

60375

ROWLAND, CEYLON

MD R C  
5/31/94

*B+C upgrade*

~~ATB~~

~~BT~~

~~EXAM~~

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**MEDICAL AND CONTROLLED SUBSTANCES LICENSE APPLICATION  
(Continued)**

Provide a complete chronological record of all your educational preparation and work experience to the present date. Attach additional sheets, if necessary.

Name and Address of Institution	Dates of Attendance		Degree Earned
	From	To	
NORTHEAST HIGH SCHOOL MACON, GA	1978	1982	HIGH SCHOOL DIPLOMA
NORTHWESTERN UNIVERSITY EVANSTON, IL	1982	1986	B.S. R.M.E.
GA. STATE UNIV. - ATL. GA. MOREHOUSE SCH. OF MEDICINE ATLANTA, GA	1986	1988	RESEARCH ASSISTANT
	1988	1992	M.D.

**AFFIDAVIT**

I understand that it is the policy of this agency to secure conviction criminal history information 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.

The statements in this application are true and correct. I have not withheld information which might affect the decisions 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 is punishable by law.

Applicant's Signature Clyde W. Rowland Date 5/25/94

Subscribed and sworn before me this 25th day of May, 1994.

Signature of Notary Public Jennifer L. Graham

County of Stamper My Commission Expires on March 11, 1997

JENNIFER L. GRAHAM  
NOTARY PUBLIC STATE OF MICHIGAN  
WAYNE COUNTY  
MY COMMISSION EXP. MAR 11 1997

**CONTROLLED SUBSTANCES LICENSE APPLICATION**

A controlled substances 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 1976, as amended. Information regarding DEA registration may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 357 Federal Building, 231 Lafayette, Detroit, Michigan 48226, (Telephone 313-226-7290).

I hereby make application for a Michigan Controlled Substances License.

Applicant's Signature Clyde W. Rowland Date \_\_\_\_\_

Department of Commerce - Office of Health Services - FEE CARD

OPRLMD-090 (2/92)

YOUR REQUEST IS BEING DELAYED FOR SUBMISSION OF APPROPRIATE FEE CHECKED BELOW. PLEASE ATTACH ALL COPIES OF THIS FORM WITH APPROPRIATE FEE IN THE ENCLOSED ENVELOPE. MAIL CHECK OR MONEY ORDER PAYABLE IN U.S. CURRENCY TO: STATE OF MICHIGAN

BOARD

43

DATE

6-30-94

PROFESSION

- 01
- 02
- 03
- 04
- Other

FEE CODE

- 04 Temporary
- 06 Reinsurance
- 23 Late Renewal
- 37 Controlled Substance
- 51 Certification
- 90 Duplicate License
- Additional Fee
- Other 3257

FEE AMOUNT

- \$ 5.00
- \$ 10.00
- \$ 15.00
- \$ 20.00
- \$ 25.00
- \$ 30.00
- \$ 40.00
- \$ 45.00
- \$ 50.00
- \$ 60.00
- \$ 80.00
- \$ 100.00
- \$ 150.00
- Other \$ 75.00

PLEASE COMPLETE:

LICENSE NUMBER

060375

SOCIAL SECURITY NUMBER

MCL 15.243(1)(w)

Please return enclosed documents with Fee Card, if applicable.

Ceylon Rowland, MD  
 26480 Berg Rd #1210  
 Southfield, MI 48034



NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

Diplomate Name: Ceylon Maurice Rowland, MD

Date of Birth: MC 1965

Certification Date: 07/01/1993

Certificate #: 412680

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME PART I	Jun 1990	MCL 15.243(1)(a)		PASS	MCL 15.243(1)(a)						
NBME PART II	Sep 1991	MCL 15.243(1)(a)		PASS	Med	Surg	Ob/Gyn	PM/PH	Ped	Psych	
NBME PART III	May 1993	MCL 15.243(1)(a)		PASS							

DATE: 06/22/1994

SEE OTHER SIDE FOR SCORE INFORMATION

PAGE: 1 of 1

MI1060



STATE OF MICHIGAN  
BOARD OF MEDICINE  
P.O. BOX 30192  
LANSING, MICHIGAN 48909  
(517) 335-0918

### CERTIFICATION OF POSTGRADUATE TRAINING

Authority: P.A. 368, as amended.

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 director of medical education where you completed your postgraduate training.

