ved by:	HAY 30 1991	STATE OF MICHIGAN STATE OF MICHIGAND BOARD OF MEDICINE P.O. 80X 30192 LANSING, MICHIGAN 489 (517) 373-0680	***	968 of 1978	required by P., in order for yo ed in Michigan
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EXPLANATION FOR	ANY YES ANSWER	TO EACH OF THE FOL YOU CHECK.	LOWING QUESTIONS	S. ATTACH DE	ETAILED
Have you ever been u	nder treatment for add	dition or insobriety?		☐ YES	D NO
Have you ever been lacility's staff or had yo	warned, censured, our health care facility	or requested to withdraw fr staff privileges modified?	om a health care	□ YES	DINO
Are you now or have y	ou ever been a defen	dant in a medical malpractic	e civil suit?	☐ YES	ELNO-
Have you ever been r state or federal agency	efused a license to p	practice professionally for a	ny reason by any	☐ YES	: OLNO
Have you ever been d board?	lenied the privilege of	f taking an examination by	any state medical	YES	[Z-HO
Hav∌ you ever had you approval revoked or sy board or a board respo	spended, or have you	d substance license, certific u ever been otherwise discip controlled substances?	ate, registration or lined by a medical	☐ YES	B110
Do you currently have board or a board respo	any charges or comp nsible for regulating c	plaints pending against you controlled substance?	before a medical	☐ YES	IZ-NO
	a restricted state or	federal lice e, certificate		ID√FS	□ NO
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NAME AND ADDRESS OF INSTITUTION	DATES OF	ATTENDANCE To	DEGREE
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State of Michigan

Department of Licensing and Regulation

BOARD OF MEDICINE

P.O. Box 30192

Lansing, Michigan 48909

This form is required by P.A. 368 of 1978 in order far you to be licensed in Michigan.

CERTIFICATION OF POSTGRADUATE TRAINING

APPLICANT INSTRUCTIONS

Type or print your name in Section I exactly as it appears on your application. Send this form to be completed and mailed directly to the board by the director of medical education where you completed your postgraduate training.

	TION I: APPLICANT INFORMATION
NAME OF APPLICANT (last, first, middle) Boyd, Katheri	ne Lee
ADDPESS Inc., street., city, state, ZIP) DATE OF BIRTH	SOCIAL SECLIBITY NUMBER
	TION I: APPLICANT INFORMATION
HOSPITAL NAME	HOM. AT LIGANT IN CHIMATION
	John Hospital and Medical Center
HOSPITAL'S COMPLETE ADDRESS	4
22101 Moross Road, Detroi	t, Michigan, 48236
1 contity that <u>Katherine Lee Boyd</u> Meharry Medical College	medical school, has successfully completed postgraduate
clinical training offered by the hospital name 19 91* in the clinical area of Obst. *Or. Boyd is expected to complete	
	etrics and Gynecology ete our 4-year program 6/30/93.
19 91* in the clinical area of Obst. *Or. Boyd is expected to comple	etrics and Gynecology ete our. 4-year program 6/30/93. Sconting of Director of Medical Education
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19 91* in the clinical area of Obst. *Dr. Boyd is expected to comple June 17, 1991	etrics and Gynecology ete our 4-year program 6/30/93: Signature of Director of Medical Education Steven E. Minnick, M.D., Director of Medical Education

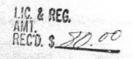
If hospital has no seal, please so indicate.

NOTE: Certification of postgraduate training will not be accepted if certified more than 15 days prior to actual completion.

