Michigan Department of Community Health **Board of Medicine**

APPLICATION FOR MEDICAL DOCTOR LICENSURE

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

Have you ever held a health professional license in Michigan?

Michigan Department	of Community Health	DCH/LMD-040 (02/06)	Page 1 of 2
Board of M P.O. Box Lansing & (517) 3.0 www.nichigan.gov	30192 48909 -0918	Tran Info:430101	15884226-1 04/12/1
APPLICATION FOR MEDIC Authority Public Act 36	CAL DOCTOR LICENSURE 8 of 1978, as amended.	Chk#: 226 Amt ID: 276767984	: \$150.00
If this form is not completed,	a license will not be issued		
distributes, or dispenses any controlled subst Public Act 368 of 1978, as amended Inf	every person who prescribes, manufactures ance in Michigan as described in Article 7 of ormation on obtaining a Federal controlled cting the Regional Branch, Drug Enforcement 48226 (Telephone 1-800-882-9539)	License Number 096	361
Type or Print Only		Date of Licensure (13)	in di
AM APPLYING FOR THE FOLL	.OWING:	01181	10
	.00 71-4301-01 inancial institution and made payable to the S1 ipon receipt and can only be refunded under or		
First Name Abigail	Middle Name Lynch	Last Name Low H	ver
1 - (MCL 15.243(1)(a))	1 - (MCL 15.243(1)(a)) 980	2 6 - 1 - (MCL 15.2	43(1)(a))
1 - (M	CL 15.243(1)(a))		

44106

Michigan Permanent I.D. Number and Expiration Date

☐ Yes Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation

OH

Have you ever been convicted of a felony?	0	Yes	9	No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	0	Yes		No
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)?	0	Yes		No
4. Have you been treated for substance abuse in the past 2 years?	0	Yes		No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	0	Yes	9	No
Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?	0	Yes	•	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?	0	Yes	9	No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	0	Yes	0	No

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

Canadian Province? If yes have held a medicine licens license was obtained. DO Nagency verify licensure di	se, the license NOT LIST TEM rectly to this	or registration num PORARY LICENSI board office. (Atta	ber, the date issued, and ES. You must have ea	nd how the ach licensing if necessary)
State, U.S. Territory or Province License Number			Date of issue	How obtained (Endorsement or examination
Provide a			ecord of your edu	cational preparation.
Name and Address of Ins	titution	Dates o	of Attendance To	Degree
Swart more	College C.PA 19031	9/1998	6/2002	BA
Capital Univer	1 ty 4520	7/2000	8/2000	none
noo colla Ave clare	ne University Lad 44106	8/2003	5/2007	MD
Prov	ide a descr	iption of your ttach additional	professional medi sheets if necessary	cal experience. /-
Name and Address of En	nployer	Dates From	of Practice To	Duties
Iniversity Hopitals	Case ela 1. OH 94106	7/2007	6/2010	Family Medicine
process. I authorize this a file search from the Centra judicial record-keeping orga I further consent to the re similar licensure, registratio federal government, or of ar	gency to use all Records Divinization. Jease of information, or specialty another country.	ency to secure a ci the information pro vision of the Michi mation to this age certification board	vided in this application gan Department of States ncy regarding are discording of this or any other states	y as part of the pra-licensure screening in to obtain a criminal conviction historate Police or other law enforcement of ciplinary investigations conducted by ate, of the United States military, of the ion that might affect the decision to be

Michigan Department of Community Health

Board of Pharmacy

P.O. Box 30670 Lansing, MI 48909 (517) 335-0918

www.michigan.gov/healthlicense

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 manufacturers, 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. All pharmacies, practitioners, and veterinarians who dispense controlled substances in Schedules 2-5 must report this prescription data to the Michigan Automated Prescription System (MAPS) as stated in Board of Pharmacy Rules 338.3162b.(d). 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.

DCH/LPH-090 (02/10) Tran Info:430137 15884226-2 04/12/10 Chk#: 226 Amt: \$65.00 Than 27676730157 15884226-3 04/12/10 Chk#: 226 Ast: \$20.00 ID: 276767984 License Number

Type or Print Only

INSTRUCTIONS

- 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)

Date of Licensura

Last Name,

2. M.D./D.O. Applicants: This application may not be used for prescribing physicians for drug treatment programs. Please request an application for the Prescribing Physician for a Drug Treatment Program.

Middle Name

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.

