LARA/LOS-060 (04/15)

Michigan Department of Licensing and Regulatory Affairs
Board of Osteopathic Medicine and Surgery
PO Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

For Board Use Only	
License #:	21937
CS License #:	531502 1482
Issue Date:	6-9-15

Fee on file

APPLICATION FOR OSTEOPATHIC EDUCATIONAL LIMITED AND CONTROLLED SUBSTANCE LICENSES

I am applying for the following:

☑ **Educational Limited and Controlled Substance Licenses Fee: $170.00 71-5101-375705**

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: Sarah	Middle Name: Rose	Last Name: Pearl
U.S. Social Security #: [redacted]	Birth Date: [redacted] 1985	
Street Address: 10508 Manor Rd		Apt/Bldg. #:
City: Leawood	State: Kansas	Zip Code: 66206
Country: USA		
Phone Number: 909- [redacted]	E-mail Address: SRPearl@gmail.com	
Name of Appointing Hospital: Spartan Health System		
Hospital Street Address: 1215 E Michigan		
City: Lansing	State: MI	Zip Code: 48909

Have you ever held a health professional license in any profession in Michigan? ☐ Yes ☑ No

Was your health professional license issued after 2008? ☐ Yes ☑ No

Health Professional Permanent I.D./License Number:	Expiration Date:

LARA/LOS-060 (04/15)

Full Name: Sarah Rose Pearl

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 judgments in any consecutive 5 year period? ☐ Yes ☑ No

If yes, please explain

5. Have you had one or more malpractice settlements, awards, or judgments 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.

LARA/LOS-060 (04/15)

Full Name: ~~Sara~~ Sarah Rose Pearl

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

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

3. Professional Education

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
Kansas City University of Medicine 1750 Independance Ave KS, MO	8/2011	5/2015	DO
California State University 5500 University Parkway San Bernadino CA	2004	2009	BA. Biology

4. Post-graduate Experience

Provide a description of your intern/residency training experience. Attach additional sheets if necessary.

Hospital Name and Location	Dates of Practice From	To	Program Title

LARA/LOS-060 (04/15)

Full Name: Sarah Rose Pearl

5. License(s) in Other State(s) or Province(s)

Do you hold or have you held a permanent osteopathic license 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 endorsement or examination).
DO NOT LIST TEMPORARY/LIMITED LICENSES. (Attach additional sheets if necessary.)

☐ Yes
☒ No

State/Country	Permanent License/Registration Number	Date of Issue	How Obtained (Exam or Endorsement)

6. 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 Sarah Pearl Date May 14, 2015

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.

Wrong app

LARA/LMD-051(05/14)

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

Tran Info:430137 20360572-1 04/09/15
Chk#: 763760 Amt: $65.00
ID: [redacted]

Tran Info:430157 20360572-2 04/09/15
Chk#: 763760 Amt: $20.00
ID: [redacted]

Tran Info:430105 20360572-3 /09/15
ID: [redacted]

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License #:
CS License #:
Issue Date:

APPLICATION FOR MEDICAL EDUCATIONAL LIMITED AND CONTROLLED SUBSTANCE LICENSES

I am applying for the following:

