a replacement of the bad check in the amount of \$165.00 dated February 20, 1986.

Until we receive a replacement fee in the amount of \$165.00 no licenses will be issued by this department, including your license for controlled substances.

Thank you.

Sincerely,

A handwritten signature in cursive script, reading "Carol S. Johnson".

Carol S. Johnson  
Administrative Assistant

csj

cc: Board of Pharmacy

THERE ARE NO EXCEPTIONS TO THIS REQUIREMENT

See requirement #5: Complete top portion and forward one to each State Medical Board where you hold or have held a medical license. To insure immediate response, enclose a stamped envelope addressed to:

COUNTER PAYMENT

N.C. Board of Medical Examiners, Suite 214 - 222 N. Person St., Raleigh, NC 27601

CLEARANCE FROM OTHER STATE BOARDS

FEB - 5 1988

I am applying for a North Carolina medical license based on endorsement

RECEIPT # 19777

I was granted license # \_\_\_\_\_ on \_\_\_\_\_ by the State of \_\_\_\_\_.

The Board of Medical Examiners of the State of North Carolina requires that I submit evidence that my license in the State of \_\_\_\_\_ is in good standing and that no charges of unprofessional conduct have ever been filed against me.

This is your authority to release any information in your files, favorable or otherwise, direct to the Board of Medical Examiners of North Carolina, Suite 214, 222 N. Person Street, Raleigh, North Carolina 27601. Your early attention to this is appreciated.

Clarence J. Washington III  
Printed or Typed Name

(Signature)

MOST STATES HAVE A FEE FOR PROCESSING VERIFICATIONS

EXECUTIVE OFFICE OF STATE BOARD:

Please complete and return this portion to: N. C. Board of Medical Examiners  
Suite 214 - 222 N. Person Street  
Raleigh, NC 27601

This is to certify that the records of the \_\_\_\_\_

Board of Medical Examiners indicate that \_\_\_\_\_

was issued license number \_\_\_\_\_ on \_\_\_\_\_ 19\_\_\_\_ to practice as a  
physician and surgeon in the State of \_\_\_\_\_

Dr. \_\_\_\_\_'s license is in good standing and no charges of  
unprofessional conduct have ever been filed against him.

Derogatory information ( ) NO ( ) YES If yes, explain. \_\_\_\_\_

Remarks \_\_\_\_\_

Authorized Signature

(BOARD SEAL)  
1703R

## Michigan Department of Community Health - Bureau of Health Professions - FEE CARD

YOUR REQUEST IS BEING DELAYED FOR SUBMISSION OF THE APPROPRIATE FEE CHECKED BELOW. PLEASE RETURN ALL COPIES OF THIS FORM WITH THE APPROPRIATE FEE. MAKE THE CHECK OR MONEY ORDER, DRAWN ON A U.S. FINANCIAL INSTITUTION, PAYABLE TO: STATE OF MICHIGAN.

BOARD

13

DATE

7/11/05

## PROFESSION

- ☒ 01  
☐ 02  
☐ 03  
☐ 04  
☐ Other \_\_\_\_\_

## FEE CODE

- ☐ 04 Temporary  
☒ 06 Relicensure  
☐ 37 Controlled Substance  
☐ 51 Certification  
☐ 90 Duplicate License  
☐ \_\_\_\_\_ Additional Fee  
☐ Other \_\_\_\_\_

## FEE AMOUNT

- |                                  |   |
|----------------------------------|---|
| <input type="checkbox"/> \$5.00  | <input type="checkbox"/> \$45.00          |
| <input type="checkbox"/> \$10.00 | <input type="checkbox"/> \$50.00          |
| <input type="checkbox"/> \$15.00 | <input type="checkbox"/> \$60.00          |
| <input type="checkbox"/> \$20.00 | <input type="checkbox"/> \$80.00          |
| <input type="checkbox"/> \$25.00 | <input type="checkbox"/> \$100.00         |
| <input type="checkbox"/> \$30.00 | <input type="checkbox"/> \$150.00         |
| <input type="checkbox"/> \$40.00 | <input checked="" type="checkbox"/> Other |
|                                  | \$ 255                                    |

Clarence Washington

## PLEASE COMPLETE:

MICHIGAN PERMANENT I.D. NUMBER

4301035289

SOCIAL SECURITY NUMBER

SB

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

Page 1 of 2

DCH/LMD-094 (01/04)

**APPLICATION FOR RELICENSURE**

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

**Evidence that you have earned 150 hours of continuing medical education (CME) in the three years preceding this application, including a minimum of 75 hours in Category (1), must be submitted with this application.**

NOTE: Relicensures will expire on January 31 of the following year. Subsequent renewals are for a three year period.

