

You may duplicate this form (front and back) if necessary. All sheets must have the verification completed on the reverse side and the medical school must have its section completed and sealed.

VERIFICATION

SECTION 1: (Continued)

Name of Applicant: (please print or type) Pierre Bernard Eugene

I verify that the information regarding my medical education is true and correct to the best of my knowledge and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

Signature of Applicant: _____

Date: 1-12-1997

Following completion of the reverse side and the above verification, send to your medical school for completion of the next section.

SECTION 2 TO BE COMPLETED BY DEAN OR REGISTRAR:

Name of Medical School: Faculte de Medecine et de Pharmacie (UEH)

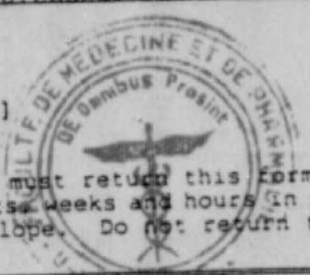
I certify that I have carefully reviewed this report.

I certify that the hospitals in a country other than the United States or Canada which are listed on the reverse side are either a formal part of this medical school or have a formal affiliation with this medical school.

I further certify that the statements made herein are true and complete to the best of my knowledge and belief.

Signature of Dean or Registrar: Professeur Mario ALVAREZ, PU-PH, Doyen

[MEDICAL SCHOOL SEAL]



Upon completion, school must return this form, the Verification of Medical Education and the Official Document listing subjects, weeks and hours in study directly to the Pennsylvania State Board of Medicine in official school envelope. Do not return to the applicant.

Regular Mailing Address:
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649 U.S.A.

Courier Delivery Address:
State Board of Medicine
124 Pine Street
Harrisburg, PA 17101 U.S.A.

RECEIVED
FEB 25 1997
Health Licensing Boards

| | | | |
|-------|--------|----------------|--------|
| Name: | Eugene | Pierre Bernard | |
| | Last | First | Middle |

SECTION 1: Report of Clinical Rotations - in support of medical education credentials
Applicant - Complete this section and have the verification completed on the reverse side and forward to your medical school.

* Name of Instructor and Program Director need not be completed if not available.

** ALL other information MUST be completed or forms will be returned.

Hospital-Name & Address: State University Hospital (HUEH) Of Haiti
23 Rue MGR Guilloux, Port au Prince, Haiti 40

Clinical Area: Urology Hours per Week: 55

From: 04 01 86 To: 04 30 86 Weeks of Credit: 4
Month / Day / Year Month / Day / Year

Name of Instructor: DR. Décatrel MIRVILLE

Name of Program Director: DR. Décatrel MIRVILLE 160

Hospital-Name & Address: State University Hospital (HUEH)
24 Rue Mgr Guilloux, Port au Prince, Haiti 40

Clinical Area: Pediatrics Hours per Week: 55

From: 05 01 86 To: 05 30 86 Weeks of Credit: 4
Month / Day / Year Month / Day / Year

Name of Instructor: DR. Buffon MONDESTIN

Name of Program Director: DR. Buffon MONDESTIN 160

Hospital-Name & Address: State University Hospital (HUEH) of Haiti
25 Rue MGR Guilloux, Port au Prince, Haiti 40

Clinical Area: Pathology Hours per Week: 42

From: 06 01 86 To: 06 30 86 Weeks of Credit: 4
Month / Day / Year Month / Day / Year

Name of Instructor: DR. JACQUES BONCY

Name of Program Director: DR. JACQUES BONCY 160

You may duplicate this form (front and back) if necessary. All sheets must have the verification completed on the reverse side and the medical school must have its section completed and sealed.

VERIFICATION

SECTION 1: (Continued)

Name of Applicant: (please print or type) Pierre Bernard Eugene

I verify that the information regarding my medical education is true and correct to the best of my knowledge and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

Signature of Applicant: _____

Date: 1-12 -1997

Following completion of the reverse side and the above verification, send to your medical school for completion of the next section.