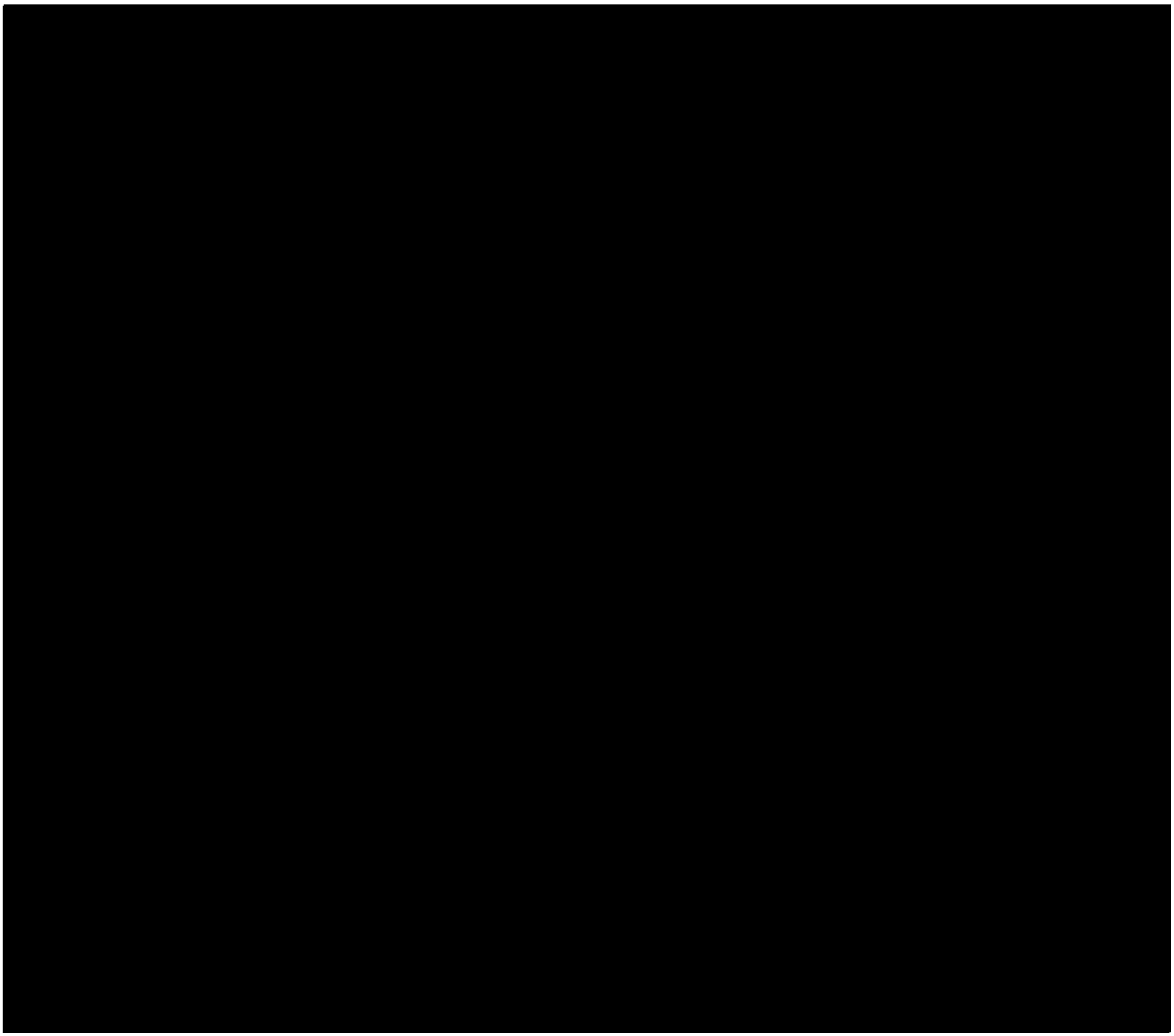
☒ **Medical Educational Limited and Controlled Substance Licenses Fee: $170.00 71-4301-375705**

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: Sarah	Middle Name: Rose	Last Name: Pearl
U.S. Social Security #: [redacted]	Birth Date [redacted] 1985	
Street Address: 10508 Manor Rd.		Apt/Bldg. #:
City: Leawood	State: Kansas	Zip Code: 66206
Country: USA		
Phone Number: 909 [redacted]	E-mail Address: SRPearl1@gmail.com	
Name of Appointing Hospital: Sparrow Health System		
Hospital Street Address: 1215 E Michigan Ave		
City: Lansing	State: Michigan	Zip Code: 48909
Have you ever held a health professional license in any profession in Michigan?		☐ Yes ☑ No
Health Professional Permanent I.D./License Number:		Expiration Date:

Original



LARA/LMD-091 (02/14)

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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, certification will not be issued.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Print this form and then 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.

First Name: Sarah	Middle Name: Rose	Last Name: Pearl
Street Address: 10508 Manor Rd		Apt/Bldg#:
City: Leawood	State: Kansas	Zip Code: 66206
SSN: [redacted]	Date of Birth: [redacted]1985	
E-mail: SRPearl1@gmail.com	Phone Number: 909-[redacted]	
Sarah Rose Flores All Previous Names and/or Birth Name Used (if applicable):		
Date of Admission: 08/2011	Date of Graduation: 05/2015	

Signature Sarah Pearl Date 03/23/2015

Upon completion of Section I, print, sign, and date the form then send the form to the Dean of your medical school for completion of Section II. **This certification must be submitted directly to the Michigan Board of Medicine.**

Full Name: Sarah Rose Pearl

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

Please complete the following information. Return this completed certification directly to Department of Licensing and Regulatory Affairs, Michigan Board of Medicine, PO Box 30192, Lansing MI 48909.