#### SECTION I - APPLICANT INFORMATION

Applicant's Name (Last, First, Middle)	
ROWLAND, CEYLON MAURICE	
Street Address	
20480 BERG ROAD, #1210	
City	
SOUTHFIELD	
State	Zip Code
MICHIGAN	48034

Social Security Number	Date of Birth
MCL 15.243(1)(w)	MCL 15.243(1)(a) 65

Signature of Applicant	Date
Ceylon W. Rowland	05-02-94

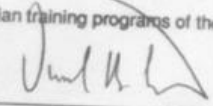
**Applicant:** Upon completion of Section I, send this form to your director of medical education for completion of Section II on the reverse side of this form.

(SEE OTHER SIDE)

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 reverse side of this form.

### SECTION II - CERTIFICATION OF POSTGRADUATE TRAINING

Name of Hospital	Wayne State University/Hutzel Hospital		
Street Address of Hospital	4707 St. Antoine		
City, State and Zip Code	Detroit, Mi 48201		
<b>CERTIFICATION</b>			
I certify that	Ceylon Rowland <small>(Applicant's Name)</small>	a graduate of the	
	Morehouse School of Medicine	medical school,	
has successfully completed postgraduate clinical training offered by the hospital named above			
from	July 1	19 92	through Present
		19	
in the clinical area of Obstetrics and Gynecology			
Is this training program accredited by ACGME or by the national joint committee on accreditation of preregistration physician training programs of the Canadian medical association? <input type="checkbox"/> YES <input type="checkbox"/> NO			
* 		+	
Signature of Director of Medical Education		Date of Signature	
Dr. David B. Cotton		(SEAL)	
Print or Type Name of 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.

STATE OF MICHIGAN  
 BOARD OF MEDICINE  
 P.O. BOX 30192  
 LANSING, MICHIGAN 48909  
 (517) 335-0918

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

Authority: P.A. 368, as amended.

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) ROWLAND, CEYLON MAURICE	
Street Address 20480 BERG ROAD, APT. #1210	
City SOUTHFIELD	
State MICHIGAN	Zip Code 48034
Social Security Number MCL 15.243(1)(w)	Date of Birth MCL 15.243(1)(a) - 65
Date of Birth JULY 1988	Date of Graduation MAY 1992

Signature of Applicant Ceylon M. Rowland	Date 05-01-94
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**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.**


(SEE OTHER SIDE)



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 Morehouse School of Medicine	
Street Address of Medical School 720 Westview Drive	
City, State and Zip Code Atlanta, Georgia 30310	
I certify that <u>Ceylon Maurice Rowland</u> attended the medical school <small>(Applicant's Name)</small>	
named above from <u>July 6,</u> 19 <u>88</u> , through <u>April 30</u> , 19 <u>92</u>	
and was/will be granted the degree of <u>Doctor of Medicine</u>	
on <u>May 16</u> , 19 <u>92</u>	
<u>Claudia B. Cian</u> <small>Signature of Dean or Registrar</small>	<u>5-27-94</u> <small>Date of Signature</small>
<u>CLAUDIA B. CIAN</u> <small>Print or Type Name of Dean or Registrar Registrar</small>	<b>(SEAL)</b> 
<small>If school has no seal, please so indicate.</small>	
<b>NOTE:</b> This certification must be returned by the medical school directly to the Michigan Board of Medicine and the address shown above.	

Date Approved: 6-30-92 AID & REG.

License No. 060375 AMT. REGD. \$140.00

Approved by: TJ

MAY 29 1992

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATION  
BOARD OF MEDICINE  
P.O. BOX 30192  
LANSING, MICHIGAN 48909  
(517) 373-0680

LMD-851 (3-89)

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

### APPLICATION FOR LIMITED MEDICAL AND CONTROLLED SUBSTANCE LICENSES

I am applying for the following license(s):

Limited Educational  
Fee: \$80.00

Limited Clinical Academic  
Fee: \$80.00

Controlled Substance  
Fee: \$60.00

#### APPLICANT INFORMATION

This application will not be accepted unless properly signed and sworn to by the applicant before a notary public. Your fee should accompany this application and should be in the form of a check or money order. No responsibility will be assumed for fees sent in any other manner.

NAME OF APPLICANT (last, first, middle)

Rowland, Ceylon Maurice

LIST PREVIOUS NAMES USED:

ADDRESS (no. street, state, zip)

GRADUATE MEDICAL EDUCATION  
4201 ST. ANTOINE BOULEVARD  
DETROIT, MI 48201

DATE OF BIRTH

MCL 15.243(1)(a) 1965

SOCIAL SECURITY

MCL 15.243(1)(w)

CHECK THE APPROPRIATE ANSWER TO EACH OF THE FOLLOWING QUESTIONS. ATTACH DETAILED EXPLANATION FOR ANY YES ANSWER YOU CHECK.

