STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF LICENSING AND REGULATION

ELIZABETH P HOWE, Director

Michigan Board of Medicine
P.O. Box 30018
Lansing, Michigan 48909
Telephone: (517) 373-0680

November 1, 1984

Debra Lynn Birenbaum, M.D.
University of Mich. Hlth.Ctr.
Women's Hospital
Ann Arbor, Mich. 48109

Dear Doctor:

We are enclosing your copy of Michigan medical licensure # 48037 dated ~~Oct. 31, 1984~~, and effective to ~~Jan. 31, 1986~~.

This certificate will enable you to practice medicine and apply for your Controll Substances Registration, and hospital staff privileges.

The engraved certificate of medical licensure will be ordered and forwarded to you when it has been obtained from the engraver, and the proper seal and signatures affixed. This usually takes several months.

YOU ARE ADVISED TO KEEP THIS OFFICE INFORMED OF ANY CHANGE IN ADDRESS.

PLEASE NOTE ENCLOSURES:

1. Continuing Medical Education Rules
2. Rules - Standards of Practice Regarding Amphetamines
3. Informational material from the Michigan Department of Health

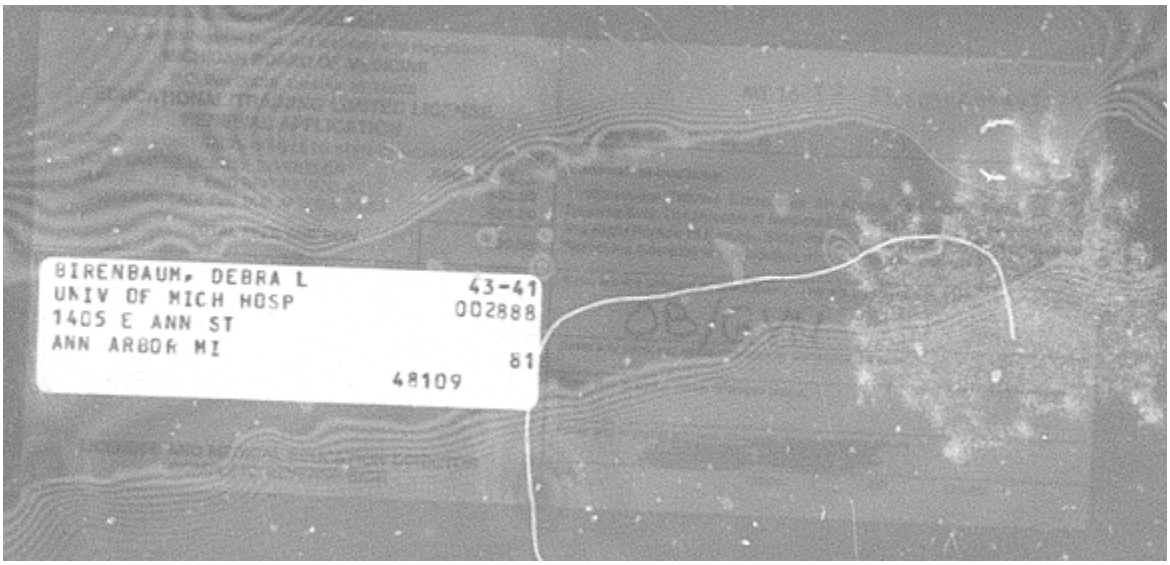
Sincerely yours,

MICHIGAN BOARD OF MEDICINE

Herman Fishman
Licensing Executive

Encls.

NOTE: Copy of the Michigan Public Health Code, Act 368, PA 1978, as amended, may be obtained by forwarding a check for $2.00 for each booklet to: Receipts Accounting Section, Dept. of Licensing & Regulation, P.O. Box 30018, Lansing, MI 48909. Checks should be made payable to State of Michigan - P.H.S.R.P.


