IOWA STATE BOARD OF MEDICAL EXAMINERS
State Capital Complex
Executive Hills West
Des Moines, Iowa 50319

RECEIVED
MAY 29 1984
BD. OF MED. EXAM.

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY ON THE BASIS OF INTER-STATE ENDORSEMENT OR BY ACCEPTANCE OF THE CERTIFICATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS OF THE UNITED STATES OF AMERICA, INC.

To: The Iowa State Board of Medical Examiners:

I hereby make application for a license to practice medicine and surgery or osteopathic medicine and surgery in the State of Iowa and submit for your consideration the following statement concerning my age, moral character, preliminary and medical education and practice.

(Name must coincide with medical diploma)

THIS APPLICATION MUST BE TYPEWRITTEN

1. Name Joseph Michael Freund
2. Address [redacted] Home Address County
3. Place of Birth [redacted] Place Date of Birth [redacted] Month Day Year Age [redacted]
4. Name and address (Father) [redacted]
5. Name and address (Mother) [redacted]
6. Are you a citizen of the United States? Yes Give particulars
7. Identification: Height [redacted] Weight [redacted] Color of Hair [redacted]
   Color of Eyes [redacted] Identifying marks [redacted]

8. PRELIMINARY EDUCATION (Beginning with High School. Give names of institutions attended and location, with concise statement of periods of study.)

   High School Brooklyn Center HIgh , Brooklyn Center, MN 1969-73 (Name, location, dates of attendance)

   College University of MN-Morris, Morris, MN 1973-77 (Name, location, dates of attendance)

   Academic Degree of B.A. from Univ. of MN. on June 1977 Date

9. MEDICAL EDUCATION

   I have spent 4 years in the study of medicine, each year comprising 12 (Months) each, in the following institutions:

   Freshman University of MN-MPLS (Name and location of college) from Sept (Month) 1978 (Year) to AUG (Month) 1979 (Year)

   Sophomore same (Name and location of college) from Sept (Month) 1979 (Year) to Aug (Month) 1980 (Year)

   Junior same (Name and location of college) from Sept (Month) 1980 (Year) to Aug (Month) 1981 (Year)

   Senior same (Name and location of college) from Sept (Month) 1981 (Year) to June (Month) 1982 (Year)

   _____ (Name and location of college) from _____ (Month) 19__ (Year) to _____ (Month) 19__ (Year)

   I was granted the degree of Doctor of Medicine by University of Minnesota (Name of Institution)

   located at Minneapolis Minnesota, on the 12th day of June, 1982

   A photostatic copy of my diploma is submitted herewith. (Photostat must not be larger than 8x10 in. or smaller than 6x8 in.)

   I further state that I am the identical person to whom this diploma was granted, that the same was procured in the regular course of instruction without fraud or misrepresentation and that the copy presented herewith is a true copy of the original diploma of said institution.

10. INTERNSHIP

    I have (will or have) serve an internship in the following hospital: as first year of residency (below) (Name)

    _____ (Location) from _____ 19__ to _____ 19__

    (A photostatic copy of my internship certificate is submitted herewith.)

11. RESIDENCIES (Give places and dates of each service) I have served Residencies in the following hospitals:

    St. Joseph- Mercy Hospital Fam. Pract. from July 1982 to present 19__
    (Name) (Location) (Specialty)

    Mason City, IA from _____ 19__ to _____ 19__
    (Name) (Location) (Specialty)

    I was certified by -- (Name of Specialty Board) on _____ (Date)

    (Enclosed is a photostatic copy of certificate)

12. CERTIFICATION OF MEDICAL EDUCATION: (MUST BE COMPLETED BY MEDICAL SCHOOL)

    It is hereby certified that Joseph Michael Freund, M.D.

    of Mason City, Iowa, was granted a diploma with the degree of

    Doctor of Medicine by the University of Minnesota Medical School (Name of School)

    located at Minneapolis, State of Minnesota

    on the 12 day of June, 1982, and that the attached photograph is a true likeness of applicant.

    _____ Secretary or Dean of School

    W. Albert Sullivan, Jr., M.D., Associate Dean

13. STATES AND COUNTRIES IN WHICH YOU HAVE BEEN LICENSED.

State Iowa License No. R-2561 Date July1, 1982 How Obtained Nat. Boards (Exam. Recip., Nat'l. Bd.)

State _____ License No. _____ Date _____ How Obtained _____

State _____ License No. _____ Date _____ How Obtained _____

14. Answer all questions. **(If the answer to any question is YES and not fully answered below, give details in a notarized affidavit attached to the application.)**

A. Name states and/or foreign countries in which you have practiced and length of time in each none except as a resident physician since July 1982 in residency program.

