

Licensee: Katherine Boyd, MD

File Number: COM22-003189

BOARD REVIEW SHEET

You have SEVEN days to either AUTHORIZE or DENY an investigation in this matter. Board failure to act on an allegation within seven-days results in mandatory investigation of the allegation by the Department. To avoid unwarranted investigations prompt Board response is appreciated. Indicate whether you authorize or deny an investigation by checking one of the boxes below. Please include an explanation of your recommendation.

X Investigation Authorized

The information provided in the allegation, if true, would constitute a violation of the Michigan Public Health Code or administrative rules and warrants an investigation by the Department. (Please cite the applicable section number of the statute or rule violated by the alleged facts).

Was the patient vaccinated against their will/or
without consent? If not, nothing else here to
find against IAC.

Investigation Not Authorized

Please indicate the basis for your recommendation that no investigation is needed. Please be specific.

Chaff

Printed Name

[Signature]

Signature

7/16/22

Date

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File Number: COM22-003189

BOARD REVIEW SHEET

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Investigation Authorized

The information provided in the allegation, if true, would constitute a violation of the Michigan Public Health Code or administrative rules and warrants an investigation by the Department. (Please cite the applicable section number of the statute or rule violated by the alleged facts).

Council Duty

Investigation Not Authorized

Please indicate the basis for your recommendation that no investigation is needed. Please be specific.

mccinnity
Printed Name

[Signature]
Signature

7/18/22
Date

Licensed Professional: License # 4301054361

Save Reset Help

License Type: Medical Doctor License #: 4301054361 License Issue Date: 07/09/1991 License Expiration Date: 01/31/2022 License Status: Active

First Name: Katherine Middle Name: Lee Last Name: Boyd Birth Date: [Redacted]

Organization Name: [Redacted] SSN: [Redacted] DBA/Trade Name: [Redacted]

Primary Phone: [Redacted] Primary Phone Extension: [Redacted]

Secondary Phone: [Redacted] Secondary Phone Extension: [Redacted]

E-mail: drboyd@kathboyd.com

Address Line 1: 3800 Van Dyke Ave. Address Line 2: Suite 130 Address Line 3: [Redacted]

Country/Region: --Select-- City: Sterling Heights State: MI ZIP Code: 48312 County: Macomb

CONTROLLED SUBSTANCE LIST

<input type="checkbox"/>	Address Line 1 (Text)	Address Line 2 (Text)	Address Line 3 (Text)	City (Text)	State or Province	ZIP or Postal Code (Text)	CS Record Number (Text)	CS Status	CS Expiration Date	Enabled
<input type="checkbox"/>	15801 W Mc Nichols			Detroit	Michigan	48235	5315074759	Lapsed	01/31/2019	<input checked="" type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/>	3800 Van Dyke Ave.	Suite 130		Sterling Heights	Michigan	48312	5315097579	Active	01/31/2022	<input checked="" type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/>	15921 E 8 Mile Rd #1			Eastpointe	Michigan	48021	5315074807	Active	01/31/2022	<input checked="" type="radio"/> Yes <input type="radio"/> No

New Delete

DRUG CONTROL LIST

<input type="checkbox"/>	Address Line 1 (Text)	Address Line 2 (Text)	Address Line 3 (Text)	City (Text)	State	ZIP Code (Number)	DC Record Number (Text)	DC Status	DC Expiration Date	Enabled
<input type="checkbox"/>	15801 W Mc Nichols			Detroit	Michigan	48235	5307003483	Lapsed	01/31/2019	<input checked="" type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/>	15921 E 8 Mile Rd #1			Eastpointe	Michigan	48021	5307003361	Active	01/31/2022	<input checked="" type="radio"/> Yes <input type="radio"/> No

New Delete

DRUG TREATMENT PROGRAM PRESCR.

<input type="checkbox"/>	Drug Treatment Program Name (Text)	Address Line 2 (Text)	Address Line 1 (Text)	Address Line 3 (Text)	City (Text)	State	ZIP Code (Number)	DTPP Record Number (Text)	DTPP Status	DTPP Expiration Date	Enabled
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New Delete

Form Name: Reference Professional Form

Licensed Professional: License # 4301054361

Menu Delete Look Up Reports Help

Showing 1-10 of 16

<input type="checkbox"/> Record ID	Assigned to Staff	Record Type	Active Task	Internal Status	Public Record Status	Status Date	Opened Date	Expiration Date	Last Name	First Name	Organization Name
<input type="checkbox"/> COM19-004689	Stephanie Rose...	Complaint		Closed		07/15/2020	12/11/2019				
<input type="checkbox"/> COM19-001203	Stephanie Rose...	Complaint		Closed		06/12/2019	06/07/2019				
<input type="checkbox"/> COM19-001204	Stephanie Rose...	Complaint		Closed		06/12/2019	06/07/2019				
<input type="checkbox"/> 43-XX-154889		Enforcement		Closed		07/14/2020	02/22/2019				NPDB
<input type="checkbox"/> COMXX-155038		Complaint		Closed			12/10/2018				
<input type="checkbox"/> COMXX-151527		Complaint		Closed			05/21/2018				
<input type="checkbox"/> COMXX-148381		Complaint		Closed			10/13/2017				
<input type="checkbox"/> COMXX-147138		Complaint		Closed			06/05/2017				
<input type="checkbox"/> 43-XX-146543		Enforcement		Closed			05/01/2017		Boyd	Katherine	
<input type="checkbox"/> COMXX-146405		Complaint		Closed			04/25/2017		Boyd	Katherine	

Page 1 of 2

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Licensed Professional: License # 5315074807