BIRENBAUM, DEBRA L
UNIV OF MICH HOSP
1405 E ANN ST
ANN ARBOR MI
48109
43-41
002888
81

Fee paid 10-12-84 165.00
Rec # 04536

LMD-050 (10/82)

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATION
MICHIGAN BOARD OF MEDICINE
P.O. BOX 30018
Lansing, Michigan 48909

(DO NOT WRITE IN THIS SPACE)

APPLICATION FOR LICENSURE BY EXAMINATION (NATIONAL BOARDS)

Approved by _____

FEE $165.00 — Make check or money order, in U.S. currency, payable to: STATE OF MICHIGAN — MEDICINE
(ALL FEES SUBMITTED ARE NOT REFUNDABLE)

INSTRUCTION TO APPLICANT
1. If additional space is necessary, use separate paper.
2. The application must be completely filled out.
3. The affidavit must be properly completed.
4. Before a license is issued, a personal appearance before the Board may be required.
5. Examination dates and locations will be determined by the Board.

BIRENBAUM DEBRA LYNN
NAME OF APPLICANT (last) (first) (middle)

Mail to →
[redacted]
ADDRESS (No., Street, City, State, Zip)

ANN ARBOR MI 48105

DATE OF BIRTH

* Business: Univ of Mich Hosp - Women's Hosp. A.A. 48109

1. Have you ever been convicted of a felony or misdemeanor for which you could have been sent to jail? (You may exclude traffic violations not related to alcohol or substance abuse.)	☐ Yes ☑ No	If yes, do NOT give details at this time.
2. Have you ever had an adverse civil judgment (including malpractice)?	☐ Yes ☑ No	If yes, state subject of judgment.
3. Have you been examined by the National Board or any State Board of Medicine?	☐ Yes ☑ No	If "YES", give details.
4. Do you hold a license to practice medicine in any state or states?	☐ Yes ☑ No	If "YES", give states.

5. EDUCATIONAL RECORD

	NAME AND LOCATION OF INSTITUTION ATTENDED	DATES OF ATTENDANCE Mo/Yr	TO	Mo/Yr	Degrees Obtained
MEDICAL EDUCATION (Submit Dates for Each School Year)	TEMPLE UNIVERSITY SCHOOL OF MEDICINE	9/78		6/79	
		9/79		6/80	
		6/80		6/81	
		6/81		5/82	MD
POST GRADUATE EDUCATION	UNIVERSITY OF MICHIGAN - DEPT OB/GYN	6/82		6/83	
		6/83		6/84	
		6/84 -		present	

Note: Please attach complete summary of medical training and experience

6. AFFIDAVIT OF APPLICANT

STATE OF	COUNTY OF	DATE
Michigan	Ingham	10-12-84

Debra L. Birenbaum being duly sworn, deposes and says that he is the applicant named in the foregoing application for a Certificate to practice Medicine and Surgery in the State of Michigan; that he has read the foregoing application and knows the contents thereof and swears the same to be true.

Debra Lynn Birenbaum
Signature of Applicant in Full

Subscribed and sworn to before me Genevieve Dionne
NOTARY PUBLIC
Aug. 4, 1986
MY COMMISSION EXPIRES

Note: This form required by PA368 of 1978, as amended. Must be completed for licensure

7. POST-GRADUATE TRAINING

(This space should be left blank if the required residency has not been completed at the date the application is submitted)

I hereby certify that Dr._____ satisfactorily served twelve months _____ (Rotating or mixed or straight)

_____ residency

_____ internship in_____Hospital from_____ (DATE) to_____ (DATE)

(CHECK ONE OF ABOVE)

SEAL

ADDRESS OF HOSPITAL

DATE

SIGNATURE OF MEDICAL DIRECTOR, SUPERINTENDENT OR CHIEF OF STAFF

omit

8. CERTIFICATE OF DEAN, SECRETARY OR REGISTRAR OF MEDICAL COLLEGE

I hereby certify that I have reviewed the answers in the above application. I certify that to the best of my knowledge all of the within answers or statements are true and are a matter of official record in this school, and that I am unaware of information that would suggest that said applicant is not of good moral and professional character.

