OHS/LMD-851 (12/01)

[redacted]
License Number: 081734
Date of Licensure: 6-17-03

Michigan Department of Consumer & Industry Services
Board of Medicine
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918
TTY (517) 373-7489

Tran:430105 8064074-1 04/24/03
Chk#: 160 Amt: $85.00
ID: MCL

APPLICATION FOR EDUCATIONAL LIMITED AND CONTROLLED SUBSTANCE LICENSES

531501383S

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

Tran:430157 8064074-2 04/24/03
Chk#: 160 Amt: $20.00
ID: MCL

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)

I AM APPLYING FOR THE FOLLOWING:
☒ Educational Limited and Controlled Substance Fee: $170.00

Tran:430137 8064074-3 04/24/03
Chk#: 160 Amt: $65.00
ID: MCL

Daytime Phone Number	Previous License Number
773 MCL	

(Last Name)	(First Name)	(Middle Name)
Hallberg	Amanda	Joy

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

Date of Birth	U.S. Social Security Number
MCL 1977	MCL 15.243(1)(w)

Street Address: 812 Newport Rd

City	State	ZIP Code
Ann Arbor	MI	48103

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 term 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 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
6. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	☐ Yes	☒ No
7. Have you had one or more settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☒ No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	☐ Yes	☒ No
9. Have you ever had a federal or state medical or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes	☒ No
10. Do you hold or have you ever held a medical license in Michigan or any other state? If yes, list each state, the license number, the date issued, and the basis for licensure. **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	Licensure
ILLINOIS	125-044836	6/20/2002	Temporary - resident

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
University of Michigan	8/95	6/98	BA
11	8/98	6/02	MD
St. Joseph / Northwestern	6/02	6/03	Internship.

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 conviction criminal history as part of their pre-licensure screening process, and I authorize this agency to use the information provided in this application to obtain a conviction criminal 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 which 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	Date
Amanda Hallberg	4.11.03

OHS/LMD-093 (9/99)

Michigan Department of Consumer &Industry Services
Board of Medicine
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918
TTY (517) 373-7489

CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL

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

Please complete the following information. **Return this completed certification directly to the Michigan Board of Medicine at the address shown above.**

Name of Training Hospital
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

Street Address of Training Hospital
1500 EAST MEDICAL CENTER DRIVE, MCHC F2306, BOX 0215

City, State and ZIP Code
ANN ARBOR, MI 48109-0215

I certify that AMANDA HALLBERG (Applicant's Name) has been duly appointed to a training program in the clinical area of FAMILY MEDICINE

beginning 6/17/03 (Month/Day/Year), and ending 6/30/04 (Month/Day/Year),

in the UNIVERSITY OF MICHIGAN HEALTH SYSTEM (Name of Training Hospital)

Is this program accredited by ACGME? ☒ YES ☐ NO

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

Andrea Dragon for
Signature of Director of Medical Education

APRIL 4, 2003
Date of Signature

CYNTHIA GRONVALL
Print or Type Name of Director of Medical Education

SEAL

If school has no seal, please indicate.

8392 7817 TM

TRANSCRIPT & CERTIFICATION

APR 2 9 2003

DHS/LMD-091 (8/99)

Michigan Department of Consumer & Industry Services
Board of Medicine
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918
TTY (517) 373-7489

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

RECEIVED
MAY 0 5 2003
DEPT. OF CIS

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

Instructions: Applicant complete Section I. Type or print your name exactly as it appears on your application. Send this form to be completed and mailed directly to the board by 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 I - APPLICANT INFORMATION

Applicant's Name (Last, First, Middle) Hallberg, Amanda, Joy	
Street Address 812 Newport Rd.	
City Ann Arbor	
State MI	Zip Code 48103
Social Security Number MCL 15.243(1)(w)	Date of Birth MCL 15.243(1)(a) /77
Date of Admission 6/98	Date of Graduation 6/2002

Signature of Applicant Amanda Hallberg	Date 4·11·03

Applicant: Upon completion of Section I, send this form to the dean of your medical school for completion of Section II on the reverse side of this form.

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

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

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School	THE UNIVERSITY OF MICHIGAN
Street Address of Medical School	TRANSCRIPT AND CERTIFICATION DEPARTMENT ROOM 555B LSA BLDG. ANN ARBOR, MI 48109-1382
City, State and ZIP Code	

I certify that AMANDA JOY HALLBERG (Applicant's Name) attended the medical school named above from 08-18-1998 (Month/Day/Year), to 06-07-2002 (Month/Day/Year), and was granted the degree of DOCTOR OF MEDICINE on JUNE 07, 2002 (Month/Day/Year).

Paul Robinson
University Registrar

Signature of Dean or Registrar

APR 30 2003
Date of Signature

PAUL ROBINSON
Print or Type Name of Dean or Registrar

SEAL

If school has no seal, please indicate.

DCH/LMD-040 (03/04)

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

Tran Info:430101 9990479-1 12/02/04
Chk#: 1563 Amt: $150.00
ID: MCL

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).