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**

License Number

635289

Date of Licensure

7/12/05

**I AM APPLYING FOR THE FOLLOWING:**

☒ Relicensure Fee: \$170.00 71-4301-06

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 <b>CLARENCE</b>	Middle Name <b>Joseph</b>	Last Name <b>WASHINGTON III</b>
U.S. Social Security Number [REDACTED]	Date of Birth [REDACTED] - 47	Michigan Permanent I.D. Number and Expiration Date 4301035289
[REDACTED]		
City <b>CARY</b>	State <b>NORTH CAROLINA</b>	ZIP Code <b>27511</b>
Daytime Phone Number 919 [REDACTED]	All Previous Names and/or Birth Name Used (if applicable)	
Has your Michigan medical license been lapsed more than three years? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

**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 checked="" type="checkbox"/> Yes <input 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 ever been warned, censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges modified?	<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](http://www.michigan.gov/healthlicense)



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

Page 1 of 2

DCH/LMD-094 (01/04)

Tran Info: 430106 10760244-1 06/02/05  
Chk#: 1692 Amt: \$170.00  
ID: [REDACTED]

### APPLICATION FOR RELICENSURE

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

**Evidence that you have earned 150 hours of continuing medical education (CME) in the three years preceding this application, including a minimum of 75 hours in Category (1), must be submitted with this application.**

NOTE: Relicensure will expire on January 31 of the following year. Subsequent renewals are for a three year period.

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

#### I AM APPLYING FOR THE FOLLOWING:

☒ Relicensure Fee: \$170.00 71-4301-06

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 <b>CLARENCE</b>	Middle Name <b>Joseph</b>	Last Name <b>WASHINGTON III</b>
U.S. Social Security Number [REDACTED]	Date of Birth [REDACTED] - 47	Michigan Permanent I.D. Number and Expiration Date:
Street Address [REDACTED]		
City <b>CARY</b>	State <b>NORTH CAROLINA</b>	ZIP Code <b>27511</b>
Daytime Phone Number <b>919</b> [REDACTED]	All Previous Names and/or Birth Name Used (if applicable)	
Has your Michigan medical license been lapsed more than three years? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

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 checked="" type="checkbox"/> Yes <input 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 ever been warned, censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges modified?               | <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](http://www.michigan.gov/healthlicense)



Name

Page 2 of 2

6. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?

☐ Yes ☒ No

7. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?

☐ Yes ☒ No

8. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?

☒ Yes ☐ No

List each state(s) in which you hold or have ever held a permanent medical license, the license number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. You must have each state board verify license directly to this board office. (Attach additional sheets if necessary)

State	License Number	Date of Issue	How obtained (Endorsement or examination)
MICHIGAN	#35289	1975	
NORTH CAROLINA	#32295	1988	
Georgia	#024879	1983	

#### 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

Agency: J. J. L. M.D.

Date

5-30-05

## Michigan Department of Community Health

## Board of Pharmacy

P.O. Box 30670

Lansing, MI 48909

(517) 335-0918

www.michigan.gov/healthlicense

DCH/PLH-090 (03/05)

## CONTROLLED SUBSTANCE LICENSE APPLICATION

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

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

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

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

Tran Info: 430157 10760244-2 06/02/05  
Chk#: 1692 Amt: \$20.00  
Tran: 10760244-3 06/02/05  
Chk#: 1692 Amt: \$65.00  
ID: [REDACTED]

License Number

G23807

Date of License

7/12/05

## Type or Print Only

## INSTRUCTIONS

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

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

2. M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.

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

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

First Name CLARENCE	Middle Name JOSEPH	Last Name WASHINGTON
Street 101 Lochwood EAST DR		Telephone Number 919 818 6815
City CARV	State N.C.	ZIP Code 27511