SECTION II - CERTIFICATION OF MEDICAL EDUCATION

Name of Medical School: Kansas City University of Medicine and Biosciences

Street Address of Medical School: 1750 INDEPENDENCE AVE

City: KANSAS CITY MO 64106 Zip Code:

I certify that SARAH ROSE PEARL attended the medical school named above
(Applicant's Full Name)

from 08/08/2011 to PROJECTED 05/09/2015 and was/will be granted
(Month/Day/Year) (Month/Day/Year)

the degree of D.O. on PROJECTED 05/09/2015
(Month/Day/Year)

Signature of Dean or Registrar

Dr. Richard ~~Winslow~~
Interim Registrar
Print or Type Name of Dean or Registrar

APR 0 6 2015
Date of Signature

(Seal)
If hospital has no seal, please indicate

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.

LARA/LOS-040 (04/15)

Michigan Department of Licensing and Regulatory Affairs
Board of Osteopathic Medicine and Surgery
PO Box 30670
Lansing MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING PROGRAM

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

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Print this form and then for completion of Section II, send this form to the Program Director or Superintendent of the Michigan training hospital where you have been appointed. This certification must be submitted directly to the Michigan Board of Osteopathic Medicine and Surgery by the hospital

First Name: Sarah	Middle Name: Rose	Last Name: Pearl
Hospital Street Address:		
City: 1215 E Michigan	State: Michigan	Zip Code: 48909
SSN: [redacted]	Date of Birth: [redacted]85	Email: SRPearle gmail.com
All Previous Names and/or Birth Name Used (if applicable): Sarah Rose Flores		Phone Number: 909 [redacted]

Program (Internship or Residency):	OB/GYN. Residency
Name of Hospital:	Sparrow Health System

Signature: Sarah Pearl Date: May 14, 2015

Upon completion of Section I, print, sign, and date the form then send the form to the Medical Director or Superintendent of the Michigan training hospital for completion of Section II. **This certification must be submitted directly to the Michigan Board of Osteopathic Medicine and Surgery by the Director or Superintendent of the training program.**

[redacted]

Full Name: Sarah Rose Pearl

THIS SECTION TO BE COMPLETED BY THE PROGRAM DIRECTOR

INSTRUCTIONS FOR COMPLETING SECTION II:
Please complete the following information. Return this completed certification directly to Department of Licensing and Regulatory Affairs, Michigan Board of Medicine, PO Box 30192, Lansing, MI 48909.

SECTION II - CERTIFICATION OF RESIDENCY APPOINTMENT

Name of Training Hospital: Sparrow Health System

Street Address of Hospital: 1215 E Michigan Avenue

City: Lansing | State: MI | Zip Code: 48909

I certify that Sarah Rose Pearl has been duly appointed to the training program in
(Applicant's Full Name)

the clinical area of OB GYN

beginning 7/1/2015 and ending 6/30/2019
(Month/Day/Year) (Month/Day/Year)

at Sparrow Health System.
(Name of Training Hospital)

Is the program accredited by ACGME? ☒ Yes ☐ No

Ted Glynn
Signature of Director Medical Education

3-30-15
Date of Signature

Print or Type Name of Director of Medical Education

(Seal)

If hospital has no seal, please indicate

Ted Glynn, MD
Vice President - Medical Education

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.

ORIGINAL

STATE OF MICHIGAN
RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES

MIKE ZIMMER
DIRECTOR

June 9, 2015

Sarah Rose Pearl
Sparrow Health System
1215 E Michigan Avenue
Lansing MI 48909

Dear Applicant:

The Bureau of Health Care Services recently reviewed your file. Your license has been issued.

The program that you have been approved for at Sparrow Health System in OBGYN is not AOA accredited. The requirements for full licensure include the completion of an AOA approved internship. Unless, the program you are participating in receives approval by the AOA it will not meet the requirements for full licensure.

If you have any questions, please feel free to contact our office at the number below.

Sincerely,

Licensing Section
Applications - Osteopathic Medicine & Surgery
Phone: (517) 335-0918

5101021937

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CUSTOMER DRIVEN BUSINESS MINDED.

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MAY 01 2017
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PO Box 30670 • Lansing, MI 48909
Telephone: (517) 335-0918
www.michigan.gov/bpl
BPLHelp@michigan.gov

CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING PROGRAM FOR AN OSTEOPATHIC PHYSICIAN LICENSE

Authority: 1978 PA 368

This form must be submitted directly to this office by the training program. If this form is submitted by the applicant, it will not be accepted.

