Michigan Department of Licensing and Regulatory Affairs
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
~~(517) 335-0918~~
www.michigan.gov/healthlicense

LARA/LPH-070 (04/11)

Tran Info:430138 17968840-1 09/17/12
Chk#: 2692 Amt: $45.00
ID: 4301087565 ✓

[redacted]

Date of Licensure: 2/15/2013
License Number: 9-21-[illegible]

DRUG CONTROL LICENSE APPLICATION

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

A drug control license must be obtained by all licensed medical doctors, doctors of osteopathic medicine, podiatric medicine 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.

Type or Print Only

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 applied for professional licensure, contact your board immediately for an address change form. This drug control license will be issued to the address on file with the Board.**
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 (circled) **13-24 months the fee is $65.00** **25-36 months the fee is $85.00**

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.

TYPE OF PROFESSIONAL LICENSE

(Please Check One).

- [X] 43 - 01 M.D. 71-4301-38
- [ ] 51 - 01 D.O. 71-5101-38
- [ ] 29 - 01 D.D.S. 71-2901-38
- [ ] 69 - 01 D.P.M. 71-6901-38

STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**
   - [ ] Yes
   - [X] No

   If Yes, please explain on separate sheet. ✓
2. **Is your current professional license limited as a result of Board disciplinary action?**
   - [ ] Yes
   - [X] No

Michigan Permanent I.D. Number: 4301087565
Expiration Date of License: 01/31/2013
[redacted]

First Name: Katherine
Middle Name: Allison
Last Name: DAMM

I hereby make application for a drug control license in Michigan and submit that the statements and information above are true.

Katherine Damm
Signature

9/12/12
Date

Street: 35000 Ford Rd. Ste. 3
Telephone Number: 734 721 4700
City: Westland
State: MI.
ZIP Code: 48185

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
Board of Pharmacy
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Lansing, MI 48909
(517) 335-0918
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LARALPH-090 (07/11)

Tran Info:430137 17968844-1 09/17/12
Chk#: 2691 Amt: $65.00
ID: 4301087565

Tran Info:430157 17968844-2 09/17/12
Chk#: 2691 Amt: $20.00
ID: 4301087565

License Number: 53 05 15 27

Date of Licensure: 09-21-12

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.

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

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	Middle Name	Last Name
Katherine	Allison	Damm

Street	Telephone Number
35000 Ford Rd. Ste 3	734 721 4700

City	State	ZIP Code
Westland	MI.	48185

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

Michigan Permanent I.D. Number (as shown on your pocket card): 4301087565

Expiration Date of License: 01/31/2013 [redacted]

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

Signature: Katherine Damm Date: 9/12/12

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 American's with Disabilities Act, you may make your needs known to this agency.

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

DCH-MD-851 (03/04) Page 1 of 2

Tran Info1430137 11613884-1 05/31/06
Chk#: 1134 Amt: 865.00
ID: [redacted]

APPLICATION FOR EDUCATIONAL LIMITED AND CONTROLLED SUBSTANCE LICENSES

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)

[redacted]

License Number 6201565

C.S. License Number 826146

Date of Licensure 8/1/00

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

X **Educational Limited and Controlled Substance Fee: 170.00**
71-43-01-376705

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
Katherine	Allison	Damm

U.S. S[redacted]	Date of Birth [redacted]	Previous MI License Number and Expiration Date, if applicable
		N/A

Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)
(989) 670-2994	N/A

Tran Info1430157 11613884-2 05/31/06
Chk#: 1134 Amt: 920.00
ID: [redacted]

Have you ever held a health professional license in Michigan?
☐ Yes X No

Name of Training Hospital: William Beaumont Hospital

Tran Info1430105 11613884-3 05/31/06
Chk#: 1134 Amt: 885.00
ID: [redacted]

Street Address of Training Hospital: 3601 W. 13 Mile Road

City	State	ZIP Code
Royal Oak	MI	48073

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 X No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	☐ Yes X 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 X No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes X No
5. Have you had 3 or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes X 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 X No
7. Have you ever had a federal or state health professional license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes X 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

Name: Katherine Allison Damm

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

9. Do you hold or have you held a medical license in any state? If yes, list each state, the license or registration number, the date issued, and how the license was obtained DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.) ☐ Yes ☒ No

State	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
MSU College of Human Medicine A110 East Fee Hall East Lansing, MI 48824	08/26/02	05/13/06	M.D.
Michigan State University East Lansing, MI 48824	08/31/98	05/03/02	B.S.- Lyman Briggs School Physiology

Provide a description of your professional medical experience. Attach additional sheets if necessary.