	Abigail			L	44	ch	LowTher	
Name of Pharmacy or Manufacturer/Wholesaler (if applicable) 1 - (MCL 15.243(1)(a)) 2 - (MCL 15.243(1)(w)) 2 - (MCL 15.243(1)(w)) 2 - (MCL 15.243(1)(w)) 2 - (MCL 15.243(1)(a)) 2 - (MC	ichigan Permanent I.D/License Number Expiration Date of License							
Street Address 2 - (MCL 15.243(1)(w)) State CTY Code CTY	Name of Pharmacy or Manufacturer/Wholesale	er (if ap	plica	ble)			1 - (MCL 15.243(1)(a)) @gnail.co	
TYPE OF PROFESSIONAL LICENSE (Please Check One): Regular Educ. Lmt. Volunteer 1. Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered Yes No If Yes, please explain on separate sheet. 69 - 01 D.V.M. 71-5315 Or Or Or Or Or Or Or O				0	. ^		Telephone Number	
TYPE OF PROFESSIONAL LICENSE (Please Check One): Regular Educ. Lmt. Volunteer 1. Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered Yes No If Yes, please explain on separate sheet. 69 - 01 D.V.M. 71-5315 Or Or Or Or Or Or Or O	conclored	State	0	1+			ZIP Code 44106	
29 - 01 D.D.S. 71-5315		NSE						
Yes No Yes No	(Please Check One):	agular		Educ. I	Lmt.	Volunteer		
59 - 01 D.P.M. 71-5315	□ 29 - 01 D.D.S. 71-5315		or	0				
69 - 01 D.V.M. 71-5315	□ 59 - 01 D.P.M. 71-5315		or	0	or	0		
43 - 01 M.D. 71-5315	☐ 69 - 01 D.V.M. 71-5315		or	0				
51 - 01 D.O. 71-5315	# 43 - 01 M.D. 71-5315	9	or	0	or	0		
□ 53 - 01 Pharmacy Store 71-5301 □ license? Solve Yes □ No	□ 51 - 01 D.O. 71-5315	0	or	0	or	0	☐ Yes 😿 No	
Yes No	□ 49 - 01 O.D. 71-5330	0						
☐ 53 - 02 R.Ph. 71-5302 ☐ 4. Is this application for an additional location?	☐ 53 - 01 Pharmacy Store 71-5301	0					9 Yes □ No	
	□ 53 - 02 R.Ph. 71-5302						4. Is this application for an additional location?	
□ 53 - 06 Manuf. Wholesaler 71-5306 □ □ Yes Ø No	☐ 53 - 06 Manuf./Wholesaler 71-5306	0					☐ Yes 197 No	
	Signature (Date 04/06/2010	

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.

Murphy, Tracy S

From: Abigail Lowther 1 - (MCL 15.243(1)... @gmail.com]

Sent: Tuesday, April 20, 2010 9:30 PM

To: Murphy, Tracy S

Subject: Abigail Lowther's license application

Dear Ms. Murphy,

I wanted to correct my address for my Michigan Medical License and Michigan Controlled Substance (Pharmacy License).

My correct address is:

Abigail Lowther L2003 Women's Hospital 1500 E. Medical Center Drive Ann Arbor, Michigan 48109-5239

I apologize for the error. Please let me know if you have any questions or concers about this. Thank you,
Abby Lowther

Abigail Lowther cell: 216. 1-(MCL 15.2...

Norris, Brittany

From: Sent: aliasresponse@michigan.gov Saturday, April 17, 2010 1:39 FM

o: 1

To: Subject: bhpdata Administrative Hit/No Hit Notification.

STATE OF MICHIGAN
DEPARTMENT OF STATE POLICE
CRIMINAL RECORDS DIVISION
PO BOX 30634, LANSING MI 48913

DATE: 04/17/2010

TCN: AD10959955J01

Requester: MI DEPT OF COMMUNITY HEALTH

Reason Printed: LHP - Licensed Health Care Professional (MCL 333,16174) Subject Printed:

LOWTHER, ABIGAIL L DOB: 1-(MCL 1... 1980

The following e-mail response(s) is computer generated and is based on the criminal history information on file as of the date noted above.

Since entry of new arrests, court dispositions for prior arrests or other database changes occur daily, a future record search for this person could be different.

STATE RESPONSE:

A Michigan record has not been found that meets the dissemination criteria.

FBI RESPONSE:

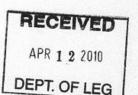
An FBI record has not been found that meets the dissemination criteria.