Have you ever been convicted of a crime?  YES  NO

Have you ever been under treatment for addiction or insobriety?  YES  NO

Have you ever been warned, censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges modified?  YES  NO

Are you now or have you ever been a defendant in a malpractice civil suit?  YES  NO

Have you ever been denied the privilege of taking an examination by any state medical board?  YES  NO

Have you ever had a medical or controlled substance license, certificate, registration or approval revoked or suspended, or have you ever been otherwise disciplined by a medical board or a board responsible for regulating controlled substances?  YES  NO

Do you currently have any charges or complaints pending against you before a medical board or a board responsible for regulating controlled substances?  YES  NO

Have you ever held a restricted state or federal license, registration, or approval?  YES  NO

Do you hold or have you ever held a medical license in this or any other state? If yes, list each state below and the date such license was issued and cause certification of license in good standing to be submitted directly from all other states:  YES  NO

Provide a complete chronological record of all your educational preparation and work experience to the present date. Attach additional sheets if necessary.

NAME AND ADDRESS OF INSTITUTION	DATES OF ATTENDANCE		DEGREE OBTAINED
	From	To	
Northeast H.S. - Macon, GA	1978	1982	H.S. Diploma
Northwestern Univ - Evanston, IL	1982	1986	B.S.
Morehouse Sch of Med - Atl, GA	1988	1992	M.D.
Georgia State University	1986	1988	

I understand that it is the policy of the Department of Licensing and Regulation to secure conviction criminal history information as part of their pre-licensure screening process, and I authorize the department to use 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. I hereby certify that the information in this application is true and correct and I hereby make application for limited licensure in Michigan.

Signature Ceylon W. Rowland Date 5/12/92  
 Submitted and sworn to before me this 12th day of May, 1992  
 Signature of Notary Public Jamison Mosley  
 County of Fulton My commission expires June 5, 1992

**CONTROLLED SUBSTANCE LICENSE APPLICATION**

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, 357 Federal Building, 231 Lafayette, Detroit, Michigan 48226 (Telephone 313-226-7290).

I hereby make application for a Michigan controlled substance license.  
 Signature Ceylon W. Rowland Date 5/12/92

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

This certifies that Ceylon Rowland  
(name of applicant)

has been duly appointed to a training program in the clinical area of Obstetrics/Gynecology

beginning July 1 1992 and ending June 30 1993

in the Wayne State University/Detroit Medical Center  
(name of training hospital)

4201 St Antoine 9C Detroit, MI 48201  
(Address of hospital - this address will be printed on license)

Mary F. Euth  
Type or print name of Director of Medical Education

Mary F. Euth  
Signature

5-26-92  
Date



Is program accredited by ACGME?

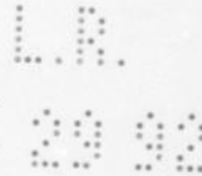
YES NO

Is hospital or institution accredited by JCAH?

If hospital is not accredited, 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 30192  
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

**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 I: APPLICANT INFORMATION	
NAME OF APPLICANT (last, first, middle) <u>Rowland, Ceylon, Maurice</u>	
COLLEGE PARK GA 30337	
MCL 15.243(1)(a) [REDACTED]	SOCIAL SECURITY NUMBER [REDACTED] MCL 15.243(1)(w)
MCL [REDACTED] 65	
DATE OF ADMISSION <u>JULY 5, 1988</u>	DATE OF GRADUATION <u>MAY 16, 1992</u>
SECTION II: CERTIFICATION OF MEDICAL EDUCATION	
NAME OF MEDICAL SCHOOL <u>Morehouse School of Medicine</u>	
FULL ADDRESS OF MEDICAL SCHOOL <u>720 Westview Drive, Atlanta, Georgia 30310</u>	

I certify that Ceylon Maurice Rowland attended the medical school named  
above from July 6, 19 88 through April 30 19 92 and was/will  
be granted the degree of Doctor of Medicine  
on May 16 19 92

June 1, 1992  
(Date)

Angela W. Franklin, Ph.D.  
Signature of Dean or Registrar  
Angela W. Franklin, Ph.D.

( S E A L )

Angela W. Franklin, Ph.D.  
Type or Print Name of Dean or Registrar

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