Type or Print Only

I AM APPLYING FOR THE FOLLOWING (Check One Only):

- [X] **License by Examination Fee: $150.00 71-4301-01**
- [ ] **License by EndorsementFee: $150.00 71-4301-09**
  (Must currently be licensed in another state)

License Number: 081734
Date of Licensure: 2/24/05

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
Amanda	Joy	Kaufman

U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date
MCL 15.243(1)(w)	MCL -77	Temporary Only.

Street Address: 812 Newport Rd.

City	State	ZIP Code
Ann Arbor	MI	48103

Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)
734- MCL MCL 15.243(1)(a)	Amanda Joy Hallberg - Birth Name.

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: Amanda Joy Kaufman

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? ☐ Yes ☒ No
If yes, list the state(s) 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 state board verify licensure directly to this board office. (Attach additional sheets, if necessary)**

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
1.	University of Michigan Ann Arbor, Michigan	Aug 1995 – ~~May 1998~~	May 1998	BA
2.	University of Michigan Ann Arbor, Michigan	July 1998	June 2002	MD
3.	St. Joseph Hospital Chicago, ILLINOIS	July 2002	June 2003	Internship – Family Medicine

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

	Name and Address of Employer	Dates of Practice From	To	Duties
4.	University of Michigan Family Medicine Residency	June 2003	June 2005	Residency

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: AKaufman Date: 11/20/04

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

TRANSCRIPT & CERTIFICATION

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
Amanda	Joy	Kaufman

Social Security Number	Date of Birth
MCL 15.243(1)(w)	MCL 15.243(1)(a) 1977

Street Address
812 Newport Rd.

City	State	ZIP Code
Ann Arbor	MI	48103

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)
734- MCL 15.243(1)(a)	Hallberg (Maiden Name)

Date of Admission	Date of Graduation
June 1998	June 2002

Signature of Applicant	Date
A Kaufman	10/20/04

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

Name Amanda Joy Kaufman

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 THE UNIVERSITY OF MICHIGAN
TRANSCRIPT AND CERTIFICATION DEPARTMENT
ROOM 555 LSA BLDG.
ANN ARBOR, MI 48109-1382

City, State and ZIP Code

I certify that Amanda Kaufman **attended the**
(Applicant's Name)

medical school named above from 08/18/1998 (Month/Day/Year) **, to** 06/02/2002 (Month/Day/Year) .

and was/will be granted the degree of Doctor of Medicine **on**

06/07/2002 (Month/Day/Year) .

Signature of Dean or Registrar

1/17/05
Date of Signature

(SEAL)

Paul Robinson - University Registrar
Print or Type Name of Dean or Registrar

If school has no seal, please indicate

DCH/LMD-200 (03/04)

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

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
Amanda	Joy	Kaufman

Social Security Number	Date of Birth
MCL 15.243(1)(w)	MCL 15.243(1)(a) 1977

Street Address
812 Newport Rd.

City	State	ZIP Code
Ann Arbor	MI	48103

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)
734- MCL 15.243(1)(a)	Amanda Joy Hallberg.

Signature of Applicant	Date
A Kaufman	10/20/04

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

Name: Amanda Joy Kaufman

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 of Michigan Health System

Street Address of Hospital
1500 E. Hospital Medical Center DR.

City, State and ZIP Code
Ann Arbor, MI 48109-0239

I certify that Amanda Joy Kaufman (Applicant's Name) a graduate of the University of Michigan medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 06/23/2003 (Month/Day/Year), to 06/30/2004 (Month/Day/Year).

In the clinical area of Family Medicine.

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

Lynn Donnelly signing for — Signature of Director of Medical Education

2-16-05 — Date of Signature

Lisa Colletti, M.D. — 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.

UNITED STATES MEDICAL LICENSING EXAMINATION

STEP 3 SCORE REPORT
9/10/2003

FILE COPY

NAME: Hallberg, Amanda Joy

USMLE ID: 5074[illegible]566

SSN: MCL 15.243(1)(w)

TEST DATE: 8/19/2003

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 207 and 18, respectively, with most of the scores falling between 140 and 260.

Pass

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

MCL 15.243(1)(a

This score is determined by your overall performance on Step 3. A score of 182 is recommended by USMLE to pass Step 3. The standard error of measurement (SEM) for this scale is approximately five points.

This score is also determined by overall performance on the examination. A score of 75 on this scale is equivalent to a score of 182 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 approximately one and a half points.

OHS/LMD-050 (3/03)

Michigan Department of Consumer & Industry Services
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918
TTY (517) 373-7489

APPLICATION FOR USMLE STEP 3 EXAMINATION

Authority: Public Act 368 of 1978, as amended

Tran:430125 8245716-1 06/03/03
Chk#: 1381 Amt: $50.00
ID: MCL

USMLE Step 3 Examination Fee: $50.00 71-4301-25

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.

The Department of Consumer & Industry Services 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.