TYPE OF PROFESSIONAL LICENSE		STATUS:	
(Please Check One):	Regular Educational Limited		
<input type="checkbox"/> 29 - 01 D.D.S. 71-5315	<input type="checkbox"/> or <input type="checkbox"/>	1. Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, please explain on separate sheet.	
<input type="checkbox"/> 59 - 01 D.P.M. 71-5315	<input type="checkbox"/> or <input type="checkbox"/>		
<input type="checkbox"/> 69 - 01 D.V.M. 71-5315	<input type="checkbox"/> or <input type="checkbox"/>	2. Is your current professional license limited as a result of Board disciplinary action? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<input type="checkbox"/> 43 - 01 M.D. 71-5315	<input type="checkbox"/>		
<input type="checkbox"/> 51 - 01 D.O. 71-5315	<input type="checkbox"/>	Michigan Permanent I.D. Number (as shown on your pocket card)	
<input type="checkbox"/> 49 - 01 O.D. 71-5330	<input type="checkbox"/>		
<input type="checkbox"/> 53 - 01 Pharmacy Store 71-5301	<input type="checkbox"/>		
<input type="checkbox"/> 53 - 02 R.Ph. 71-5302	<input type="checkbox"/>		
<input type="checkbox"/> 53 - 06 Manuf./Wholesaler 71-5306	<input type="checkbox"/>	Expiration Date of License	Social Security Number

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

Signature [Signature]	Date 5-30-05
--------------------------	-----------------

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



JENNIFER M. GRANHOLM  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY SERVICES  
LANSING

JANET OLSZEWSKI  
DIRECTOR

### **CLEARANCE MEMORANDUM**

**TO:** Lucinda Clark, Supervisor  
Application Section

**FROM:** Rae Ramsdell, Licensing Manager  
Licensing Division

**SUBJECT:** Clarence J. Washington III, MD  
Applicant for Licensure – Medicine

**DATE:** June 27, 2005

Information provided for the captioned applicant indicates that the applicant is not in violation of Section 16221 (b)(ii) or (v) of the Public Health Code. Please proceed with the processing of the application.



JENNIFER M. GRANHOLM  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JANET OLSZEWSKI  
DIRECTOR

# MEMORANDUM

To: Application Section

From: Sandra L Lovell, Credentials

Date: July 7, 2005

Subject: **Clarence Joseph Washington, III**, Application for Relicensure

License Number: **4301035289**

The applicant named above has submitted evidence that he/she meets the continuing education requirement for relicensure. Please continue processing his relicensure application.



# COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

EXECUTIVE DIRECTOR  
LaSharn Hughes, MBA



MEDICAL DIRECTOR  
Jim H. McNatt, MD

2 Peachtree St., N.W., 36<sup>th</sup> Floor • Atlanta, Georgia 30303 • Tel: 404.656.3913 • Fax 404.656.9723  
<http://www.medicalboard.georgia.gov> E-Mail: [Medbdc@dch.state.ga.us](mailto:Medbdc@dch.state.ga.us)

RECEIVED

Wednesday, May 25, 2005

MAY 31 2005

DEPT. OF CIS

## TO WHOM IT MAY CONCERN:

This is to certify that **Clarence Washington, MD** was issued Physician license number 24879, on April 6, 1983. It is further certified that the status of this License is: Lapsed.

The license expiration date is December 31, 1989.

A review of public records indicates that no public board orders have been docketed.

This day Wednesday, May 25, 2005.

Composite State Board of Medical Examiners

A handwritten signature in cursive script that reads "LaSharn Hughes".

LaSharn Hughes  
Executive Director

*Administratively Attached to Community Health  
An Equal Opportunity Employer*





**NORTH CAROLINA  
MEDICAL BOARD**

Charles L. Garrett, Jr., MD  
*President*

Robert C. Moffatt, MD  
*President-Elect*

H. Arthur McCulloch, MD  
*Secretary*

Janelle A. Rhyne, MD  
*Treasurer*

**LICENSE VERIFICATION FORM**

**DATE:** 5/24/2005

**TO WHOM IT MAY CONCERN:**

This is to verify that the physician noted below was issued a North Carolina License.

A review of the files of the Medical Board indicate the following information:

<b>License Number:</b>	0000-32295
<b>Name:</b>	Clarence Joseph Washington III
<b>Address:</b>	Hallmark Clinic 1919 Gillespie St Fayetteville, NC 28306
<b>Type of License Issued:</b>	MD, Full license
<b>License Issued Date:</b>	04/18/2002
<b>Limitations:</b>	
<b>Current Status:</b>	ACTIVE
<b>Annual Renewal Date:</b>	01/11/2006
<b>License Expire Date:</b>	
<b>Public File:</b>	Yes

Sincerely,  
North Carolina Medical Board

*R. David Henderson*

By: R. David Henderson  
Executive Director

To expedite the verification process, the above is the standard format the North Carolina Board uses.

