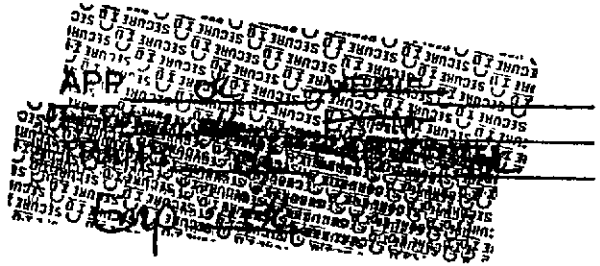
Wolfe, Taida Jamour
[redacted] 4301940556
CS - 3
April 20, 2015



FOR BOARD USE ONLY
License # 5315070386
Issue Date 5-14-2015

Bureau of Health Care Services
Health Licensing Division
PO Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

Tran Info:430137 20384264-1 04/20/15
Chk#: 101 Amt: $65.00
ID: 4301094056

CONTROLLED SUBSTANCE LICENSE APPLICATION

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 3 68 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 All practitioners, and veterinarians who dispense controlled substances in Schedules 2-5 must report this prescription data to the Michigan Automated Prescription System (MAPS) as stated in Board of Pharmacy Rules 338 3162d YOUR ADDITIONAL CONTROLLED SUBSTANCE LICENSE WILL EXPIRE ON THE SAME DATE AS YOUR PROFESSIONAL LICENSE

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard St., Detroit, MI 48226 (800) 882-9539 The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process

INSTRUCTIONS

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

2. 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 13-24 months the fee is $160 00 25-36 months the fee is $235 00

3. M D./D O Applicants. This application may not be used for physicians who are prescribing for drug treatment programs Please request an application for the Prescribing Physician in a Drug Treatment Program

4. 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.

Please select the license you are applying for from the drop down list below:

Medical Doctor Expiring in 0-12 Months Fee: $85.00 71-5315-13757

Tran Info:430157 20384264-2 04/20/15
Chk#: 101 Amt: $20.00
ID: 4301094056

Business Name: University of Michigan Von Voightlander Hospital		
First Name: Taida	Middle Name Jamour	Last Name: Wolfe
Street Address. [redacted]		Apt/Bldg #:
City. [redacted]	State: [redacted]	Zip Code: [redacted]
Michigan Health Professional ID/License Number. 4301094056		Expiration Date 1/31/2016
U.S. Social Security #: [redacted]	Phone Number: [redacted]	

Note: If you answer "yes" to the question below, you must provide a detailed explanation with copies of all official and/or court documents related to your explanation along with your application. If you do not provide the explanation, your application will be deemed incomplete and processing will be delayed.

1 Have you ever been fined, denied, revoked, suspended, reprimanded, placed on probation, otherwise disciplined, or the subject of a final adverse action by a licensure, registration, disciplinary or certification board as a holder of or applicant for, a license or registration regulated by this state, another state or territory of the United States, the United States military, the federal government, or another country?

☐ Yes
☒ No

If yes, please explain

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

Signature of Applicant _____ Date 4/16/15

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status,

Wolfe, Taida Jamour
[redacted] 4301094056
Medical Doctor
February 13, 2015

DE ok

[redacted] ok

[redacted] ok

[redacted] ok

LARA/REL-400 (05/14)

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Care Services
Health Licensing Division
PO Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

FOR BOARD USE ONLY

License Number: 0940516
CS License Number:
Issue Date: 3-20-15

Tran Info:430106 20200484-1 02/13/15
Chk#: 686 Amt: $170.00
ID: [redacted]

APPLICATION FOR RELICENSURE

Please select the license type you are applying for from the drop down list below:

Medical Doctor by Relicensure Fee: $170.00 71-4301-06

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

1. Demographic Information

First Name:	Middle Name	Last Name:
Taida	Jamour	Wolfe

U.S. Social Security #: [redacted] Birth Date: [redacted]

Street Address: [redacted] Apt/Bldg #:

City: [redacted] State: [redacted] Zip Code: [redacted]

Country: [redacted]

Phone Number: [redacted] Email Address: [redacted]

Has your Michigan health professional license been lapsed more than three years? ☐ Yes ☒ No

Health Professional Permanent ID/License Number: 4301094056

Expiration Date: 01/31/2013

Have you ever been known under any other name? ☐ Yes ☒ No
If yes, list name(s):

Will documents be received in any other name? ☐ Yes ☒ No
If yes, list name(s):

Full Name: Taida Wolfe

2. Personal Data Questions

1 Have you ever been convicted of a felony?

☐ Yes
☒ No

If yes, please explain

2 Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?

☐ Yes
☒ No

If yes, please explain

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

If yes, please explain

4. Have you had 3 or more malpractice settlements, awards, or judgements in any consecutive 5 year period?

☐ Yes
☒ No

If yes, please explain

5 Have you had one or more malpractice settlements, awards, or judgements totaling $200,000 in any consecutive 5 year period?