Name and Address of Employer	Dates of Practice From	To	Duties

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of their 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: Katherine A Damm Date: 03/29/2006

DM

COHA/MD-093 (03/06)

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

CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL

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 Program Director of the Michigan hospital where you have been appointed. This certification must be submitted to the Board of Medicine by the hospital.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Katherine	Allison	Damm

Social Security Number	Date of Birth
[redacted]	[redacted]

Street Address: William Beaumont Hospital 3601 West 13 Mile Road

City	State	ZIP Code
Royal Oak	Michigan	48073

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)
(989) 670-2994	N/A

Signature of Applicant	Date
Katherine A. Damm	03/27/2006

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR FOR COMPLETION OF SECTION II ON PAGE 2 OF THIS FORM.

Name: Katherine A. Damm

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR

INSTRUCTIONS FOR COMPLETING SECTION II:
Please complete the following information. Return this completed certification directly to the Michigan Board Medicine at the address shown on page 1 of this form.

SECTION II - CERTIFICATION OF RESIDENCY APPOINTMENT

Name of Training Hospital

William Beaumont Hospital

Street Address of Training Hospital

3601 West 13 Mile Road

City, State and ZIP Code

Royal Oak, Michigan 48073

I certify that Kathurine A. Damm has been duly

appointed to a training program in the clinical area of Obstetrics and Gynecology

beginning 7/1/2006 (Month/Day/Year) and ending 6/30/2007 (Month/Day/Year)

at William Beaumont Hospital, Royal Oak (Name of Training Hospital)

Is this program accredited by ACGME? ☒ YES ☐ NO

Is this hospital or institution accredited by JCAH? ☒ YES ☐ NO

Signature of Director of Medical Education

4/6/06
Date of Signature

(S E A L)

John R. Muaich, M.D.
Print or Type Name of Director of Medical Education

If hospital has no seal, please indicate

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

RECEIVED
APR - 5 2006
DEPT. OF CIS-OMS

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 completion of Section II, send this form to 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
Katherine	Allison	Damm
Social Security Number [redacted]	Date of Birth [redacted]	
Street Address: William Beaumont Hospital – 3601 W. 13 Mile Road		
City: Royal Oak	State: MI	ZIP Code: 48073
Daytime Telephone Number: (989) 670-2994	All Previous Names and/or Birth Name Used (if applicable): N/A	
Date of Admission: 08/26/2002.		Date of Graduation: 05/13/2006

Signature of Applicant	Date
Katherine A. Damm	03/29/2006

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

Name: Katherine Allison Damm

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
Michigan State University, College of Human Medicine

Street Address of Medical School
A254 Life Sciences Building

City, State and ZIP Code
East Lansing, MI 48824-1317

I certify that Katherine Allison Damm (Applicant's Name) attended the medical school named above from 08/26/2002 (Month/Day/Year) to 04/28/2006 (Month/Day/Year).

and was/will be granted the degree of Doctor of Medicine on 05/05/2006 (Month/Day/Year).

Marsha D. Rappley — Signature of Dean or Registrar

April 3, 2006 — Date of Signature

(SEAL)

Marsha D. Rappley, N.D., Acting Dean — Print or Type Name of Dean or Registrar

If school has no seal, please indicate

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

DCH-HL-MD-050 (09/06)

[redacted]

Tran Info:430125 12783735 09/06/07
Chk[redacted] Amt: $50.00
ID[redacted]

APPLICATION FOR USMLE STEP 3 EXAMINATION

Authority: Public Act 368 of 1978, as amended

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

☑ USMLE Step 3 Examination Fee: $50.00 71-4301-23

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
KATHERINE	ALLISON	DAMM
[redacted]	[redacted]	Michigan Permanent I.D. Number and Expiration Date

Street Address
1585 E. 13 MILE RD #208

City	State	ZIP Code
MADISON HEIGHTS	MI	48071

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)
248/404-8255	N/A

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you previously taken USMLE Step 3 in Michigan?	☐ Yes	☑ No
2. Have you previously taken USMLE Step 3 in another State? If yes, Please list state(s) and date of exam.	☐ Yes	☑ No
3. Do you now or have you ever held an educational limited license in the State of Michigan? If yes, please give license number below. 4301087565	☑ Yes	☐ No

ELIGIBILITY

To be eligible to take USMLE Step 3, you must establish BOTH of the following:

a) That you have passed USMLE Step 1 and USMLE Step 2 and

b) That you have completed not less than six months of postgraduate clinical training in a program approved by board.