SECTION 2 TO BE COMPLETED BY DEAN OR REGISTRAR:

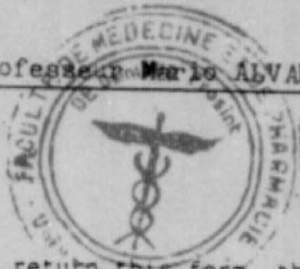
Name of Medical School: Faculte de medecine et de Pharmacie (UEH)

I certify that I have carefully reviewed this report.

I certify that the hospitals in a country other than the United States or Canada which are listed on the reverse side are either a formal part of this medical school or have a formal affiliation with this medical school.

I further certify that the statements made herein are true and complete to the best of my knowledge and belief.

Signature of Dean or Registrar: Professeur Mario ALVAREZ, PU-PH, Doyen



[MEDICAL SCHOOL SEAL]

Upon completion, school must return this form, the Verification of Medical Education and the Official Document listing subjects, weeks and hours in study directly to the Pennsylvania State Board of Medicine in official school envelope. Do not return to the applicant.

Regular Mailing Address:
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649 U.S.A.

Courier Delivery Address:
State Board of Medicine
124 Pine Street
Harrisburg, PA 17101 U.S.A.

RECEIVED
FEB 25 1997
Health Licensing Boards

Name: Eugene Pierre Bernard
Last First Middle

SECTION I: Report of Clinical Rotations - in support of medical education credentials
Applicant - Complete this section and have the verification completed on the reverse side and forward to your medical school.

* Name of Instructor and Program Director need not be completed if not available.

** ALL other information MUST be completed or forms will be returned.

Hospital-Name & Address: State University Hospital (HUEH) Of Haiti

26

Rue MGR Guilloux, Port au Prince, Haiti

Clinical Area: Emergency Room

Hours per Week: 55 40

From: 07 01 86 To: 07 30 86
Month / Day / Year Month / Day / Year

Weeks of Credit: (4)

Name of Instructor: DR. MATHIEU JOSEPH

Name of Program Director: DR. MATHIEU JOSEPH

160

Hospital-Name & Address: State University Hospital (HUEH) of Haiti

27

Rue Mgr Guilloux, Port au Prince, Haiti

Clinical Area: Internal Medicine

Hours per Week: 55 40

From: 08 01 86 To: 09 30 86
Month / Day / Year Month / Day / Year

Weeks of Credit: (2)

Name of Instructor: DR. CLAUDE BLANCHARD

Name of Program Director: DR. CLAUDE BLANCHARD

80

Hospital-Name & Address: _____

Clinical Area: _____

Hours per Week: _____

From: _____ To: _____
Month / Day / Year Month / Day / Year

Weeks of Credit: _____

Name of Instructor: _____

Name of Program Director: _____

You may duplicate this form (front and back) if necessary. All sheets must have the verification completed on the reverse side and the medical school must have its section completed and sealed.

VERIFICATION

SECTION 1: (Continued)

Name of Applicant: (please print or type) Pierre Bernard Eugene

I verify that the information regarding my medical education is true and correct to the best of my knowledge and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

Signature of Applicant: _____

Date: 1-12 -1997

Following completion of the reverse side and the above verification, send to your medical school for completion of the next section.

SECTION 2 TO BE COMPLETED BY DEAN OR REGISTRAR:

Name of Medical School: FACULTE DE MEDECINE ET DE PHARMACIE D'HAITI

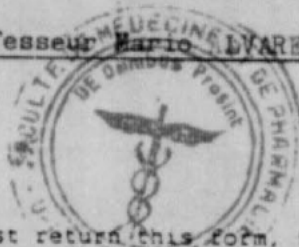
I certify that I have carefully reviewed this report.

I certify that the hospitals in a country other than the United States or Canada which are listed on the reverse side are either a formal part of this medical school or have a formal affiliation with this medical school.

I further certify that the statements made herein are true and complete to the best of my knowledge and belief.

Signature of
Dean or Registrar: Professeur Mario LYVAREZ, PU-PH, Doyen

[MEDICAL SCHOOL SEAL]



Upon completion, school must return this form, the Verification of Medical Education and the Official Document listing subjects, weeks and hours in study directly to the Pennsylvania State Board of Medicine in official school envelope. Do not return to the applicant.