B. Do you intend to practice your profession in this state? Yes Where? Mason City, ~~Charles City~~

C. List hospital staff positions (Give address and dates of service) Resident PHysician, Family Practice Dept. St. Joseph- Mercy Hospital, Mason City, IA July 1982 to present

D. Have you ever been denied Staff Membership in any hospital? no

E. Have you ever been warned or censured by, or requested to withdraw from any hospital in which you have trained, been a staff member, or held hospital privileges? no

F. Have you ever been notified, or requested to appear before any Medical Society in regard to charges or complaints filed against you? no Have you ever been rejected by a Medical Society? no

G. Have you ever failed to pass any State Medical or Osteopathic Board Examination, National Board or FLEX examination? [redacted] If so, where and how many times? [redacted]

H. Have you ever been denied a certificate by, or the privilege of taking an examination before any State Medical Board? no Have you ever been notified by, or requested to appear before any State Medical Board in regard to charges or complaints filed against you? no Has any State Medical Board suspended or revoked a license it had granted you? no

I. Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or habit-forming drugs? no

J. Are you now or have you ever been emotionally or mentally ill? no Have you ever received psychotherapy? no Have you ever been a patient (voluntarily or otherwise) in any institution for the treatment of mental or emotional illness, drug addiction, or alcohol problems? no Have you ever been treated, but not hospitalized for mental or emotional illness, drug addiction, or alcohol problems? no

K. Have you ever been convicted of a felony? no A misdemeanor? no Have any judgements ever been entered against you? no Have you ever been sued for malpractice? no

L. Do you understand that if the license asked for is granted by this Board, it will be on the truth of the statements contained herein, which if false, will subject you to criminal prosecution, and revocation of the said license certificate? I understand.

15. AFFIDAVIT OF APPLICANT:

State of IOWA

ss.

County of Cerro Gordo

I, Joseph MIchael Freund, being duly sworn state, under penalty of perjury, that the foregoing information contained in this application and any attachment is true and correct, and the attached photo is a true likeness of myself.

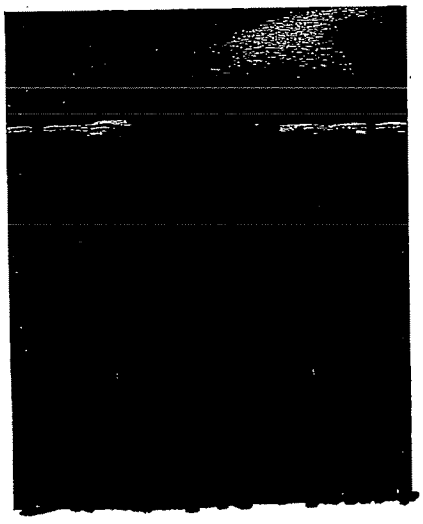
Joseph Michael Freund M.D.
(Signature of Applicant)

Sworn to before me this 16th day of May, 1984.

Susan O. Curtis
(Notary Public)

My Commission expires Sept 15, 1985.

(S E A L)



(NOTE: This Board cannot require you to attach a recent photograph on this application, however, in the absence of a photograph please furnish this Board with evidence that you are one and the same person referred to in Section 12 and Section 17.)

16. RECOMMENDATION OF SECRETARY OF LOCAL, COUNTY MEDICAL OR OSTEOPATHIC SOCIETY: If you are not a member of a county medical society, this affidavit must be signed by the Chief of Staff of the Hospital in which you are practicing or the head of the Department in which you are receiving hospital training.

I, P. R. Caropreso, M.D., Secretary
(Secretary, Chief of Staff, Department Head)
Cerro Gordo County Medical Society
(Medical or Osteopathic Society-Hospital-Department & Hospital),
certify that Dr. Joseph M. Freund, of Mason City, Iowa

is personally known to me, and that he/she is an ethical practitioner and is of good moral and professional character; I further certify that the said Dr. Joseph M. Freund is engaged in the reputable practice of medicine and surgery in the State of Iowa. I have carefully examined all the statements made by the applicant and believe them to be true in every respect. I also state the photograph attached to this application is a recent one and the likeness of said Dr. Joseph M. Freund.

Signed P. R. Caropreso MD

Date May 16, 1984 Title Secretary, Cerro Gordo County Medical Society

*AFFIDAVIT OF SECRETARY OF COUNTY MEDICAL OR OSTEOPATHIC SOCIETY, CHIEF OF STAFF OR HEAD OF DEPARTMENT IN WHICH YOU ARE TRAINING.

County of Cerro Gordo
ss.
State of Iowa

In Mason City (City) Cerro Gordo (County) Iowa (State), on the 16th day of May, 19 84 before me personally appeared ~~Dr. Joseph M. Freund~~ P. R. Caropreso MD to me known to be the party executing the foregoing instrument, and he/she acknowledged said instrument, by him/her executed, to be his/her voluntary act and deed.

NOTARY SEAL

Susan J. Cave (Notary Public)
Mason City, Iowa (Address)

17. CERTIFICATION OF SECRETARY OF THE STATE BOARD OF MEDICAL EXAMINERS
(This endorsement should not be executed unless the applicant has signed the affidavit on Page 2)

I, _____, Secretary of the _____ Board of Medical Examiners, certify that _____ was granted Certificate No. _____ on the _____ day of _____, 19____, based on _____ (Written Examination) (Date), and said certificate has never been revoked.