I further certify that _____ M.D. matriculated in the _____ (Name and Address of Medical School)

on _____ (Date) and was graduated _____ (Date) at which time, he was granted the

degree of_____ If the degree, Bachelor of Medicine is conferred upon completion of four years of medical school, further state the conditions and time the degree, Doctor of Medicine will be granted

_____

_____

SEAL

NAME AND ADDRESS OF MEDICAL SCHOOL

DATE

SIGNATURE OF DEAN, SECRETARY OR REGISTRAR

9. NATIONAL BOARD CERTIFICATE OF RECORD: (copies are not acceptable)
Please submit your National Board Certificate of Records with this application:
or you may ask the National Board to forward it director to this office.

MICHIGAN DEPARTMENT OF
LICENSING AND REGULATION
P.O. Box 30018
Lansing, MI 48909

LAD-530 (11/81)

OCT 12 1 84644443 ***165.00

Do not write in this space

COUNTER PAYMENT

Please print. Make check or money order, in U.S. Currency, payable to "STATE OF MICHIGAN" (name of board).

Name	Board
Debra L. Birenbaum	Medicine
Street Address [redacted]	**Type of License** Lic by N.B. (1)
City Ann Arbor **State** **ZIP Code** 48105	**License Number**

Is this a new address? - ☐ Yes ☐ No

The University of Michigan Hospitals

OFFICE OF CLINICAL AFFAIRS

A6019 Box 54
Ann Arbor, Michigan 48109

Keep for [illegible]

MICHIGAN BOARD OF MEDICINE
905 SOUTHLAND
P.O. BOX 30018
LANSING, MICHIGAN 48909

CERTIFICATE OF TRAINING:

This certifies that Debra Lynn Birenbaum M.D.
was
~~Was/Was~~ appointed to the position of:

Categorical 1st year in _____

Categorical* 1st year in _____

1st year Resident in Obstetrics & Gynecology

NAME OF HOSPITAL University of Michigan Hospitals

beginning June 24, 1982 and ending June 30, 1983.

DATE: October 12, 1984

Confirmed as satisfactorily completed 10-12-84 this year of training per Arlene Schneider Adm. Asst

Herbert Sloan

Herbert Sloan, M.D.
Chief of Clinical Affairs

G. Bonnie

Hospital Seal

ars
2/15/83

Office (313) 764-3186 Staff Records (313) 764-3194

NATIONAL BOARD OF MEDICAL EXAMINERS** 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Debra L. Birenbaum, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest C. WILLIAM DAESCHNER, JR., M.D.
Chairman of the Board

SEAL EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa.
07/01/83

Certificate # 267600

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from TEMPLE U. SCHOOL MEDICINE in MAY 1982 and whose birth date is [redacted]/1956. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

RECEIVED
OCT 30 1984
DEPT. OF LIC. & REG.
BOARD OF MEDICINE

RECEIVED
OCT 30 1984
DEPT. OF LIC. & REG.

	Standard Score	Scale [redacted]
PART I passed 06/80		
Anatomy, incl. histology and embryology		
Physiology		
Biochemistry		
Pathology		
Microbiology, incl. immunology		
Pharmacology and Materia Medica		
Behavioral Sciences		
TOTAL TEST (Minimum Passing Score 380/75)		
Part II passed 09/81		
Internal medicine and the medical specialties		
Surgery and the surgical specialties		
Obstetrics and Gynecology		
Public Health and Preventive Medicine		
Pediatrics		
Psychiatry		
TOTAL TEST (Minimum Passing Score 290/75)		
PART III passed 03/83		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)		
GENERAL AVERAGE (Parts I, II, and III Scale Score)		

Received 10-30-84 JJ Thomas

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Ann K. Heverling
Secretary for Certification
10/26/84

SEAL

Date

State of Michigan – Dept. of Licensing and Regulation
MICHIGAN BOARD OF MEDICINE
P.O. Box 30018, Lansing, MI 48909
EDUCATIONAL/TRAINING LIMITED LICENSE RENEWAL APPLICATION

