STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATION

DATE 2-10-81

ERRONEOUS VALIDATION

Validation number 30776

Validation date 2-6-81

Name [illegible]

1. Numeric Code 12

Group Code 68

Amount $ 15.00

2. Numeric Code _____

Group Code _____

Amount $ _____

CORRECTED VALIDATION

1. Numeric Code 13

Group Code 68

Amount $ 5.00

2. Numeric Code _____

Group Code _____

Amount $ _____

REASON:

Agency Social Workers

Signature [signature]

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATION

DATE _____

ERRONEOUS VALIDATION

Validation number 3076
Validation date 2-6-81
Name Chelian, Renee D.

1. Numeric Code 12
Group Code 628
Amount $15.00

2. Numeric Code _____
Group Code _____
Amount $ _____

CORRECTED VALIDATION

1. Numeric Code 13
Group Code 68
Amount $ 15.00

2. Numeric Code _____
Group Code _____
Amount $ _____

REASON: SWT coded in SW

Agency Soc Wkrs

Signature Pamela K. Mayhew

BOARD OF EXAMINERS OF SOCIAL WORKERS
P.O. Box 30018
1116 S. Washington Ave., Lansing, Michigan 48909

APPLICATION FOR REGISTRATION

LSW-01 (8/76)

83 12442 OCT -7 3 77937268 ****15.00

(DO NOT WRITE IN THIS SPACE)

(Check one)

- ☐ Certified Social Worker. FEE: $25.00
- ☐ Social Worker. FEE: $25.00
- ☒ Social Worker Technician. FEE: $15.00

Make check or money order, payable in U.S. currency, to:
STATE OF MICHIGAN - SOCIAL WORKERS
and send with application

IMPORTANT: You must read the attached letter of instructions before completing this form.

(PLEASE PRINT OR TYPE)

NAME OF APPLICANT (last, first, middle) Chelian Renee N.	TELEPHONE NO. RESIDENCE 313 956-7113
RESIDENCE (No., Street, City, County, State, Zip) ADDRESS 53 PILGRIM HIGHLAND PARK WAYNE MICH. 48203 (82)	BUSINESS 313 559-0590
BUSINESS (No., Street, City, County, State, Zip) ADDRESS ONE NORTHLAND PLAZA #1104 SOUTHFIELD OAKLAND MICH. 48075	BIRTH DATE (Mo., day, yr.) [redacted]

ARE YOU REGISTERED (OR LICENSED) IN ANOTHER STATE IN ANY OF THE CATEGORIES LISTED AT THE TOP OF THIS FORM? ☐ Yes ☒ No

IF "YES", WHERE? (State)

IF "YES" TYPE OF REGISTRATION	DATE OF REGISTRATION	CERTIFICATE NO.	BY EXAMINATION?	IF "YES"
			☐ Yes ☐ No	☐ Oral ☐ Written

HAVE YOU EVER HAD A LICENSE AS A CERTIFIED SOCIAL WORKER, SOCIAL WORKER, OR SOCIAL WORKER TECHNICIAN REVOKED OR SUSPENDED IN ANOTHER STATE? ☐ Yes ☒ No

IF YOU ARE REQUESTING REGISTRATION BY RECIPROCITY FROM THIS STATE, CHECK THIS BOX . . . . . ☐

A POSITIVE RESPONSE TO THIS QUESTION WILL NOT BE AN ABSOLUTE BAR TO LICENSURE BUT IS NECESSARY TO EVALUATE MORAL CHARACTER.

EDUCATIONAL RECORD

NAME OF HIGH SCHOOL ATTENDED	LOCATION (City, State)	CHECK HIGHEST YEAR COMPLETED	DID YOU RECEIVE A DIPLOMA? G.E.D.?	IF "YES" GIVE YEAR.
HIGHLAND PARK HIGH SCHOOL	HIGHLAND PARK, MICH	☐ 9 ☐ 10 ☐ 11 ☒ 12	DIPLOMA	1968

	NAME AND LOCATION OF COLLEGE	MAJOR AREA OF STUDY	YEARS ATTENDED	DEGREE & DATE OF GRADUATION
Undergrad and Post-graduate Experience				

	NAME OF INSTITUTION	LOCATION	DATES ATTENDED	COURSE PURSUED	COMPLETED?
Field Training or Short courses					

Obtain and attach evidence, verified by oath, of highest relative degree

Complete reverse side

Include paid employment for the last ten years in chronological order, beginning with your present position. Attach extra sheets if necessary. On a separate sheet list voluntary employment using the same format as for paid employment.