NATIONAL BOARD OF MEDICAL EXAMINERS OF THE UNITED STATES OF AMERICA Kather ine L. Boyd M. M.D. having satisfied all the requirements and having successfully passed the examinations is hardly declared a Diplomas of the National Board of Medical Examiners. Attest L.* THOMPS DN BOWLES M.D.* PH.D.* Chairman of the Board SEAL ROBERT L.* VOLUE, PH.D.* Philludeliphia, Ps. O7/01/90 Certificate # 376261 1t is certified that the above is a facsimile of the Diplomate Certificate which has been or will be avaried to the physician named above, who graduated from MEHARRY MEDICAL COLLEGE in MAY 1989 and whose birth date is all examinations required for certification by the National Board of Medical Examinars. The scores obtained by this physician upon which his/her certification is based are as follows: Standard Scale Score Score PART I passed 09/88 Medicine Surgery Obsterrics and Gynecology Physiology Behavioral Sciences TOTAL TEST (Minimum Passing Score 290/75) PART II passed 03/90 A General Test of Clinical Competence TOTAL TEST (Minimum Passing Score 290/75) PART II passed 03/90 A General Test of Clinical Competence TOTAL TEST (Minimum Passing Score 290/75) GENERAL AVERAGE (Parts, I, II, and III Scale Score)	NATIONAL BOARD OF MEDICAL EXAMINERS® • 3 ENDORSEMENT OF	and the second of the second o	EET, PRICADEL	
UNITED STATES OF AMERICA Katherine L. Boyd. M.D. having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diploman of the National Board of Medical Examiners. Attest L. THOMPSON BOWLES. M.D., PH.D. Chilman of the Board SEAL ROBERT L. VOLLES PH.D. President of the Board SEAL ROBERT L. VOLLES PH.D. President of the Board O7/01/90 Certificate # 376251 It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be awarded to the physician named above, who graduated from MEHARRY MEDICAL COLLEGE In MAY 1989 and whose birth date is This physician as successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows: Standard Scale Score Score PART I passed 09/87 Anatomy Physiology Biochemistry Pathology Microbiology Pharmacology Behavioral Sciences TOTAL TEST (Minimum Passing Score 390/75) PART III passed 03/90 A General Test of Clinical Compatence TOTAL TEST (Minimum Passing Score 290/75)			all appellagged to	
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having satisfied all the requirements and having successfully passed the examinations is hareby declared a Diplomate of the National Board of Medical Examiners. Attest L • THOMPSON BOWLES • M • D • e PH • D • Chairman of the Board SEAL ROBERT L • VOI. CE* PH • D • President of the Board SEAL ROBERT L • VOI. CE* PH • D • President of the Board Certificate # 376261 It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be awarded to the physician named above, who graduated from MEHARRY MEDICAL COLLEGE In MAY 1989 and whose birth date is an Available of the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows: Standard Scale Score Score PART I passed 09/87 Anatomy Physiology Biochemistry Pathology Microbiology Public Health and Preventive Medicine Padiatrics Psychiatry TOTAL TEST (Minimum Passing Score 290/75) PART III passed 03/90 A General Test of Clinical Competence TOTAL TEST (Minimum Passing Score 290/75)	BOUNDED TO THE RESERVE A DESCRIPTION OF THE PARTY OF THE	or the first some the constitution of the constitution of the		
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For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date.	Board will be fulfilled and such certification will be awarded:	e ure date on which this rec	purement for certifica	non by the National
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Provide a complete chronological record of all your educational preparation and work experience from secondary or high school to the present date. Attach additional sheets if necessary.

NAME AND ADDRESS OF INSTITUTION	DATES OF A	TO	DEGREE OBTAINED
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Kansas State University			7
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Auburn University in Montgomery			720
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Melarry Medical College	and the second second		
Nashville, Tn.	1983	1989	M.D.
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An Control of the Con	(5.50 p. 2.3)	66 (0) (0.5) (0.6)	10 mg - 10 mg 2 mg
I hereby certify that the information in this application is limited medical licensure in Michigan. Signature Subscribed and sworn to before me this 444 day of	a receipt of	Date 4-4-	and the state of t
Signature of Notary Public Came Tr	My commission	on expires	N. 23, 1993
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county of DHUIDSON	Dicense APPLICAT prescribes, manufact of Public Act 368 of 1 obtained by contain	TON tures, distributes 1978, as amende	d. Information on nai Branch, Drug



STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATION
BOARD OF MEDICINE
P.O. BOX 30018
LANSING, MICHIGAN 48909
(517) 373-0680

This form is required by P.A. 368 of 1978 in order for you to be licensed in Michigan.

APR 24 1989

APPLICATION FOR LIMITED MEDICAL AND CONTROLLED SUBSTANCE LICENSES

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☐ Limited Clinical Academic Fee: \$30.00	Controlled Sul Fee: \$50.00	
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defendant in a medical malpractice civil	suit? YES	⊠ NO
e to practice professionally for any reason	on by	⊠ NO
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State of Michigan
Department of Licensing and Regulation
BOARD OF MEDICINE
P.O. Box 30018
Lansing, Michigan 48909

CERTIFICATION OF APPOINTMENT TO MICHIGAN TRAINING HOSPITAL

		(name of applicant)	
has been	duly appointed to a tra-	ning program in the clinical area of $\frac{\partial b_0}{\partial x}$	stetrics and Gynecolog
beginning	July 1, 1989	and ending June 30,	, 1990
in the	St. John Hospital		
		(name of training hospits!)	RECEIVED
	22101 Moross Road, 1	Detroit, Michigan 48236	APR 2 8 1985
	(Addre	as of hospital - this address will be printed on license)	DEPT, OF LIC. & REG. BOARD OF MEDICINE
			4
The second second second	E. Minnick, M.D.		
The second second second	E. Minnick, M.D. name of Director of Medical Education		
Type or print	name of Director of Medical Education	rao .	4-10-89
Type or print	name of Director of Medical Education	· M.O	4-10-89 Date
Type or print	name of Director of Medical Education	(NO	The state of the s
Type or print	name of Director of Medical Education	Is program accredited by ACGME?	Date

If hospital has no seal, please indicate.