MAKE CHECK OR MONEY ORDER PAYABLE TO: STATE OF MICHIGAN – MEDICINE

YOUR LIMITED LICENSE EXPIRES ON	JUNE 30, 1984.
RENEWAL FEE IF PAID BEFORE 6-30-84	$30.00
ADDITIONAL LATE FEE DUE AFTER 6-30-84	$20.00
TOTAL FEES DUE NOW	$30.00

BIRENBAUM, DEBRA L
UNIV OF MICH HOSP
1405 E ANN ST
ANN ARBOR MI 48109

43-41
002888
81

LICENSEE AND MEDICAL EDUCATION DIRECTOR COMPLETE REVERSE SIDE

LMD-230 (1/83)

JAN -8 12 84952643 ****30.00
(Do Not Write in This Space)

Renewal Instructions: OB-GYN

Postgraduate Trainee Completes All Appropriate Items Below and o
Reverse Side. The Director of Medical Education Must Complete all Items o
the Right Portion of Reverse Side. Postgraduate Trainee is Responsible fo
Returning Completed Application in the Envelope Provided.

If you are in a different program than you were last year, give new program name below

Enter any personal name changes or corrections below.

Enter any hospital name changes below.

Enter any hospital address changes or corrections below.
OB-GYN Box 07 15048
City State ZIP County

THIS SIDE TO BE COMPLETED BY POSTGRADUATE TRAINEE

Check One Box Below Which Describes Your Renewal Status:

Renewal Status:

☒ I am continuing my training beyond June 30 at the same location shown in the label on the reverse side. Correct any errors that appear on the label in the area provided on the reverse side.

☐ I am continuing my training beyond June 30, but will transfer to a new hospital and/or program. Enter new program name, new hospital name and address in area provided on reverse side.

☐ I will not continue my training in Michigan beyond June 30.

Termination Date _____

Forwarding Address: _____

THIS SIDE MUST BE COMPLETED, SIGNED AND SEALED BY THE DIRECTOR OF MEDICAL EDUCATION

CERTIFICATION OF TRAINING APPOINTMENT

This Certifies That DEBRA BIRENBAUM Has Been
Print Name of Postgraduate Trainee

Appointed to the Position of (Check one box below and enter Program Name).

☐ Categorical First Year In _____

☐ Categorical* First Year In _____

☐ Flexible First Year In _____

☒ 2 (3) 4 5 (Circle One) Year Resident In OB-GYN

Hospital Seal

Hospital Name UM

Signature of Director of Medical Education

Printed Name of Director of Medical Education
H SLOAN MD

Date Completed (Month, Day, Year) 6/6/84

LMD-000 (3-91)

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

MAY 10 ? 82122543 ****30.00

Do not write in this space

APPLICATION FOR LIMITED LICENSE FOR POST-GRADUATE TRAINING IN AN APPROVED TRAINING HOSPITAL

FEE: $30.00
Do not send cash.
Make check or money order in U.S. currency payable to
STATE OF MICHIGAN — MEDICINE

This is a sworn statement.

Name (last, first, middle)
BIRENBAUM, DEBRA LYNN

Daytime Telephone Number
(215) [redacted]

Address (street and number, city, state, ZIP code)
[redacted] PHILA PA 19130
[redacted] WYNCOTE PA 19095

Date of Birth + Place
[redacted] 58 [redacted]

Citizenship
☒ U.S. ☐ Other (give visa status, date and number) _____

Have you ever been convicted of a felony or misdemeanor for which you could have gone to jail? (You may exclude traffic violations.)	☐ Yes	☒ No	If yes, do NOT give details at this time.
Have you ever had an adverse civil judgment (including malpractice)? (You may exclude divorce decrees.)	☐ Yes	☒ No	If yes, give details on a separate sheet.
Have you been examined by the National Board or any State Board of Medicine?	☒ Yes	☐ No	If yes, give details. PASS - Parts I and II
Have you been certified by the Educational Council for Foreign Medical Graduates?	☐ Yes	☒ No	If yes, give certificate number: _____
Have you been certified by the Visa Qualifying Examination?	☐ Yes	☒ No	If yes, give certificate number: _____
Have you ever been denied a license to practice medicine?	☐ Yes	☒ No	If yes, give details.
Do you hold a license to practice medicine in any other states?	☐ Yes	☒ No	If yes, give states: _____