Regular Mailing Address:
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649 U.S.A.

Courier Delivery Address:
State Board of Medicine
124 Pine Street
Harrisburg, PA 17101 U.S.A.

RECEIVED
FEB 25 1997
Health Licensing Boards

| | | |
|-------|---------------|----------------------------|
| Name: | <u>Eugene</u> | <u>Pierre Bernard</u> |
| | <u>Last</u> | <u>First</u> <u>Middle</u> |

SECTION I: Report of Clinical Rotations - in support of medical education credentials
Applicant - Complete this section and have the verification completed on the reverse side and forward to your medical school.

* Name of Instructor and Program Director need not be completed if not available.

** ALL other information MUST be completed or forms will be returned.

Hospital-Name & Address: State University Hospital (HUEH) Of Haiti
Rue MGR Guilloux, Port au Prince, Haiti

Clinical Area: OBGYN Residency Hours per Week: _____
From: 10 1 1988 To: 10 1 1991 Weeks of Credit: 3 years
Month / Day / Year Month / Day / Year
Name of Instructor: _____
Name of Program Director: Walter B. Joseph

Hospital-Name & Address: _____

Clinical Area: _____ Hours per Week: _____
From: _____ To: _____ Weeks of Credit: _____
Month / Day / Year Month / Day / Year
Name of Instructor: _____
Name of Program Director: _____

Hospital-Name & Address: _____

Clinical Area: _____ Hours per Week: _____
From: _____ To: _____ Weeks of Credit: _____
Month / Day / Year Month / Day / Year
Name of Instructor: _____
Name of Program Director: _____

You may duplicate this form (front and back) if necessary. All sheets must have the verification completed on the reverse side and the medical school must have its section completed and sealed.

VERIFICATION

SECTION 1: (Continued)

Name of Applicant: (please print or type) Pierre Bernard Eugene

I verify that the information regarding my medical education is true and correct to the best of my knowledge and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

Signature of Applicant: _____

Date: 1-12 -1997

Following completion of the reverse side and the above verification, send to your medical school for completion of the next section.

SECTION 2 TO BE COMPLETED BY DEAN OR REGISTRAR:

Name of Medical School: Faculte de Medecine et de Pharmacie (UEH)

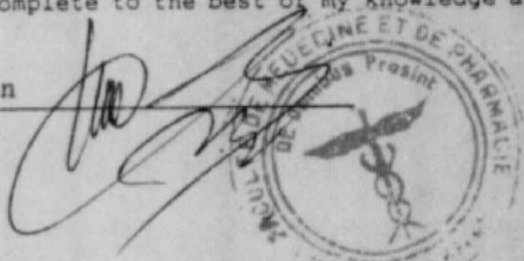
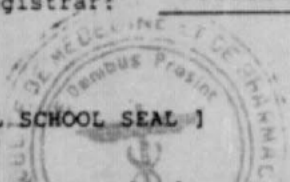
I certify that I have carefully reviewed this report.

I certify that the hospitals in a country other than the United States or Canada which are listed on the reverse side are either a formal part of this medical school or have a formal affiliation with this medical school.

I further certify that the statements made herein are true and complete to the best of my knowledge and belief.

Signature of Dean or Registrar: Professeur Mario ALVAREZ, PU-PH, Doyen

[MEDICAL SCHOOL SEAL]



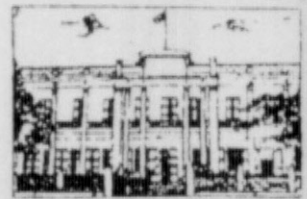
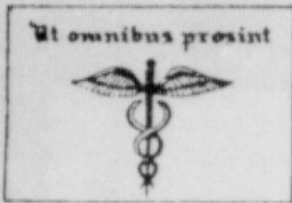
Upon completion, school must return this form, the Verification of Medical Education and the Official Document listing subjects, weeks and hours in study directly to the Pennsylvania State Board of Medicine in official school envelope. Do not return to the applicant.

Regular Mailing Address:
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649 U.S.A.