NOTE: This certification must be mailed directly to the Michigan Board of Medicine from the training hospital or institution.

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

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 HECEIVED

APPLICANT INSTRUCTIONS

APR 12 1989

Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the dean of the medical school you attended for completion of Section II. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

NAME OF APPLICANT (last, first,	PLICANT INFORMATION middle)
ADDRESS (no. street city state	e zip)
DA C UF BIRTH	S BR
8-12-85	5-2889
	TIFICATION OF MEDICAL EDUCATION
Mehurry Medical S	chool RECEIVE
FULL ADDRESS OF MEDICAL SCHOOL	APR 1 ? 1989
	OF IN A REG
I certify that Katherine	L. Boyd at BOARD OF MEDICINE
school named above from Augus	1985 through May 1 1989
and was/will be granted the degree on MRY 28, 1989.	ee of
April 6 1989 (Date)	- OLD ONT
	Signature of Dean or Registrar
	Ottle L. West
(SEAL)	Type or Print Name of Dean or Registrar DIRECTOR, ADMISSIONS & RECORDS

NOTE: This certification must be returned by the medical school directly to the Michigan Board of Medicine at the address shown above.

State of Michigan
Department of Licensing and Regulation
BOARD OF MEDICINE
P.O. Box 30192
Lansing, Michigan 48909

Mekarry Medical College on 1005 N.B. Todd Jr. Blud Noshville, The + 3+208

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

APPLICANT INSTRUCTIONS

Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the dean of the medical school you attended for completion of Section II. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION II: CERTIFICATION OF MEDICAL EDUCATION ANE OF ADMISSION SECTION II: CERTIFICATION OF MEDICAL EDUCATION ANE OF MEDICAL SCHOOL ADMISSIONS AND RECORDS MEHARY MEDICAL COLLEGE JOS DAVID B. TODD, R. BLVD. NASHVILLE, TENNESSER 37208 Dertify that Katherine L. Boyd Granted the degree of Ductor of Medicine 5/28/ 19.85 through 5/17/ 19.89 and Was we granted the degree of Ductor of Medicine 5/28/ 19.89 September of Dean or Registry Interim Director, Admissions & Records Doris E. Petway Type or Pred Name of Davin or Registry This certification must be returned by the medical school directly to the Michigan Board of Medicine at the address shown above. State of Michigan Department of Medicine Admissions Admissions Admissions Records Department of Medicine Admissions	May 1989
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P.O. Box 30192.	of Medicine
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438/05436/ Boxd, Katherine Lee

CS - 3 March 14, 2016

Michigan Department of Licensing and Regulatory Affairs

Bureau of Health Care Services Health Licensing Division PO Box 30670

> Lansing, MI 48909 (517) 335-0918

www.michigan.gov/healthlicense

TranInfo:531557 21198282-1 03/14/16 Chk#: 23597 Amt:# 27000

LARA/LPH-095 (06/14)

TD: 4301054361

CONTROLLED SUBSTANCE ADDITIONAL LOCATION LICENSE APPLICATION

PLEASE NOTE: If you only prescribe controlled substances at more than one location, you only need one controlled substance license. A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. All 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 338.3162d. YOUR ADDITIONAL CONTROLLED SUBSTANCE LICENSE WILL EXPIRE ON THE SAME DATE AS YOUR PROFESSIONAL LICENSE.

Chk#: 23597 Amt: \$65.00

 ADDRESS CHANGES FOR PRACTITIONERS: If your license address has changed since you have applied for professional licensure, download the Data Change/Duplicate License Request Form from our website and fax it to (517) 373-7179 or mail it to the address above.