DATES EMPLOYED: (Mo., Day, Yr.)		
	EMPLOYER: NORTHLAND FAMILY PLANNING CLINIC, INC	ADDRESS OF EMPLOYER: ONE NORTHLAND PLAZA SOUTHFIELD 48075
FROM: 8/76	POSITION HELD: DIRECTOR	IMMEDIATE SUPERIOR: J. B. ACOSTA M.D.
TO: Present	DESCRIBE DUTIES: ALL ADMINISTRATIVE RESP., COUNS. (PROBLEM PREGNANCY ALTERNATIVES, ABORTION, BIRTH CONTRO, VD,	
HRS PER WEEK: 40-50		
	EMPLOYER: PLANNED FAMILY CLINIC INC	ADDRESS OF EMPLOYER: 17555 JAMES COUZENS DET MICH 48235
FROM: 3-73	POSITION HELD: DIRECTOR	IMMEDIATE SUPERIOR:
TO: 8-76	DESCRIBE DUTIES: all administrative resp, counseling abortion	
HRS PER WEEK: 40-50	PATIENTS, BIRTH CONTROL COUNSELING	
	EMPLOYER: J. GILBERTO HIGUERA M.D	ADDRESS OF EMPLOYER:
FROM: 6-68	POSITION HELD: Medical ASSISTANT	IMMEDIATE SUPERIOR: J.G. HIGUERA M.D.
TO: 3-73	DESCRIBE DUTIES: Medical ASSISTANT, COUNSELING PATIENTS WHO	
HRS PER WEEK	WERE GOING TO N.Y. FOR ABORTIONS,	
Membership in Professional or Scientific Societies	MICHIGAN HEALTH RIGHTS COUNCIL	
	NATIONAL ABORTION RIGHTS ACTION LEAGUE (STATE COOR.)	
Civil Service Examinations and Special Honors		

This form must be signed by three references who will certify to moral character who are familiar with your work, and whom we may contact		
	SIGNATURE OF REFERENCE: J. GILBERTO HIGUERA M.D.	ADDRESS (No., Street, City, State, Zip): 48203 3700 Woodward Highland Park
	SIGNATURE OF REFERENCE: ANGEL OJEDA M.D.	ADDRESS (No., Street, City, State, Zip): 27634 Five Mile Rd Livonia 48154
	SIGNATURE OF REFERENCE: Steven J Klobuchar	ADDRESS (No., Street, City, State, Zip): 24001 BLACKSTONE OAK PARK, mich 48084

HAVE YOU EVER BEEN CONVICTED OF A CRIME INVOLVING SEX OFFENSES OR ASSAULTS? ☐ YES ☒ NO

IF "YES," GIVE DETAILS (NATURE OF CONVICTION, DATES, SENTENCE ON SEPARATE SHEET.)

A POSITIVE RESPONSE TO THIS QUESTION WILL NOT BE AN ABSOLUTE BAR TO LICENSURE BUT IS NECESSARY TO EVALUATE MORAL CHARACTER.

ARE YOU CURRENTLY PHYSICALLY OR PSYCHOLOGICALLY DEPENDENT UPON ALCOHOL OR DRUGS? (CONTROLLED SUBSTANCES AS IN ACT 196, P.A. OF 1971) ☐ YES ☒ NO

IF "YES," ENCLOSE A CERTIFIED LETTER, ON LETTERHEAD, FROM THE LICENSED PHYSICIAN OR STATE APPROVED THERAPEUTIC AGENCY WHERE YOU ARE RECEIVING TREATMENT. (YOUR LICENSE WILL NOT BE DENIED IF RECEIVING THIS TREATMENT.)

I hereby affirm that I have read and completed this application, and that to the best of my knowledge, the foregoing statements are true.

9-26-77 (Date) Jessie McClellan (Signature of applicant)

Subscribed and sworn to before me this 5th day of October, 19 77, in the county of Oakland, State of Michigan.

My commission expires 6/28/78. Ada M Law (Signature of Notary Public)

LSW 03

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATION
BOARD OF EXAMINERS OF SOCIAL WORKERS
1116 SOUTH WASHINGTON AVENUE
LANSING, MICHIGAN 48926

ENDORSERS EVALUATION OF APPLICANT FOR CERTIFICATION AS A
(APPLICANT check the proper level)

- [x] CERTIFIED SOCIAL WORKER
- [ ] SOCIAL WORKER
- [x] SOCIAL WORK TECHNICIAN

INSTRUCTIONS TO ENDORSER:

You have been chosen as an endorser by the applicant for certification. Please complete this form and return it to the Board of Examiners of Social Workers at the above address. Thank you for your prompt cooperation.

Name of Applicant Renee N. Chelian

Address 53 PILGRIM HIGHLAND PARK 48203

Endorsers Name

What is your basic profession(s)

Your present professional position(s) MEDICAL DIRECTOR

1. What is (was) Your relationship to the applicant?

2. Keeping in mind our obligation to the public, the mature judgement and the ethical standards for porfessional practice required, do you consider the applicant qualified for certification at the level indicated above?

Yes X No ____

3. Please express any reservations or additional comments you may have in respect to your evaluation of the applicant.

Ms Chelian is the administrative director of the institution of which I am the Medical Director and I can have only words of praise for her many qualities which make her a valuable & irreplaceable asset to this Clinic not only as an administrator, but because of her tremendous empathy & human understanding of the patient's needs.

(Use reverse side if necessary)

Your Signature Julio [illegible] MD Business Address 27634 FIVE MILE Rd.

Title Medical Director City, State, & ZIP LIVONIA MICH. 48154