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

DCH/LMD-040 (02/06) Page 1 of 2

Tran Info:430101 15884226-1 04/12/10
Chk#: 226 Amt: $150.00
ID: 276767984

APPLICATION FOR MEDICAL DOCTOR LICENSURE

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)

License Number 9960361

Date of Licensure 5/18/10

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

☑ **License by Examination Fee: $150.00 71-4301-01**

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
Abigail	Lynch	Lowther

U.S. Social Security Number	Date of Birth	Daytime Phone Number
1 - (MCL 15.243(1)(a))	1 - (MCL 15.243(1)(a)) 1980	216- 1 - (MCL 15.243(1)(a))

1 - (MCL 15.243(1)(a))

City	State	ZIP Code
Cleveland	OH	44106

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

Have you ever held a health professional license in Michigan?	Michigan Permanent I.D. Number and Expiration Date
☐ Yes ☑ 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?	☐ Yes ☑ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	☐ Yes ☑ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ Yes ☑ No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes ☑ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	☐ Yes ☑ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes ☑ No
7. Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes ☑ No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	☐ Yes ☑ No

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

Name: Abigail Lynch Lowther

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

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

State, U.S. Territory or Province	License Number	Date of Issue	How obtained (Endorsement or examination)

Provide a complete chronological record of your educational preparation.
Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From	To	Degree
Swarthmore College 500 College Ave, Swarthmore, PA 19081	9/1998	6/2002	BA
Capital University 1 College & Main, Columbus, OH 43209	7/2000	8/2000	none
Case Western Reserve University School of Medicine 10900 Euclid Ave, Cleveland, OH 44106	8/2003	5/2007	MD

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 Hospitals Case Medical Center 11100 Euclid Ave, Cleveland, OH 44106	7/2007	6/2010	Family Medicine Resident

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant: [signature] Date: 4/6/2010

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-090 (02/10)

Tran Info:430137 15884226-2 04/12/10
Chk#: 226 Amt: $65.00
ID: 276767984
Tran Info:430157 15884226-3 04/12/10
Chk#: 226 Amt: $20.00
ID: 276767984

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 Prescripton 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.

License Number: 045225
Date of Licensure: 5/18/10

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 prescribing physicians for drug treatment programs. Please request an application for the Prescribing Physician for a Drug Treatment 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	Middle Name	Last Name
Abigail	Lynch	Lowther
Michigan Permanent I.D/License Number	Expiration Date of License	U.S. [redacted]
		1 - (MCL 15.243(1)(a))
Name of Pharmacy or Manufacturer/Wholesaler (if applicable)		1 - (MCL 15.243(1)(a))@gmail.com
Street Address 2 - (MCL 15.243(1)(w))		Telephone Number 216 1 - (MCL 15.243(1)(a))
City Cleveland	State OH	ZIP Code 44106

TYPE OF PROFESSIONAL LICENSE

(Please Check One):	Regular		Educ. Lmt.		Volunteer
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐		
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐		
☑ 43 - 01 M.D. 71-5315	☑	or	☐	or	☐
☐ 51 - 01 D.O. 71-5315	☐	or	☐	or	☐
☐ 49 - 01 O.D. 71-5330	☐				
☐ 53 - 01 Pharmacy Store 71-5301	☐				
☐ 53 - 02 R.Ph. 71-5302	☐				
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐				

STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**
   ☐ Yes ☑ No
   If Yes, please explain on separate sheet.
2. **Is your current professional license limited as a result of Board disciplinary action?**
   ☐ Yes ☑ No
3. **Do you already hold an active controlled substance license?**
   ☑ Yes ☐ No
4. **Is this application for an additional location?**
   ☐ Yes ☑ No

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

Signature [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: aliasresponse@michigan.gov
Sent: Saturday, April 17, 2010 1:39 PM
To: bhpdata
Subject: 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
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CP

RECEIVED
APR 12 2010
DEPT. OF LEG

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 I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Abigail	Lynch	Lowther

Social Security Number	Date of Birth
2 - (MCL 15.243(1)(w))	1 - (MCL 15.243(1)(a)) 1980

1 - (MCL 15.243(1)(a))

City	State	ZIP Code
Cleveland	OH	44106

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)
216- 2 - (MCL 15.243(1)(w))	NA

Signature of Applicant	Date
	4/6/2010

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

Name Abigail Lynch Lowther

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
University Hospital Case Medical Center

Street Address of Hospital
11100 Euclid Ave.

City, State and ZIP Code
Cleveland, OH 44106

I certify that Abigail Lowther (Applicant's Name) **a graduate of the** Case Western Reserve University **medical school, has successfully completed postgraduate clinical training offered by the hospital named above from** 7/1/2007 (Month/Day/Year) **to** 6/30/2010 (Month/Day/Year).

In the clinical area of Family Medicine.

Is this an active training program accredited by the ACGME, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, or by the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association? ☒ Yes ☐ No

Signature of Director of Medical Education

4-7-10
Date of Signature

ALAN CADESKY, MD
Print or Type Name of Director of Medical Education

(SEAL)
If hospital has no seal, please indicate

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

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

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

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

INSTRUCTIONS TO APPLICANT:

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

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Abigail	Lynch	Lowther
Social Security Number: 1 - (MCL 15.243(1)(a))	Date of Birth: 1 - (MCL 15.243... /1980	Daytime Telephone Number: 216 1 - (MCL 15.243(1)(a))
Street Address: 1 - (MCL 15.243(1)(a))		
City: Cleveland	State: OH	ZIP Code: 44106
All Previous Names and/or Birth Name Used (if applicable): N/A		
Date of Admission: 8/2003		Date of Graduation: 5/20/2007

Signature of Applicant	Date
	4/6/2010

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

Name Abigail Lynch Lowther

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 Case Western Reserve University
School of Medicine T408
10900 Euclid Ave

City, State and ZIP Code Cleveland, OH 44109

I certify that ABIGAIL Lowther (Applicant's Name) attended the medical school named above from 8-7-03 (Month/Day/Year) to 4-30-07 (Month/Day/Year) and was/will be granted the degree of Doctor of Medicine on 5-20-07 (Month/Day/Year).

Joseph J. Corrao MEd
Signature of Dean or Registrar

4-14-10
Date of Signature

Joseph Corrao MEd
Registrar
Print or Type Name of Dean or Registrar

(SEAL)
If school has no seal, please indicate

USMLE
United States Medical Licensing Examination™

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 : 02/23/2010

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 113048

Examinee: Lowther, Abigail Lynch
Alt Name(s):

Examinee ID#: 5-152-688-7
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

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	06/18/2005	Pass	1 - (MCL 15.243(1)(a))				

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	02/07/2007	Pass	1 - (MCL 15.243(1)(a))				

Clinical Skills (CS)*

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	01/17/2007	Pass					

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
OHIO	09/19/2009	Pass	1 - (MCL 15.243(1)(a))				

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

XEN

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.