CONTROLLED SUBSTANCE FEE: Initial (first time) If you already hold a professional license and your professional license.	professional license o ofessional license exp	r relicensure of your profi ires in:	essional licens Chk#:		1198282-3 : \$150.00	03/14/16
0-12 months the fee is \$85.00 13-2	4 months the fee is \$1	60.00 25-36 mor	nths thể lee is:	\$2ds.66361		
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Your check or money order drawn on a U.S. financial SEND CASH. Fees are deposited upon receipt and c					y this applicat	on. DO NOT
Please select the license you are app	lying for from t	the drop down lis	t below:			
Dentist Expiring in 0-12 Months Fee: \$85.	00 71-5315-1375	7				
First Name: Katherine	Middle Name:	Lee	Last Na	me: Boyd		
Additional Location Street Address: 15801	W. Mc Nichols		Ste #	‡ :		
City: Detroit	State: Mi	chigan		Zip Code:	48235	
Michigan Health Professional ID/License Nu	mber: 4 3 0	1 0 5 4 3 6	1 Expi	ration Date:	01/31/2019	9
U.S. Social Security #:		Phone Number:		313 272	J 5-10	3 1-8450
Note: If you answer "yes" to the question belo documents related to your explanation along to deemed incomplete and processing will be de	with your applicati					
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regulated by this state, another state or te military, the federal government, or anothe	•	ed States, the United	l States		⊠ No	
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I am applying for an additional controlled sub	stance license for	the location listed a	above and o	leclare that t	he stateme	nts and

I am applying for an additional controlled substance license for the location listed above and declare that the statements and information contained on this application are true.

Signature of Applicant

FOR BOARD USE ONLY

License #

Boyl

Date 3/9/16

The Department of Licensing and Regulatory Affairs 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.

Boyd, Katherine Lee

CS - 3 November 09, 2015

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Michigan Department of Licensing and Regulatory Affairs

LARA/LPH-095 (06/14)

FOR BOARD USE ONLY License # 5315074807 Bureau of Health Care Services Health Licensing Division PO Box 30670 Lansing, MI 48909 (517) 335-0918

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M.D./D.O Applicants: This applicants the Prescribing Physician in a D		ohysicians who are prescrib	ing for a drug treatmer	nt program. Please re	quest an application for
Your check or money order draw SEND CASH, Fees are deposite					this application. DO NOT
Please select the licens	se you are applyin	g for from the drop	down list belov	w:	•
Dentist Expiring in 0-12 M	onths Fee: \$85.00 7	1-5315-13757			
First Name: KATHERIN	√E Mid	dle Name: LEE	Las	st Name: Bo	ΥD
Additional Location Street Address: 15921 E 8 mile road Ste #: 1					
City: EAST POINTE	2	State: MZ		Zip Code:	48021
Michigan Health Profession	al ID/License Numbe			Expiration Date:	1-31-2016
U.S. Social Security #		Phone N		-774-41	
Note: If you answer "yes—to documents related to your ex deemed incomplete and prod	xplanation along with	our application. If you			
 Have you ever been fined otherwise disciplined, or to disciplinary or certification regulated by this state, as military, the federal government. 	the subject of a final a n board as a holder of nother state or territor	dverse action by a lice or applicant for, a lice y of the United States,	ensure, registration nse or registration	n, n	☐ Yes No
If yes, please explain					
	a			·	
I am applying for an addition	nal controlled substan	ce license for the loce	ion listed above a	and declare that the	ne statements and
information contained on thi					79.
Signature of Applicant	ta Mahu	OX Sm	<u> </u>	Date Date	$\omega - \Delta$

The Department of Licensing and Regulatory Affairs 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., barder the Americans with Disabilities Act, you may make your needs known to this agency.

FOR BOARD	USE.	ONLY.	
License #			,
Issue Date			

Health Problem Pivipion PO Box 30670 Lansing, MI 48909 (517) 335-0918 www.michigan.gov/healthlicense

CONTROLLED SUBSTANCE ADDITIONAL LOCATION LICENSE APPLICATION

PLEASE NOTE: If you only prescribe controlled substances at more than one location, you only need one controlled substance license. A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. All 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 338.3162d. YOUR ADDITIONAL CONTROLLED SUBSTANCE LICENSE WILL EXPIRE ON THE SAME DATE AS YOUR PROFESSIONAL LICENSE.