Courier Delivery Address:
State Board of Medicine
124 Pine Street
Harrisburg, PA 17101 U.S.A.

RECEIVED
FEB 7 5 1997
State Licensing Board

970348-00450024
LB



REPUBLIQUE D'HAITI
UNIVERSITE D'ETAT

FACULTE DE MEDECINE ET DE PHARMACIE

No. Port-au-Prince, le 9 Avril 19 97

To : State Board of Medicine
124, Pine street, 1st Floor
Harrisburg, PA. 17101
U.S.A.

Re : Clinical Rotations
EUGENE Pierre Bernard

Dear Sir,

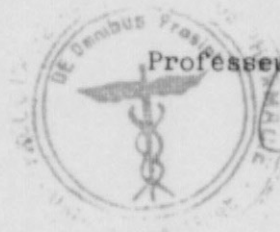
Concerning clinical rotations of Dr. Pierre Bernard EUGENE, a review of the record shows the following :

- a) A total of 2454 hours was originally reported
- b) An additional credit of 240 hours (6 weeks) registered from 08/16/86 to 09/30/86 has to be taken in account. This was regularly completed by the student after official graduation date (08/16/86)
- c) Therefore his total credit hours should be read as follow :

141 weeks 2694 hours.

Truly yours,

Professeur Mario ALVAREZ, PU-PH
Doyen.



MA/1j



REPUBLIQUE D'HAÏTI
FACULTE DE MEDECINE ET DE PHARMACIE
 89, RUE OSWALD DURAND, 89
 PORT-AU-PRINCE, HAÏTI

State Board of Medicine
 124, Pine Street, 1st Floor
 Harrisburg, PA, 17101
 U.S.A.

DHL Shipment Airwaybill
 1-800-CALL-DHL
 9136465612

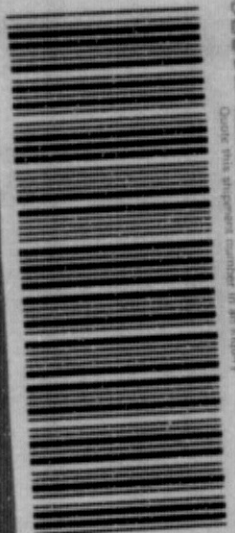
1 From (Shipper)
 Account no. 737500033
 Shipper's reference
 Company name
FACULTE MEDICINE & PHARMACIE
 Shipper's name
 Address
 RUE OSWALD DURAND #89
 PORT-AU-PRINCE, HT
 HAÏTI
 2 To (Recipient)
 Recipient's name
 220489/22-1131

3 Shipment details
 Services
 U.S. DOMESTIC
 INTERNATIONAL DOCUMENT
 INTERNATIONAL NON DOCUMENT
 WORLDWIDE TEL / FAX / 2nd
 Special Services (see charge slip)
 SATURDAY DELIVERY
 Other services to be specified

Payment Options not at receiver's available to all countries
 Shipper's account
 Recipient
 Third party
 Acc. No.

4 Pcs/Weight/Size
 No. of pieces 1
 Weight of DHL Express Document including a label, enter XZ 1.00
 Dimensions in inches
 length x width x height
 DIMENSIONAL CHARGED WEIGHT
 COGS CHARGES 350

ORIGIN: P&P DESTINATION: MDT
 DHL AIRWAYS, INC. • 333 TWIN DOLPHIN DRIVE, REDWOOD



APR 11 1997

Health Licensing Boards

| | | | |
|-------|--------|----------------|--------|
| Name: | Eugene | Pierre Bernard | |
| | Last | First | Middle |

Hospital-Name & Address: State University Hospital of Haiti
Rue Mgr Guilloux, Port-au-Prince, HAITI

Clinical Area: Internal Medicine Hours per Week: 55

From: 08 01 86 To: 09 30 86 Weeks of Credit: _____
Month / Day / Year Month / Day / Year

Hospital-Name & Address: _____

Clinical Area: _____ Hours per Week: _____

From: _____ To: _____ Weeks of Credit: _____
Month / Day / Year Month / Day / Year