APPLICANT INSTRUCTIONS

1. No application will be accepted without proper completion of the educational and training certifications by the appropriate officials. This applies to all applicants without exception.
2. The application will not be accepted unless properly signed and sworn to by the applicant, notarized, and endorsed by the medical director or superintendent of the hospital in which you will train.
3. This application must be complete and on file in the offices of the Board of Medicine on or before July 1 of the year in which the permit is requested.
4. Intentional misstatements or omissions on this application may cause denial of a license, or, if a license was issued before discovery of the misrepresentation, a license may be revoked by the Board and the applicant subjected to prosecution.
5. Your fee should accompany this application and should be in the form of a check or money order. No responsibility is assumed for fees sent in any other manner.
6. Before issuance of the limited license, a personal appearance with your medical school diploma may be required.

CERTIFICATE OF DEAN, SECRETARY OR REGISTRAR OF MEDICAL COLLEGE

I hereby certify that I have reviewed the answers of this applicant. I certify that to the best of my knowledge all of the answers or statements are true and are a matter of official record in this school, and that said applicant is of good professional character.

I further certify that Debra Lynn Birenbaum, M.D.

matriculated in the Temple University School of Medicine
(Name of medical school)

September 1, 1978 (Date), and was graduated May 27, 1982 (Date), at which time the degree of

Doctor of Medicine was granted.

If the degree Bachelor of Medicine, is conferred upon completion of four years of medical school, further state the conditions and time the degree, Doctor of Medicine, will be granted.

DATED AT Philadelphia, Pa.

THIS April 16, 1982

Nancy Solomon
(Signature of Dean, Secretary or Registrar)

Temple University Medical School
(Name of medical college)

(SEAL)
Seal of college must be attached

3400 North Broad STreet, Phila, Pa. 19140
(Address of medical college)

CERTIFICATE OF MEDICAL DIRECTOR OR SUPERINTENDENT OF MICHIGAN TRAINING HOSPITAL

This certifies that Debra Lynn Birenbaum, M.D.

has been appointed to the position of ☐ CATEGORICAL 1st yr. in Obstetrics-Gynecology

☐ CATEGORICAL* 1st yr. in

☐ FLEXIBLE 1st yr. in

RESIDENT

In University of Michigan Hospitals (Name of Hospital) beginning June 24, 1982

and ending June 30, 1983

David G Dickinson
(Signature of Medical Director or Superintendent)

(SEAL)

David G. Dickinson, M.D.
Chief of Clinical Affairs

CERTIFICATION OF FIRST YEAR OF POSTGRADUATE TRAINING:

(This space should be left blank if this year of training has not been completed at the date the application is submitted)

I hereby certify that Dr. _____ satisfactorily

served a rotating internship in _____ Hospital

from the ____ day of _____, 19____, to the ____ day of _____, 19____.

(Signed) _____
(Medical Director or Superintendent)

Date _____

_____
(Name of hospital)

(SEAL)

_____
(Address of hospital)

FOR OFFICE USE ONLY

RECORD OF LIMITED LICENSES ISSUED

No. 1

5/21/82

Number 3888 for Univ. of Mich. Hospital

Effective Date from ~~July 1,~~ June 24, 19 82 to June 30, 19 83

No. 2

6-16-83

Number 3888 for Univ of Mich Hosp Hospital

Effective Date from July 1, 19 83 to June 30, 19 84

No. 3

6-8-84

Number 3888 for Univ of Mich Hosp Hospital

Effective Date from July 1, 19 84 to June 30, 19 85

No. 4

Number ____ for ____ Hospital

Effective Date from July 1, 19 ____ to June 30, 19 ____

No. 5

Number ____ for ____ Hospital

Effective Date from July 1, 19 ____ to June 30, 19 ____