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INS:	 ~ 1	N	

- 1. ADDRESS CHANGES FOR PRACTITIONERS: If your license address has changed since you have applied for professional licensure, download the Data

Onengo Dupinosis License Request Form from	our website and tax it to (517) 373-717	g or mail it to the address above.	
CONTROLLED SUBSTANCE FEE: Initial (firs If you already hold a professional license and	t time) professional license or relicensur your professional license expires in:	e of your professional license- \$85.00	
0-12 months the fee is \$85.00	13-24 months the fee is \$160.00	25-36 months the fee is \$235.00	
M.D./D.O Applicants: This application may not the Prescribing Physician in a Drug Treatment	be used for physicians who are prescri Program.	bing for a drug treatment program. Plea	se request an application for
Your check or money order drawn on a U.S. fi SEND CASH. Fees are deposited upon receip	nancial institution and made payable to t and can only be refunded under refund	the STATE OF MICHIGAN must accom I rules promulgated by the Department.	pany this application. DO NOT
Please select the license you are	applying for from the drop	down list below:	
Dentist Expiring in 0-12 Months Fee	-		20975146-1 01/04/16 : \$65.00
First Name: KATHERINE	Middle Name: LEE	ID: Last Name:	ρολΟ
Additional Location Street Address:	15921 E8 mile	Togd Ste#: 1	
City: EASTPOINTE	State: MZ	Zip Code	× 48021
Michigan Health Professional ID/Licens	se Number.	Expiration Da	te: 1-31-2016
U.S. Social Security #	Phone N	lumber: 50/-774-1	ת מוני
Note: If you answer "yes to the question of documents related to your explanation a deemed incomplete and processing will in the complete and processing will incomplete and processing will be added to the complete and the complete and the complete and processing will be added to the complete and t	iong with your application, if you be delayed.	do not provide the explanation,	Il-official and/or court your application will be
 Have you ever been fined, denied, re otherwise disciplined, or the subject of disciplinary or certification board as a regulated by this state, another state military, the federal government, or a 	or a final adverse action by a lice tholder of or applicant for, a lice or territory of the United States	ensure, registration,	☐ Yes
If yes, please explain			
		TranInfo:531557 Chk#: 5416 Aut IV:	20975146-2 01/04/16 : \$20.00
am applying for an additional controlle	Euberana licana for the land	Son Patrick at the second	
I am applying for an additional controller information contained on this application	are true	ion listed above and declare the	at the statements and
Signature of Applicant	Bu O Ty	Date 6	30-15

The Department of Licensing and Regulatory Affairs 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.

Michigan Department of Licensing and Regulatory Affairs

LARA/LPH-075 (06/14)

Bureau of Health Care Services Health Licensing Division PO Box 30670 Lansing, MI 48909 (517) 335-0918

TranInfo:430138 21198280-1 03/14/15 Chk#: 23596 Amt: \$85.00 IO: 4301054361

FOR BOARD USE ONLY License # 3 1 5 0 7 4 8 0 8 1 Super Date 3 29-1 6

www.michigan.gov/healthlicense

DRUG CONTROL ADDITIONAL LOCATION LICENSE APPLICATION

A drug control license must be obtained by all licensed medical doctors, doctors of osteopathic medicine, podiatrist, optometrists, and dentists WHO ROUTINELY DISPENSE DRUGS from their principal place of practice. A drug control license is not necessary if the dispensing involves only the issuance of complimentary starter dose drugs. YOUR DRUG CONTROL LICENSE WILL EXPIRE ON THE SAME DATE AS YOUR PROFESSIONAL LICENSE. All practitioners 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).

INSTRUCTIONS

- 1. DO NOT SUBMIT THIS APPLICATION AND FEE UNTIL YOU HAVE OBTAINED YOUR LICENSE NUMBER FROM YOUR PROFESSIONAL BOARD. If your license address has changed since you have applied for professional licensure, download the Data Change/Duplicate License Request Form from our website and fax it to (517) 373-2179 or mail it to the address above.
- 2. Your Drug control license will expire with your current professional license. If your professional license expires in:
 0-12 months the fee is \$45.00
 13-24 months the fee is \$65.00
 25-36 months the fee is \$85.00

Please select the license type you are applying for from the drop down list below: Medical Doctor Expiring 0-12 Months Fee: \$45.00 71-4301-38 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: Email Address: Jummi U.S. Social Security #: Michigan Health Professional ID/License Number: **Expiration Date:** Additional Location Street Address: Blda/Ste #: City: State: Zip Code: Phone Number: Note: If you answer "yes" to the question below, you must provide a detailed explanation with copies of all official and/or court documents related to your explanation along with your application. If you do not provide the explanation, your application will be deemed incomplete and processing will be delayed. Have you ever been fined, denied, revoked, suspended, reprimanded, placed on probation, otherwise disciplined, or the subject of a final adverse action by a licensure, registration, Yes disciplinary or certification board as a holder of or applicant for, a license or registration regulated by this state, another state or territory of the United States, the United States military, the federal government, or another country? If yes, please explain l hereby make application for a grug control license in Mighigan and submit that the statements and information above are true. Signature of Applicant

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