DCH/LMD-200 (03/06)

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

P.O. Box 30192 Lansing, MI 48909 (517) 335-0918

www.michigan.gov/healthlicense



Page 1 of 2

CERTIFICATION OF POSTGRADUATE TRAINING

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

INSTRUCTIONS TO APPLICANT:

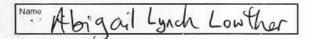
Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Director of Medical Education where you completed your postgraduate training. This certification must be submitted directly to the Michigan Board of Medicine by the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

Section 1 - APPLICANT INFORMATION First Name Abigail Lynch Last Name Low ther 2 - (MCL 15.243(1)(w)) City Cleveland Daytime Telephone Number 2 - (MCL 15.243(1)(w)) All Previous Names and/or Birth Name Used (if applicable) NA

nature of Applicant	Date
Garage Contract of the Contrac	V/(/2010
0 0	4/6/2010

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.



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

lame of Hospital			
University Hospital Case Medical C	enter		
treet Address of Hospital			
11100 Euclid Ave.			
ity, State and ZIP Code			
Cleveland, OH 44106			
certify that Abigail Lowther (Applicant's Name)	a graduate of the		
	o ground of the		
Case Western Reserve University medicals	chool, has successfully completed postgraduate		
4/1/	2007 6/20/2010		
linical training offered by the hospital named above from (Month/Da	2007 to 6/30/2010 (Month/DayNear)		
n the clinical area of Family Medicine			
s this an active training program accredited by the ACGME the College Canada, the Royal College of Physicians and Surgeons of Canada, o			
Committee on Accreditation of Preregistration Physician Training Prog			
aluneum	4-7-10		
Signature of Director of Medical Education	Date of Signature		
ALAN CADESKY, MD	(SEAL)		
Print or Type Name of Director of Medical Education	If hospital has no seal, please indicate		
NOTE: Certification of Postgraduate Training will not be accepted if signed actual completion.	and submitted more than 15 days prior to		
Caroli Component.			

DCW/LMD-091 (03/04)

Michigan Department of Community Health **Board of Medicine** P.O. Box 30192 Lansing, MI 48909

(517) 335-0918



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

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

INSTRUCTIONS TO APPLICANT:

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

SECTION I - APPLICANT INFORMATION

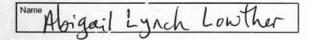
First Name Abigail	Middle Name Lynch	Low ther
1 - (MCL 15.243(1)(a))	Date of Birth 1 - (MCL 15.243 / 1980	216 1 - (MCL 15.243(1)(a))
1 - (MC	CL 15.243(1)(a))	
cleveland	State	ZIP Code 44106
All Previous Names and/or Birth Name Used	(if applicable)	
Date of Admission 8/2003		Date of Graduation 5/20/2007

Signature of Applicant	Date .
l alax	U/Chain
()20	19/6/2010

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.

www.michigan.gov/healthlicense



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

INSTRUCTIONS FOR COMPLETING SECTION II:

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

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School		
Street Address of Medical School City, State and ZIP Code	Case Western Reserve University School of Medicine T408 10900 Euclid Ave Cleveland, OH 44109	ity
I certify that ABIGA	-,"L Lowth	ek attended the
medical school named above from	8-7-03 to - (Month/Day/Year) Poctor of	4-30-07 (Month/Day/Year) Medicibe on
5-20-07 (Month/Day/Year)		
Joseph Signature of Dear	2. Corrag MEd	4-14-10
Signature or Bear	or redienal	Date of Signature
Joseph Corrao MEd Registrar		(SEAL)
Print or Type Name	e of Dean or Registrar	If school has no seal, please indicate



Unite States Medical Licensing Ex ination™ (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: 02/23/2010

Federation Credentials Verification Service

Packet ID: 113048

Alt Name(s):

Examinee ID#: 5-152-688-7

Examinee: Lowther, Abigail Lynch Date of Birth: 1-(... 1980

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	MEDICAL S		KWARA	F. As allegan of a	AGAT We CONTROL YATES WEDEN
	Test Date 06/18/2005	Pass/Fail Pass	Three-Digit Score Total MP 1 - (MCL 1	Two-Digit Score Total MP (5.243(1)(a))	Comments
USMLE STEP 2	Eninches		SECTION ASSESSED.	2.3	HAT WELL DANKED STARTS MADEE
Clinical Knowledge (Cl	Test Date 02/07/2007	Pass/Fail Pass	Three-Digit Score Total MP 1-(MCL 1) Three-Digit Score	Two-Digit Score Total MP 15.243(1)(3)) Two-Digit Score	Comments ATTICLE TO THE DESTRUCTION OF A MADERNARY
	Test Date 01/17/2007	Pass/Fail Pass	Total MP	Total MP	Comments of the conditional materials and the conditional material
USMLE STEP 3			Three-Digit Score	Two-Digit Score	
OHO:	Test Date 09/19/2009	Pass/Fail Pass	Total MP	Total MP (5.243(1)(a))	Comments of State Center Strong Comments of Comments o



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