Save Reset Help

License Type Controlled Substance	License # 5315074807	License Issue Date 03/29/2016	License Expiration Date 01/31/2022	License Status Active	Former License # 	Status Enabled
First Name Katherine	Middle Name Lee	Last Name Boyd	Suffix 	SSN ***-**-****	Birth Date MM/DD/YYYY	Reference License ID 20012010925
Organization Name 			DBA/Trade Name 		FEIN 	License State MI
Primary Phone (500) 774-4190	Primary Phone Extension 		<input checked="" type="checkbox"/> Display in ACA			
Secondary Phone	Secondary Phone Extension 					
E-mail 						
Address Line 1 15621 E 8 Mile Rd #1						
Address Line 2 						
Address Line 3 						
Country/Region --Select--	City Eastpointe	State MI	ZIP Code 48021	County Macomb		
Address Line 1 	Address Line 2 	Address Line 3 				
City 	State or Province --Select--	ZIP or Postal Code 				
CS Record Number 	CS Status 	CS Expiration Date 				

Form Name: Reference Professional Form

Licensed Professional: License # 5315074807

Menu Delete Look Up Reports Help

<input type="checkbox"/> Record ID	Assigned to Staff	Record Type	Active Task	Internal Status	Public Record Status	Status Date	Opened Date	Expiration Date	Last Name	First Name	Organization Name
<input type="checkbox"/> 5315074807		Controlled Substance License	License Status	Active	Active		03/29/2016	01/31/2022	Boyd	Katherine	



Records



My Tasks



License Professionals



COM20-004007

A SOS 4 09/03/2020 15:38:12 IP10_254_37_219/PMIPC1.

45;1;

KATHERINE LEE BOYD

F

IMAGE

26240 HARBOUR POINTE DR S R-OPER 03/01/2019 /2023

HARRISON TOWNSHIP MI 48045-3215 CORRECTIVE LENS

US

NO REPORTABLE DRIVING HISTORY ENTRIES

MI SOS (PREPARED IN COMPLIANCE WITH MCL 257.733)

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING

Record Summary for Complaint COM22-003189

Record Type

Complaint

Created: 6/9/2022 9:18 pm

Record ID: COM22-003189

Created by: PUBLICUSER1431814, MiPLUS Online

Complainant

Name (First Middle Last):

[REDACTED]

Birth Date:

[REDACTED]

Primary Phone:

[REDACTED]

Extension:

E-mail:

[REDACTED]

Preferred Channel:

Email

Section 1

Complaint Information

Select the profession for which you are lodging a complaint about:

Medicine

Full Name of Licensee:

Katherine Boyd

Address of Licensee:

38600 vandyke avenue, suite 130
Sterling Heights, MI

License Number, if known:

--

Description of Complaint:

Unauthorized vaccination-
Emotional trauma due to gynecological visit and doctor being negligent
June 9, 2022

Is this drug related?:

No

Section 1

Willingness to Testify

Are you willing to testify in a hearing?:

Yes

Section 1

Communication Consent

I authorize the Department to release my name and all relevant information pertaining to this allegation, to other law enforcement agencies. I understand I am under no obligation to do so: Yes

Do you authorize another person to communicate with the department regarding your complaint?: No

If your complaint is against a health professional, may we release your name to the professional: No

[ⓘ](#) *If your complaint is against a health professional, may we release your name and information to the practitioner*

Name: --

Address: --

Telephone Number: --

Email Address: --

Relationship to You: --

Section 2

Police Report

Is there a police report?: No

Is this drug related?: --

Police Agency: --

Police Report Incident Number: --

Section 3

Patient Medical Treatment

Is your complaint regarding the medical treatment of a patient?: Yes

Is this drug related?: No

Patient's Name: [REDACTED]

Patient's Date of Birth: [REDACTED]

Last 4 Digit's of Patient's SSN: [REDACTED]

Date of Incident: 06/09/2022

Section 4

Change in Staff Privileges

Are you reporting a change in medical staff privileges?:	No
Is this drug related?:	--
On what date did the change in staff privileges occur?:	--
Period of time licensee was employed:	--
Did the licensee resign?:	--
Was the resignation voluntary?:	--
Was the resignation in lieu of termination?:	--
Was the licensee suspended?:	--
Period of Suspension:	--
Was the licensee placed on probation?:	--
Period of Probation:	--
Was the licensee terminated?:	--

Section 5a

Criminal Convictions

Are you reporting a criminal conviction?:	No
Are you self-reporting a conviction or reporting a conviction against a licensee?:	--

Section 5b

Criminal Convictions List

Conviction:	--
Classification:	--
Offense Date:	--
Court Name:	--
Court Case Number:	--
Conviction Date:	--
Have you been sentenced?:	--
Sentencing Date:	--

Section 6

Disciplinary Action

Are you self-reporting disciplinary action taken against you by another state board?: No

State Board Name: --

Date of Action: --

Nature of Disciplinary Action: --

Attachment

Upload any supporting documentation that will help substantiate your complaint submission and expedite the complaint intake review process. Documentation may include, but is not limited to, police reports, court documents, medical records, disciplinary action dispositions, facility reporting forms, etc.

Name	Type	Size	Latest Update
1C9BE4B0-811E-41EC-8208-13A10CA75725.png	Medical Records	409 KB	06/09/2022
RPT208-OnlineApplicationQARreport_20220609_212028.pdf	Online Submission	76 KB	06/09/2022
Screens	Supporting Documentation	228 KB	06/10/2022

Signed Attestation

I understand that by submitting this complaint I authorize the Department to review and share this information with appropriate individuals involved in processing this complaint.

By checking this box, I agree to the above certification.

Date 06/09/2022

This Record Summary shows MiPLUS data in record COM22-003189 as of 7/14/2022 10:25 AM Eastern Time