R. David Henderson  
*Executive Director*  
  
1203 Front Street  
Raleigh, North Carolina 27609-7533

Mailing:  
P.O. Box 20007  
Raleigh, North Carolina 27619-0007

Telephone: (919) 326-1100  
Fax: (919) 326-1131  
Email: [info@ncmedboard.org](mailto:info@ncmedboard.org)  
Web: [www.ncmedboard.org](http://www.ncmedboard.org)

State of Michigan  
Department of Community Health  
Bureau of Health Professions  
P.O. Box 30018  
Lansing, Michigan 48909

July 13, 2005

CLARENCE WASHINGTON III  
101 LOCHWOOD EAST DR  
CARY, NC 27511

The attached check has been returned to our Department by your bank as undepositable. You must send us a replacement check or money order, drawn from a U.S. Financial Institution and made payable to the State of Michigan. Please mail your replacement payment, along with the PAYMENT STUB located at the bottom of this letter in the ENCLOSED ENVELOPE PROVIDED WITH THIS FORM. If you have any questions, please contact your Licensing Board and/or Servicing Office.

ANY LICENSE OR SERVICE PROVIDED TO YOU BASED ON THIS CHECK IS VOID. IF YOU ARE RENEWING YOUR LICENSE, YOUR REPLACEMENT CHECK MUST BE RECEIVED ON OR BEFORE THE EXPIRATION DATE OF THE CURRENT RENEWAL PERIOD OR ADDITIONAL FEES WILL BE REQUIRED. Failure to replace your check may result in collection or disciplinary action.

Please use the following information to provide this Department with the appropriate fee amount.

Board Code	Prof Code	Lic ID	Soc Sec	Lic Type	Purpose Type	Purpose Code	Fee Amount
43	1	035289			523	375706	\$ 255.00

ATTN: Accounting - Check Replacement

for CLARENCE WASHINGTON III On 06/21/2005

## Michigan Department of Community Health - Bureau of Health Professions - FEE CARD

YOUR REQUEST IS BEING DELAYED FOR SUBMISSION OF THE APPROPRIATE FEE CHECKED BELOW. PLEASE RETURN ALL COPIES OF THIS FORM WITH THE APPROPRIATE FEE. MAKE THE CHECK OR MONEY ORDER, DRAWN ON A U.S. FINANCIAL INSTITUTION, PAYABLE TO: STATE OF MICHIGAN.

BOARD 43 DATE 7/11/05	<b>PROFESSION</b> <input checked="" type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> Other _____	<b>FEE CODE</b> <input type="checkbox"/> 04 Temporary <input checked="" type="checkbox"/> 06 Relicensure <input type="checkbox"/> 37 Controlled Substance <input type="checkbox"/> 51 Certification <input type="checkbox"/> 90 Duplicate License <input type="checkbox"/> _____ Additional Fee <input type="checkbox"/> Other _____	<b>FEE AMOUNT</b> <input type="checkbox"/> \$5.00 <input type="checkbox"/> \$45.00 <input type="checkbox"/> \$10.00 <input type="checkbox"/> \$50.00 <input type="checkbox"/> \$15.00 <input type="checkbox"/> \$60.00 <input type="checkbox"/> \$20.00 <input type="checkbox"/> \$80.00 <input type="checkbox"/> \$25.00 <input type="checkbox"/> \$100.00 <input type="checkbox"/> \$30.00 <input type="checkbox"/> \$150.00 <input type="checkbox"/> \$40.00 <input checked="" type="checkbox"/> Other \$ <u>255</u>
<b>PLEASE COMPLETE:</b>			
MICHIGAN PERMANENT I.D. NUMBER <u>4301035289</u>			
SOCIAL SECURITY NUMBER <u>88</u>			

Authority: Public Act 368 of 1978, as amended.

Please return enclosed documents with Fee Card, if applicable.

Tran Info:430106 10844664-1 07/12/05  
Chk#: 08276951087 Amt: \$255.00  
ID: 4301035289