☐ Yes
☒ No

If yes, please explain

6 Have you ever been fined, denied, revoked, suspended, reprimanded, placed on probation, otherwise disciplined, or the subject of a final adverse action by a licensure, registration, disciplinary or certification board as a holder of or applicant for, a license or registration regulated by this state, another state or territory of the United States, the United States military, the federal government, or another country?

☐ Yes
☒ No

If yes, please explain

7 Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care staff privileges involuntarily modified?

☐ Yes
☒ No

If yes, please explain

8 Have you ever been treated for substance abuse in the past 2 years?

☐ Yes
☒ No

If yes, please explain

Note: If you answered "yes" to any of the questions in Section 2 (questions 1-8), you must provide a detailed explanation with copies of all available official and/or court documents related to your explanation along with your application. If you do not provide the explanation, your application will be deemed incomplete and processing will be delayed.

Full Name: Taida Wolfe

3. Professional Education

Name of Institution	Address of Institution	Graduation Date	Certificate/Diploma/Degree Granted
Tufts University School of Medicine	145 Harrison Avenue, Boston, MA 02111	5/2005	MD
Saint Barnabas Medical Center	91 Old Short Hills Road, Livingston, NJ	6/2009	OB/GYN residency

4. License(s) in Other State(s) and/or Province(s)

Do you hold or have you ever held a permanent health professional license, certification, or registration in any state or province? If yes, list each state or province, the license or registration number, the date issued and how the license was obtained (either examination or endorsement). **DO NOT LIST TEMPORARY/LIMITED LICENSES** (Attach additional sheets if necessary)

☒ Yes
☐ No

State/Country	Permanent License/ Registration Number	Date of Issue	Number of Years Licensed	Expiration Date	How Obtained (Exam or Endorsement)
New Jersey	25MA09053900	02/09/2012	> 3 years	6/30/2015	Application/Exam
Pennsylvania	MD444079	09/01/2011	> 3 years	12/31/2016	Application/Exam
Delaware	C1-0010542	07/17/2013	~ 2 years	03/31/2015	Application/Exam

5. 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, 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 _____ Date 2/5/15

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs If you need assistance with reading writing, hearing, etc , under the Americans with Disabilities Act, you may make your needs known to this agency

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MIKE ZIMMER
DIRECTOR

MEMORANDUM

DATE: February 25, 2015

TO: Board of Medicine

FROM: Dan Burns
Health Licensing Division
Credentials Unit

RE: Taida Jamour Wolfe MD
LICENSE #: 4301094056

The above referenced licensee has earned the 150 hours of continuing education required for relicensure.

CANNON BUILDING
861 SILVER LAKE BLVD , SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE (302) 744-4500
FAX (302) 739-2711
WEBSITE WWW.DPR.DELAWARE.GOV

2/5/2015 2 48 48PM

This is to certify that the records of the **Delaware Board of Medical Licensure and Discipline** show that the following person was issued a(n) **Physician M.D.** license.

Taida Wolfe

LICENSE NUMBER:	C1-0010542
LICENSURE DATE:	07/17/2013
EXPIRATION DATE:	03/31/2015
STATUS:	**Active**
DISCIPLINARY ACTION:	Good standing with no disciplinary action taken.

This license information was last updated on 02/02/2015

To expedite the verification process, the information above is the only verification provided by this office If other information is needed, please contact the Division at (302) 744-4500 or email customerservice dpr@state.de us <mailto customerservice.dpr@state de us>.

Sincerely,

DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

New Jersey Office of the Attorney General
Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183, Trenton, NJ 08625-0183

JOHN J. HOFFMAN
Acting Attorney General

STEVE C. LEE
Acting Director

For overnight deliveries:
140 East Front St
PO Box 183 , 3rd Floor
Trenton, NJ 08608
(609) 826-7100
(609) 826-7101 FAX

February 23, 2015

Michigan Board Department of Licensing
P.O. Box 30670
Lansing , MI 48909-8170

To Whom It May Concern:

The New Jersey State Board of Medical Examiners has been requested by Taida J Wolfe to forward a letter of good standing regarding the Medical Doctor's license to practice in the State of New Jersey.

A review of the Board's files indicates that Taida J Wolfe was issued a New Jersey license 25MA09053900 on or about 02/09/2012 and is currently Active with an expiration date of 06/30/2015. A review of the Board's files further indicates that no public disciplinary action has been taken against this Medical Doctor.

Very truly yours,

BOARD OF MEDICAL EXAMINERS

William V. Roeder
Executive Director

WVR/dd/mac

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O Box 2649
Harrisburg, PA 17105-2649
www.dos.pa.gov

February 17, 2015

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	TAIDA JAMOOR WOLFE
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD444079
ORIGINAL LICENSURE DATE:	09/01/2011
EXPIRATION DATE:	12/31/2016
STATUS:	Active

The license is in good standing and the records indicate no derogatory information.

SEAL

Acting Commissioner
Bureau of Professional and Occupational Affairs

Wolfe, Taida Jamoor
Medical Doctor 4130109405G
March 09, 2009

Fee
[redacted] ~~Affect~~
Med Ed
PGT
Exam Scores
~~ECFMG~~
~~HOSP APPT~~
CBC

RQC

Exam

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

DCH/LMD-040 (02/06)

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).