INSTRUCTIONS TO APPLICANT

It is your responsibility to assure that the following two documents are provided to this office directly from their sources:

1) USMLE Step 1 and USMLE Step 2 examination scores from the Federation of State Medical Boards and

2) Certification of completion of at least six months postgraduate clinical training on the enclosed form from your Program Director

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

DCH-LMD-201 (09/04)

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

CERTIFICATION OF POSTGRADUATE TRAINING FOR USMLE EXAMINATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, you will be ineligible to sit for the exam

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 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 - APPLICATION INFORMATION

First Name	Middle Name	Last Name
KATHERINE	ALLISON	DAMM
Social Security Number [redacted]		Date of Birth [redacted]
Street Address: 1585 E. 13 MILE ROAD #208		
City: MADISON HEIGHTS	State: MI	ZIP Code: 48071-5015
Daytime Telephone Number: 248/404-8255	All Previous Names and/or Birth Name Used (if applicable)	

Signature of Applicant	Date
Katherine A Damm	03/27/2007

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

Name KATHERINE A. DAMM

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

William Beaumont

Street Address of Hospital

3601 West 13 Mile Road

City, State and ZIP Code

Royal Oak, Michigan 48073

I certify that Katherine A. Damm, M.D. (Applicant's Name), a graduate of the Michigan State University medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 7/1/2006 (Month/Day/Year) to Present (Month/Day/Year).

In the clinical area of Obstetrics and Gynecology.

Is this 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

April 5, 2007
Date of Signature

John R. Musich, M.D.
Print or Type Name of Director of Medical Education

(SEAL)

If hospital has no seal, please indicate

NOTE: This form may not be completed and submitted to the Board office prior to the completion of the required 6 months of post graduate training. In order to be made eligible for the USMLE examination, the required training must be completed and verified by the established deadline date.

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 : 03/29/2007

Recipient:

Michigan Board of Medicine
ATTN: Carole Hakala Engle, Licensing Director
P.O. Box 30670
Lansing, MI 48909

Examinee: Damm, Katherine
Alt Name(s): Damm, Katherine Allison

Examinee ID#: [redacted]
Date of Birth: [redacted]

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
06/21/2004	[redacted]					

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
12/05/2005	[redacted]					

Clinical Skills (CS)*

Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
11/04/2005	[redacted]					

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

* Performance on the CS component of Step 2 is reported as pass or fail.

UNITED STATES MEDICAL LICENSING EXAMINATION

STEP 3 SCORE REPORT
8/29/2007

FILE COPY

NAME: Damm , Katherine Allison

USMLE ID: 51444438

SSN: [redacted]

TEST DATE: 3/2/2007

REPEAT (Y/N) N

The **USMLE Step 3** is designed to assess whether an examinee possesses the medical knowledge and understanding of clinical science considered essential for the unsupervised practice of medicine, with an emphasis on patient management in ambulatory-care settings. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The two numeric scores shown below are equivalent; each state or territory may use either score in making licensing decisions.

Examinee scores on the three-digit scale score are based upon the number of questions answered correctly on the entire examination. For recent administrations, the mean and standard deviation for first-time takers from U.S. and Canadian medical schools were [redacted] respectively, with most of the scores falling between [redacted].

[redacted]

This result is based on the minimum passing score recommended by USMLE for Step3.

[redacted]

This score is determined by your overall performance on Step 3. A score of [redacted] is recommended by USMLE to pass Step 3. The standard error of measurement (SEM) for this scale is approximately [redacted]

[redacted]

This score is also determined by overall performance on the examination. A score of [redacted] on this scale is equivalent to a score of [redacted] on the scale described above; this is the score set by USMLE to pass Step 3. Based upon recent administrations, the SEM for the two-digit score scale is approximate[redacted]

Michigan Department of Licensing and Regulatory Affairs
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Lansing, MI 48909
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www.michigan.gov/healthlicense

LARA/LMD-040 (04/11) Page 1 of 2

APPLICATION FOR MEDICAL DOCTOR LICENSE

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. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, DEA, 431 Howard Street, Detroit, MI 48226 (1-800-882-9539)

[redacted]

License Number 087565

Controlled Substance License Number [redacted]

Date of Licensure [redacted]

ID: [redacted]

Type or Print Only 053519

I AM APPLYING FOR THE FOLLOWING:

☑ License by ~~Examination~~ Endorsement Fee: $150.00 71-4301-01 8/16/12

☑ Controlled Substance Fee: $85.00 43-01 71-5316

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.