Hospital-Name & Address: _____

Clinical Area: _____ Hours per Week: _____

From: _____ To: _____ Weeks of Credit: _____
Month / Day / Year Month / Day / Year

Hospital-Name & Address: _____

Clinical Area: _____ Hours per Week: _____

From: _____ To: _____ Weeks of Credit: _____
Month / Day / Year Month / Day / Year

Hospital-Name & Address: _____

Clinical Area: _____ Hours per Week: _____

From: _____ To: _____ Weeks of Credit: _____
Month / Day / Year Month / Day / Year

Hospital-Name & Address: _____

Clinical Area: _____ Hours per Week: _____

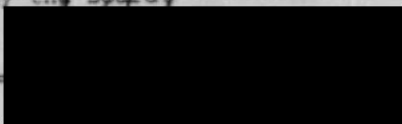
From: _____ To: _____ Weeks of Credit: _____
Month / Day / Year Month / Day / Year

VERIFICATION

SECTION 1: (Continued)

Name of Applicant: (please print or type) Pierre Bernard Eugene

I verify that the information regarding my medical education is true and correct to the best of my knowledge and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

Signature of Applicant: 

Date: 03-06-97

Following completion of the reverse side and the above verification, send to your medical school for completion of the next section.

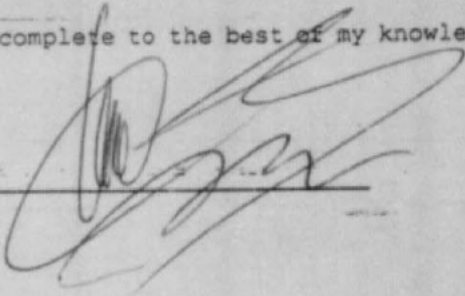
SECTION 2 TO BE COMPLETED BY DEAN OR REGISTRAR:

Name of Medical School: _____

I certify that I have carefully reviewed this report.

I certify that the hospitals in a country other than the United States or Canada which are listed on the reverse side are either a formal part of this medical school or have a formal affiliation with this medical school.

I further certify that the statements made herein are true and complete to the best of my knowledge and belief.

Signature of Dean or Registrar: Professeur Mario ALVAREZ, PU-PH, Doyen 

[MEDICAL SCHOOL SEAL]



Upon completion, school must return this form, the Verification of Medical Education and the Official Document listing subjects, weeks and hours in study directly to the Pennsylvania State Board of Medicine in official school envelope. Do not return to the applicant.

Regular Mailing Address:
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649 U.S.A.

Courier Delivery Address:
State Board of Medicine
124 Pine Street, 1st Floor
Harrisburg, PA 17101 U.S.A.

RECEIVED

APR 11 1997

Health Licensing Boards

State Board of Medicine
P.O. Box 2649, Harrisburg, PA 17105-2649

970348 0045

| | | | |
|-------|--------|----------------|--------|
| Name: | Eugene | Pierre Bernard | |
| | Last | First | Middle |

SECTION 1: Report of Clinical Rotations - in support of medical education credentials
Applicant - Complete this section and have the verification completed on the reverse side and forward to your medical school:

- τ **ALL** information **MUST** be completed or forms will be returned and required to be sent again from the medical school.
- τ You may duplicate this form (front and back) if necessary. All sheets must have the verification completed on the reverse side and the medical school must have its section completed and seals.
- τ For clinical rotations completed in U.S. hospitals - Clinical rotations are required to be completed in programs that have ACGME accreditation. If the hospital does not have an accredited residency program in the clinical area where you completed your rotation, but is affiliated with either:
a) a hospital/program that does have accreditation; OR b) an accredited medical school that provides clinical clerkships for medical students, also list in parentheses () the name and address of the accredited hospital/program or medical school.