Tran Info:430101 14755171-1 03/09/09
ChkN: 610 Amt: $150.00
ID: [redacted]

License Number 094054

Date of Licensure 5/5/09

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

☑ **License by Examination Fee: $150.00 71-4301-01**

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
Todd A	Damour	Wolfe
U.S. Social Security Number [redacted]	Date of Birth [redacted]	Daytime Phone Number [redacted]
Street Address [redacted]		
City [redacted]	State [redacted]	ZIP Code [redacted]
All Previous Names and/or Birth Name Used (if applicable)		
Have you ever held a health professional license in Michigan? ☐ Yes ☑ No	Michigan Permanent I.D. Number and Expiration Date	

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: Tada Wolfe

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)

RECEIVED
APR 10 2009
DEPT. OF LEG

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
Dartmouth College Hanover NH 03755	Sept 94	June 1998	A.B Biological + Women Studies
New York University Robert Wagner School of Public Service	Sep 1998	May 2000	Master's in Public Administration
Tufts School of Medicine	Aug/Sept 2001	May 2005	Doctor of Medicine

Provide a description of your professional medical experience.
Attach additional sheets if necessary. (none except residency)

Name and Address of Employer	Dates of Practice From	To	Duties
Saint Barnabas Hospital OB/GYN residency	July 2005	June 2009	OB/GYN Resident

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: [signature] Date: 4/4/09

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

DCH/LPH-090 (12/05)

Tran Info:430157 14755171-2 03/09/09
Chk#: 610 Amt: $20.00
ID: [redacted]

Tran Info:430137 14755171-3 03/09/09
Chk#: 610 Amt: $65.00
ID: [redacted]

[redacted]

License Number 040298

Date of Licensure 5/5/09

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
Tada	Jamour	Wolfe

Street	Telephone Number
36 Ball Terrace	201-506-2005

City	State	ZIP Code
Maplewood	NJ	07040

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	☑	or	☐
☐ 51 - 01 D.O. 71-5315	☐	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)

Expiration Date of License

Social Security Number [redacted]

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

Signature Tada Wolfe Date 3/1/09

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.

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: 02/23/2009

Recipient:

Michigan Board of Medicine
ATTN: Carole Hakala Engle, Licensing Director
611 W Ottawa
4th Floor
Lansing, MI 48909

Examinee ID#: 5-118-415-8
Date of Birth: [redacted]

Examinee: Wolfe, Taida
Alt Name(s): Wolfe, Taida Jamour

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
06/11/2003	Pass	[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
09/29/2004	Pass	[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
04/16/2005	Pass					

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score Total	Three-Digit Score MP	Two-Digit Score Total	Two-Digit Score MP	Comments
NEW JERSEY	11/07/2006	Pass	[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.

DCH/LMD-200 (03/08)

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

RECEIVED
FEB - 2 2009
DEPT. OF LEG

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
Taida	Jamour	Wolfe
Social Security Number	Date of Birth	
[redacted]	[redacted]	
Street Address		
[redacted]		
City	State	ZIP Code
[redacted]	[redacted]	[redacted]
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
[redacted]	W/A	

Signature of Applicant	Date
Taida Wolfe	1/27/09

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

DCH/LMD-200 (03/06)

Name Taida Wolfe

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
Saint Barnabas Medical Center

Street Address of Hospital
94 Old Short Hills Rd.

City, State and ZIP Code
Livingston, NJ 07039

I certify that Taida Wolfe, MD (Applicant's Name) a graduate of the Tufts school of Medicine medical school, has successfully completed postgraduate clinical training offered by the hospital named above from 7/1/05 (Month/Day/Year), to 6/30/09 (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 of Director of Medical Education

1-29-09
Date of Signature

Henry Rosenberg, MD
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.

DCH/LMD-091 (03/04)

Michigan Department of Community Health
Board of Medicine
P.O. Box 30192
Lansing, MI 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: 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 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
Tanda	Jamour	Wolfe
Social Security Number	Date of Birth	Daytime Telephone Number
[redacted]		
[redacted]		
City [redacted]	State [redacted]	ZIP Code
All F[redacted]icable)		
N/A		
Date of Admission		Date of Graduation
Sept 2001		May 2005

Signature of Applicant	Date
Tanda Wolfe	1/27/09

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

DCH/LMD-091 (03/04)

Name: Taida Wolfe

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

TUFTS UNIVERSITY SCHOOL OF MEDICINE

Street Address of Medical School

145 HARRISON AVE.

City, State and ZIP Code

BOSTON, MA 02111

I certify that TAIDA J. WOLFE (Applicant's Name) attended the medical school named above from 8/27/01 (Month/Day/Year) to 3/25/05 (Month/Day/Year)

and (was)/will be granted the degree of DOCTOR OF MEDICINE on _____ (Month/Day/Year).

[signature]

Signature of Dean or Registrar

1/28/08

Date of Signature

AMY KUHLIK MD DEAN FOR STUDENTS

Print or Type Name of Dean or Registrar

(SEAL)

If school has no seal, please indicate