Legal First Name	Legal Middle Name	Legal Last Name
Katherine	Allison	Damm
U.S. Social Security Number [redacted]	**Date of Birth** [redacted]	**Daytime Phone Number** (248) 219-1556
Street Address 5050 S. Lake Shore Dr. #3005		**E-Mail Address** katedamm@me.com
City Chicago	**State** IL	**ZIP Code** 60615
All Previous Names and/or Birth Name Used (if applicable) N/A		
Have you ever held a health professional license in Michigan? ☐ Yes ☑ No (Limited Education license only)	**Michigan Health Professional Permanent I.D. Number and Expiration Date**	

Check the appropriate answer to each of the following questions. NOTE: Submit a detailed explanation for any YES answer you check on a separate sheet with your application.

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 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.

Name: Damm, Katherine A.

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)
Illinois	036.124813	01/07/2010	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
Michigan State University East Lansing, MI	08/1998	05/2002	B.S.
Mich State Univ College of Human Medicine, East Lansing, MI	08/2002	05/2006	M.D.
University of Chicago Chicago, IL	07/2010	current	M.S. candidate

Provide a description of your professional medical experience.
Attach additional sheets if necessary.

Name and Address of Employer	Dates of Practice From	To	Duties
Beaumont Health System Royal Oak, MI	07/06	06/10	House Officer (08/GYN)
Univ. of Chicago Medical Center Chicago, IL	07/10	current	Fellow
Univ. of Chicago Dept OB/GYN Chicago, IL	05/11	current	Clinical Associate

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: Katherine A. Damm Date: 01/09/2012

Pattison, Christine (LARA)

From: aliasresponse@michigan.gov
Sent: Saturday, January 21, 2012 10:36 AM
To: DCH-BHF-CBC
Subject: Administrative Hit/No Hit Notification

STATE OF MICHIGAN
DEPARTMENT OF STATE POLICE
CRIMINAL JUSTICE INFORMATION CENTER
PO BOX 30634, LANSING MI 48909

DATE: 01/21/2012

TCN: AD12968868H01

Requester: MI DEPT OF COMMUNITY HEALTH
Reason Printed: LHP - Licensed Health Care Professional (MCL 333.16174) Subject Printed:
DAMM, KATHERINE A
DOB: [redacted]

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.

MD

Illinois Department of Financial and Professional Regulation
Division of Professional Regulation

Pat Quinn
Governor

Brent E. Adams
Secretary

Jay Stewart
Director
Division of Professional Regulation

CERTIFICATION OF LICENSURE

BUREAU OF HEALTH PROFESSIONS
PO BOX 30670
LANSING, MI 48909

Licensee:	KATHERINE ALLISON DAMM MD
License Number:	036.124813
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	01/07/2010
Expiration Date:	07/31/2014
License Status:	ACTIVE
License Method:	ACCEPT EXAM - USMLE
Disciplinary History:	Has not been disciplined

RECEIVED
FEB 03 2012
DEPT. OF CIS

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.

Jay Stewart #7
Director
Division of Professional Regulation

January 30, 2012
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

US·MLE
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, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3855 – Telephone (817) 868-4041

Date: 01/09/2012

Recipient:

Michigan Board of Medicine
ATTN: Carole Hakala Engle, Licensing Director
611 W Ottawa
1st Floor
Lansing, MI 48933

Examinee: Damm, Katherine
Alt Name(s): Damm, Katherine Allison

Examinee ID#: [redacted]
Date of Birth: [redacted]

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
	06/21/2004	[redacted]					

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
	12/05/2005	[redacted]					

Clinical Skills (CS)*

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
	11/04/2005	[redacted]					

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
MICHIGAN	08/02/2007	[redacted]					

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

LARA/MD-200 (04/11)

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

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FEB 08 2012
DEPT. OF CIS

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 legal 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
Katherine	Allison	Damm
Social Security Number [redacted]	**Date of Birth** [redacted]	
Street Address 5050 S. Lake Shore Drive #3005		
City Chicago	**State** IL	**ZIP Code** 60615
Daytime Telephone Number (248) 219-1556	**All Previous Names and/or Birth Name Used (if applicable)** N/A	

Signature of Applicant	Date
Katherine A. Damm	01/09/2012

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

Name: Damm, Katherine A.

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: William Beaumont Hospitals

Street Address of Hospital: 3601 W 13 Mile Road

City, State and ZIP Code: Royal Oak, MI 48073

I certify that Katherine Damm (Applicant's Name) a graduate of the Michigan State University medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 7/1/2006 (Month/Day/Year), to 6/30/2010 (Month/Day/Year), in the clinical area of Obstetrics and Gynecology.

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] MD — Signature of Director of Medical Education

2/3/12 — Date of Signature

Jeffrey Bevines MD, MPH — 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.