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LARA
LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Bureau of Professional Licensing
PO Box 30670 • Lansing, MI 48909
Telephone: (517) 335-0918
www.michigan.gov/bpl
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
Aliye	Lauren	Runyan
Social Security Number [redacted]	Date of Birth (MM/DD/YYYY) [redacted]	10-Digit MI Permanent ID/License Number [redacted]

GOOD MORAL CHARACTER QUESTIONS

1. Have you been convicted of a felony you have not previously reported to the Department?	Yes	No
2. Have you been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years or a misdemeanor conviction involving the illegal delivery, possession, or use of alcohol or a controlled substance you have not previously reported to the Department?	Yes	No
3. Have any sanctions been imposed against you by a similar licensure, registration, certification or disciplinary board of another state or country you have not previously report to the Department?	Yes	No

By submitting this application I certify all information to be true and correct and understand that any misrepresentation or fraud may be cause for disciplinary action. I further attest that I have a written policy for protecting, maintaining, and providing access to my medical records in accordance with Section 16213 of the Public Health Code, 1978 PA 368, MCL 333.16213, and for complying with Section 16213 in the event that I sell or close my practice, retire from practice, or otherwise cease to practice under Article 15 of the Public Health Code, 1978 PA 368, MCL 333.16101 to 333.18838.

Signature of Licensee	Date
Aliye	4/27/2017

Section of Form to be Completed by Program:

Hospital Name or Institution		
Detroit Medical Center		
Hospital or Institution Street Address		
4201 St. Antoine, 9C-UHC		
City	State	Zip Code
Detroit	MI	48201
Program Name		Program Start Date (MM/DD/YYYY)
Obstetrics - Gynecology		07/01/2017

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
Mary A Martin	05/10/2017

LARA/BPL-MEDEDLTDRENEW (Rev. 1/17)

[redacted]

413011106220

Runyan, Alive Lauren

[redacted]

Medical Doctor - Educational Limited

April 29, 2014

Fee CK

App OK

Med Ed

~~PCT~~

~~Exam Scores~~

~~ECFMG~~

HOSP APPT OV

CBC OK

~~XRG~~

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
ONLINE APPLICATION FOR A MEDICAL DOCTOR - EDUCATIONAL LIMITED
OBTAINED BY WEB BY APPLICATION WITH CS

Amount Paid - $170.00
Date Paid - 04/29/2014

License #	1206220
License #	0607201
Issue Date	6/27/14

FIRST NAME:	MIDDLE NAME:	LAST NAME:	SUFFIX:
Aliye	Lauren	Runyan	

SSN: [redacted]

DATE OF BIRTH: [redacted]

DAYTIME TELEPHONE NUMBER:

License Address - 4201 St. Antoine
UHC - 9C
Detroit MI 48201
United States

Email Address - lpingill@dmc.org

APPLICATION QUESTIONS

Have you been convicted of a felony?	N
Have you been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	N
Have you been convicted of a misdemeanor involving the illegal delivery, possession or use of alcohol or a controlled substance (including motor vehicle violations)?	N
Have you been censured or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?	N
Have you been treated for substance abuse in the past 2 years?	N
Have you had 3 or more malpractice settlements, awards or judgments in any consecutive 5 year period?	N
Have you had one or more malpractice settlements, awards or judgments totaling $200,000 or more in any consecutive 5 year period?	N
Have you had a federal or state health professional or registration revoked, suspended or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	N
Have you been denied the privilege of taking an examination by any state medical board?	N
If you have held a permanent license in another state, list the state's in which you hold or have held a medicine license.	
If you ever held a health professional license in Michigan, please provide the Permanent ID Number (License Number) and Expiration date	
List all previous names used.	

MEDICAL EXPERIENCE

Hospital &Program Name — Start Date

EDUCATION

School Name	DATE FROM	DATE TO
University of Miami	08/01/2007	05/01/2012

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES

STEVE ARWOOD
DIRECTOR

Name : Aliye Lauren Runyan
License Number : Pending
Tracking Number : 2563705
Profession : Medicine
License Type : Educational Limited Medical Doctor
Process : Apply for Initial License process

RECEIVED
APR 30 2014
DEPARTMENT OF LICENSING & REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES
LICENSING DIVISION

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 : SEE attached

Sign on the signature line and mail this page along with any required attachments to:

Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

Print Page

Close Window

Name
ALIYE E. Runyan

8. 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

9. Do you hold or have you held a medical license in any state? If yes, list each state, 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.)** ☐ Yes ☒ No

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
Eckerd College	8/2001	5/2005	B.S / B.A
Tulane University	8/2006	5/2007	M.S.
University of Miami	8/2007	5/2012	M.D.

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 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	Date
Aliye	4/8/2014

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

CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING HOSPITAL

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 legal name exactly as it appears on your application. For Section II, send this form to be completed by the Program Director of the Michigan hospital where you have been appointed. This certification must be submitted to the Board of Medicine by the hospital.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
aliye	lauren	Runyan

Social Security Number	Date of Birth
[redacted]	[redacted]

Street Address
2214 Crooks Rd

City	State	ZIP Code
Royal Oak	MI	48073

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)
727 504 9423	

Signature of Applicant	Date
aliyerunyan	4/8/2014

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

Name ALIYE L. RUNYAN

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board Medicine at the address shown on page 1 of this form.

SECTION II - CERTIFICATION OF RESIDENCY APPOINTMENT

Name of Training Hospital

Detroit Medical Center, GME Office

Street Address of Training Hospital

4201 St. Antoine, UHC 9C

City, State and ZIP Code

Detroit, Michigan 48201

I certify that ALIYE L. RUNYAN (Applicant's Name) **has been duly**

appointed to a training program in the clinical area of OBSTETRICS - GYNECOLOGY

beginning 7/1/14 (Month/Day/Year) **and ending** 6/30/15 (Month/Day/Year)

at Detroit Medical Center (Name of Training Hospital).

Is this program accredited by ACGME? ☒ **Yes** ☐ **No**

Signature of Director of Medical Education

4-18-14

Date of Signature

Terese DeClercq

Print or Type Name of Director of Medical Education

(S E A L)

If **hospital** has no seal, please indicate

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

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 legal 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
Aliye	Lauren	Runyan
Social Security Number	**Date of Birth**	**Daytime Telephone Number**
[redacted]	[redacted]	727-504-9423
Street Address		
2214 Crooks Rd		
City	**State**	**ZIP Code**
Royal Oak	MI	48073
All Previous Names and/or Birth Name Used (if applicable)		
Date of Admission		**Date of Graduation**
August 2007		May 2012

Signature of Applicant	Date
[signature]	4/8/2014

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

Name

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

UNIVERSITY OF MIAMI
MILLER SCHOOL OF MEDICINE

Street Address of Medical School

1600 NW 10 AVE (R128)
MIAMI, FL 33136

City, State and ZIP Code

I certify that Aliye Runyan (Applicant's Name) attended the medical school named above from 08/10/07 (Month/Day/Year) to 05/11/12 (Month/Day/Year)

and was/will be granted the degree of DOCTOR OF MEDICINE on 05/12/2012 (Month/Day/Year).

Signature of Dean or Registrar

6/25/14
Date of Signature

Ana Campo, M.D.
Associate Dean for Student Affairs

(S E A L)

Print or Type Name of Dean or Registrar

If school has no seal, please indicate