First Name	Middle Name	Last Name
AMANDA	JOY	HALLBERG
U.S. Social Security Number	Date of Birth	Michigan License Number
MCL 15.243(1)(w)	MCL 1977	4301081734
Street Address		
812 Newport Rd.		
City	State	ZIP Code
ANN Arbor	MI	48103
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
(773) MCL 15.243(1)(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. Will begin 2nd year residency 7.1.03 at U. of Michigan Previously in ILLINOIS	☐ 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

Michigan Department of Consumer & Industry Services
Board of Medicine
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918
TTY (517)373-7489

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: Applicant must complete Section I. Type or print your name exactly as it appears on your licensure application. Have the Director of Medical Education where you completed your postgraduate training complete this form and mail directly to the Board.

SECTION I - APPLICATION INFORMATION

First Name	Middle Name	Last Name
Amanda	Joy	Hallberg
Street Address		
812 Newport		
City		
Ann Arbor		
State		ZIP Code
MI		48103
Social Security Number		Date of Birth
MCL 15.243(1)(w)		MCL -77

Signature of Applicant Amanda Hallberg Date 5.28.03

Applicant: Upon completion of Section I, send this form to your director of medical education for completion of Section II.

USMLE
United States Medical Licensing Examination™

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 06/06/2003

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

RECEIVED
JUN 0 9 2003
BUREAU OF HEALTH SERVICES
LICENSING DIVISION

Examinee: Hallberg, Amanda Joy
USMLE ID#: 5-074-356-6
DOB: [redacted] M / 1977
Alt Name(s):

Results for all 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. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	6/8/2000	PASS	MCL 15.243(1)(a)				

STEP2	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	8/16/2001	PASS	MCL 15.243(1)(a)				

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

Patent 5636874

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination scores is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word VALID will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT, will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first-time examinees from medical schools in the United States was 200 and 20, respectively. Most scores fall between 140 and 280. An equivalent value score on a two-digit scale is also provided. A score of 75 on the two-digit scale is the recommended minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 8 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".

Name Hallberg, Amanda

THIS SIDE TO BE COMPLETED BY THE DIRECTOR OF MEDICAL EDUCATION
Please complete the following information. Return this completed certification directly to the Michigan Board of Medicine at the address shown on the first page.

SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital St. Joseph Hospital
Street Address of Hospital 2900 N. Lake Shore Drive
City, State and ZIP Code Chicago, IL 60657

I certify that Amanda Joy Hallberg (Applicant's Name), a graduate of the University of Michigan medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 6.23.02 (Month/Day/Year) to 6.22.03 (Month/Day/Year) in the clinical area of Family Practice.

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 — May 29, 2003 (Date of Signature)

Roger A. Nosal, M.D., Ph.D.
Print or Type Name of Director of Medical Education
Medical Director, Academic Affairs

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.

November 18, 2004

Michigan Department of Community Health
Board of Medicine
PO Box 30192
Lansing, MI 48909

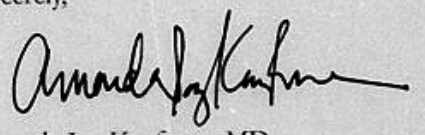
Dear Sir or Madam:

I will be completing my family medicine residency at the University of Michigan in June and will be applying for licensure in the State of Michigan. My application and fee are enclosed. I wish to clarify my chronological record of education preparation.

8/1995 to 5/1998	University of Michigan, Ann Arbor	BA
7/1998 to 6/2002	University of Michigan, Ann Arbor	MD
7/2002 to 6/2003	St. Joseph Hospital, Chicago, Illinois	Family Medicine Internship
7/2003 to 6/2005	University of Michigan, Ann Arbor	Family Medicine Residency

Should it be more convenient, feel free to contact me via email or phone at Hallberg@umich.edu or 734 [MCL] Thank you in advance for your time.

Sincerely,



Amanda Joy Kaufman, MD

812 NEWPORT ROAD • ANN ARBOR, MI • 48103
PHONE: 734- [MCL 15.243(1)(a)]

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

DCH/LPH-090 (07/04)

Tran Info:430157 1061759%-1 05/03/05
Chk#: 1579 Amt: $20.00
ID: 4301081734
Tran Info:430137 1061759%-2 05/03/05
Chk#: 1579 Amt: $65.00
ID: 4301081734

Date of Licensure

License Number

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, prescribe, or dispense controlled substances. If you are an M.D., D.O., D.P.M., D.D.S., O.D. or D.V.M. who prescribes at more than one location, a controlled substance license is required for each location. Please submit a separate application for each location.

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
Amanda	Joy	Kaufman

Street	Telephone Number
4260 Plymouth Road	734-647-5640

City	State	ZIP Code
Ann Arbor	MI	48109-5700

TYPE OF PROFESSIONAL LICENSE

(Please Check One)	Regular		Educational Limited
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐
☒ 43 - 01 M.D. 71-5315	☒		
☐ 51 - 01 D.O. 71-5315	☐		
☐ 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)
4301081734

Expiration Date of License
1/31/2006

Social Security Number

MCL 15.243(1)(w)

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

Signature	Date
A Kaufman	5·2·2005

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.

www.michigan.gov/healthlicense