Hospital-Name & Address: State University Hospital Of Haiti
Rue Mgr Guilloux, Port au Prince, Haiti

Clinical Area: Residency in OBGYN Hours per Week: 80
From: 10 01 1988 To: 09 30 1991 Weeks of Credit: 156
Month / Day / Year Month / Day / Year

Hospital-Name & Address: _____

Clinical Area: _____ Hours per Week: _____
From: _____ To: _____ Weeks of Credit: _____
Month / Day / Year Month / Day / Year

Hospital-Name & Address: _____

Clinical Area: _____ Hours per Week: _____
From: _____ To: _____ Weeks of Credit: _____
Month / Day / Year Month / Day / Year

VERIFICATION

SECTION 1: (Continued)

Name of Applicant: (please print or type) Pierre Bernard Eugene

I verify that the information regarding my medical education is true and correct to the best of my knowledge and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

Signature of Applicant: _____

Date: 03 -06-97

Following completion of the reverse side and the above verification, send to your medical school for completion of the next section.

SECTION 2 TO BE COMPLETED BY DEAN OR REGISTRAR:

Name of Medical School: _____

I certify that I have carefully reviewed this report.

I certify that the hospitals in a country other than the United States or Canada which are listed on the reverse side are either a formal part of this medical school or have a formal affiliation with this medical school.

I further certify that the statements made herein are true and complete to the best of my knowledge and belief.

Signature of
Dean or Registrar: Professeur Mario ALVAREZ, PU-PH, Doyen.

[MEDICAL SCHOOL SEAL]



Upon completion, school must return this form, the Verification of Medical Education and the Official Document listing subjects, weeks and hours in study directly to the Pennsylvania State Board of Medicine in official school envelope. Do not return to the applicant.

Regular Mailing Address:
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649 U.S.A.

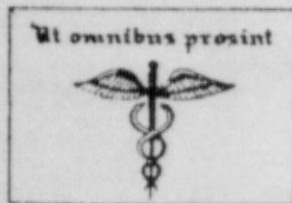
Courier Delivery Address:
State Board of Medicine
124 Pine Street, 1st Floor
Harrisburg, PA 17101 U.S.A.

RECEIVED

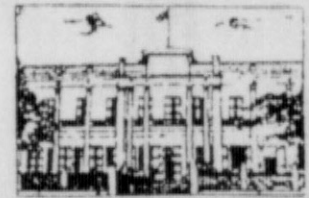
APR 11 1997

Health Licensing Board

970348 0045



REPUBLIQUE D'HAÏTI
UNIVERSITE D'ETAT



FACULTE DE MEDECINE ET DE PHARMACIE

No. _____ Port-au-Prince, le 17 AVRIL 19 97

NOMBRE DE SEMAINES ET NOMBRE TOTAL D'HEURES PAR MATIERE

NCM : EUGENE PRENOM : Pierre Bernard

DIPLOME DOCTEUR EN MEDECINE LE 18 AOUT 1986

| <u>MATIERES</u> | <u>HEURES</u> | <u>SEMAINES</u> |
|------------------------------------|---------------|-----------------|
| <u>P.C.B. OU ANNEE PREMEDICALE</u> | | |
| BIOCHIMIE | 28 | 14 |
| BIOLOGIE ANIMALE ET GENETIQUE | 112 | 28 |
| BIOLOGIE CELLULAIRE | 56 | 28 |
| CHIMIE GENERALE ET MINERALE | 56 | 28 |
| CHIMIE ORGANIQUE TP+14H | 14 | 28 |
| EMBRYOLOGIE GENERALE | 56 | 28 |
| INTRODUCTION A LA MEDECINE | 14 | 14 |
| MATHEMATIQUES | 56 | 28 |
| PHYSIQUE | 56 | 28 |
| SCIENCES DU COMPORTEMENT | 28 | 28 |
| ZOOLOGIE | 56 | 28 |
| <u>1ère ANNEE DE MEDECINE</u> | | |
| ANATOMIE TP+140H | 168 | 28 |
| ANATOMIE RADIOLOGIQUE TP | 56 | 28 |
| BIOCHIMIE | 56 | 28 |
| EMBRYOLOGIE | 56 | 28 |
| HISTOLOGIE TP+56 | 84 | 28 |
| PHYSIOLOGIE | | |
| STATISTIQUES | | |



RECEIVED
MAY 06 1997
Health Licensing Boards