Section of Form to be Completed by Applicant:

Applicant's First Name	Middle Name	Last Name
Sarah		Pearl

Address			
1215 E Michigan Ave			
City: Lansing		State: Mi	Zip Code: 48909
Date of Birth (MM/DD/YYYY): [redacted]985	Telephone: 517[redacted]	Email Address: Sarah.Pearl@Sparrow.org	
Applicant's Signature: Sarah Pearl, DO		Date: 4/11/17	

Remainder of Form to be Completed by the Medical Director or Superintendent of Training Hospital:

Name of Hospital or Institution		
Sparrow Health System		
Address of Hospital or Institution		
1215 E Michigan		
City: Lansing	State: Mi	Zip Code: 48909

CERTIFICATION AND SIGNATURE

I certify the applicant named above has been duly appointed to the training program at the hospital named above in the position of Residency (Internship or Residency) in OB GyN (Program) beginning 7/1/2015 (Month/Day/Year).

Is this training program AOA approved? ☐ Yes ☒ No

Is this training program ACGME approved? ☒ Yes ☐ No

Signature of Medical Director or Superintendent

4/26/2017
Date

Print or Type Name of Medical Director or Superintendent: Matthew T. Allswede MD

(Seal) If academic institution has no seal, please indicate.

LARA/BPL-OSTEOAPPTTRAIN (Rev 01/17)

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MAY 09 2018

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EDUCATIONAL LIMITED RENEWAL CERTIFICATION OF ADMITTANCE TO AN OSTEOPATHIC MEDICINE TRAINING PROGRAM

Authority 1978 PA 368

Your license will not be renewed until we receive this information

Section of Form to be Completed by Applicant:

Licensee's First Name	Middle Name	Last Name
Sarah	Rose	Pearl
Soc [redacted]	Date of Birth (MM/DD/YYYY) [redacted]/1985	10-Digit MI Permanent ID/License Number ~~53150~~ 71482
Signature of Licensee Sarah Pearl		Date 4/10/18

5101-021937

Section of Form to be Completed by Program:

Hospital Name or Institution **Sparrow Health System**		
Hospital or Institution Street Address **1215 E Michigan Ave**		
City **Lansing**	State **Michigan**	Zip Code **48909**
Program Name **OBGYN Residency**		Program Start Date (MM/DD/YYYY)

Please select one

☒ Licensee will be continuing their educational limited appointment in the *same program* at the *same location* as shown above

☐ Licensee will be continuing their educational limited appointment, but will transfer to a *new program* as shown above

Signature of Director of Medical Education	Date
[signature]	5-4-2018

06/06/16 done -tmu11

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EDUCATIONAL LIMITED RENEWAL CERTIFICATION OF ADMITTANCE TO A MEDICAL POSTGRADUATE TRAINING PROGRAM

Authority. 1978 PA 368

Your license will not be renewed until we receive this information

Section of Form to be Completed by Applicant:

Name (First, Middle, Last): Sarah Rose Pearl	10-Digit MI Permanent ID/License Number: 5101021937
Hospital Name or Institution: Sparrow Health System	
Hospital or Institution Street Address: 1215 E Michigan Ave	
City: Lansing / State: MI / Zip Code: 48909	
Program Name: OB-GYN / Program Start Date: 7/1/2015	

☒ I am continuing my educational limited appointment in the *same program* at the *same location* as shown above

☐ I am continuing my educational limited appointment, but will transfer to a *new program* as shown above

Signature of Director of Medical Education: Ted Glynn	Date: 5/23/16

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BPLHelp@michigan.gov

EDUCATIONAL LIMITED RENEWAL CERTIFICATION OF ADMITTANCE TO A MEDICAL POSTGRADUATE TRAINING PROGRAM

Authority: 1978 PA 368

Your license will not be renewed until we receive this information.

Section of Form to be Completed by Applicant:

Licensee's First Name	Middle Name	Last Name
Sarah	Rose	Pearl
Social Security Number [redacted]	Date of Birth (MM/DD/YYYY) [redacted]/1985	10-Digit MI Permanent ID/License Number 5101021937
Signature of Licensee Sarah Pearl		Date 3/1/19

Section of Form to be Completed by Program:

Hospital Name or Institution: Sparrow Health System		
Hospital or Institution Street Address: 215 E Michigan Ave		
City: Lansing	State: MI	Zip Code: 48912
Program Name: OB/GYN Residency Program		Program Start Date (MM/DD/YYYY): 7/1/2015

Please select one

☒ Licensee will be continuing their educational limited appointment in the *same program* at the *same location* as shown above

☐ Licensee will be continuing their educational limited appointment, but will transfer to a *new program* as shown above.

Signature of Director of Medical Education: [signature] DO	Date 3/4/2019

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MAR 11 2019
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