School of Graduation _____ (Degree B. M. — M. D.) (Date)

I further certify that the aforesaid _____ in his written examination before this Board obtained a general or flex average of _____ per cent in the following subjects:

Subject	Per Cent	Subject	Per Cent

Acting on behalf of the _____ Board of Medical Examiners, I hereby certify to the reputability of Dr. _____, based on the records of this Board, and recommend him to the Iowa State Board of Medical Examiners as a fit and proper person to receive a license to practice Medicine and Surgery.

(Secretary)

(Seal of the State Board)

(Name of Board)

(Date) (Address)

FEES: The license fee is $200.00. Fee must accompany the completed application form and the required supporting documents. No fee remitted with an application will be refunded. Fee may be remitted in any form other than a personal check.

FOREIGN GRADUATES: For information concerning the standard certificate issued by the Educational Council for Foreign Medical Graduates, write to Educational Council for Foreign Medical Graduates, 3624 Market Street, Philadelphia, Pa. 19104.

DO NOT FILL THE BLANKS BELOW

Certificate No. 24217

Book No. 5 Page 1269

Certificate Issued June 19, 1984

IOWA STATE BOARD OF
MEDICAL EXAMINERS

National Board or Interstate Endorsement Application in Medicine and Surgery and Osteopathic Medicine and Surgery

Name Joseph Michael Freund

Residence [redacted]

County of

State of

Filed 5-30, 1984

Fee Paid 5-30, 1984

STATE BOARD OF MEDICAL EXAMINERS
(Disposition of Application)

Rejected Date

Approved Date

Chairman

Vice-Chairman

Secretary

APPLICANT MUST FILL FOLLOWING BLANKS

Name Joseph Michael Freund

Present Address [redacted]

Age [redacted]

Date and Place of Birth [redacted]

Applicants Social Security or Tax No.

[redacted]

Name of College Issuing Diploma

University of Minnesota

Located at Minneapolis, MN

Date of Graduation June 12, 1982

School of Practice

Medicine
Medicine or Osteopathic Medicine and Surgery

P. O. Address to which you desire license and future renewal notices sent:

Street [redacted]

City [redacted] State [redacted]

County [redacted]

Board Member

Board Member

Board Member

Board Member

Board Member

Board Member

Instructions

Application must be accompanied by:

1. Fee of $200 (personal checks not accepted). APPLICATION FEES ARE NOT REFUNDABLE.
2. **Photostatic copies, notarized, of the following:**
   - a. Diploma from Medical College or Osteopathic College.
   - b. Certificate of one year of post-graduate training in a hospital approved by this Board.
   - c. ~~Copy of original state license~~ by examination.
   - d. A National Board Diplomat must file current certification of examination results signed by an authorized officer of the National Board.
3. FOREIGN MEDICAL GRADUATES must present a photostatic copy of a standard certificate issued by the Educational Council for Foreign Medical Graduates.
4. Foreign credentials must be translated into English.

The filing of this application does not grant any special privileges.

(Photostatic copies must be certified and exact copies of the original and must not be larger than 8x10 inches no smaller than 6x8 inches.) This application will not be accepted unless properly completed in every detail, signed and sworn to by the applicant, and properly notarized.

PAGES ONE, TWO AND FOUR MUST BE TYPEWRITTEN

Address all correspondence to:

IOWA STATE BOARD OF MEDICAL EXAMINERS
State Capitol Complex
Executive Hills West
Des Moines, Iowa 50319

CPD-76037 1/82

IOWA STATE BOARD OF MEDICAL EXAMINERS
MEDICAL DOCTOR

Name: FREUND, JOSEPH MICHAEL, M.D.	No. of Cert.: 24217
Address: [redacted]	
Birth Date: [redacted]	Date of Certif.: June 19, 1984
Degree Issued By: END:Nat. Board U of Minn. 024-04	Date of Degree: 6/12/82
Cert. Issued By: END: Nat. Board	
Remarks: S S # [redacted]	
Book 5, Page 1269	

CP-B35543 8/73

RESIDENT PHYSICIAN

NAME: FREUND, JOSEPH MICHAEL	NO.: R-2561
ADDRESS: St. Joseph Mercy Hospital, Mason City, Iowa	
AGE: 27 / DATE OF CERTIFICATE: July 1, 1982	
SPECIALITY: Family Practice	INSTITUTION: St. Joseph Mercy Hospital, Mason City, Ia.

24217

84

THE REGENTS OF

THE UNIVERSITY OF MINNESOTA

ON RECOMMENDATION OF THE FACULTY
HAVE CONFERRED UPON

Joseph Michael Freund

THE DEGREE OF

Doctor of Medicine

WITH ALL ITS PRIVILEGES AND OBLIGATIONS

GIVEN IN MINNEAPOLIS IN THE STATE OF MINNESOTA
THE TWELFTH DAY OF JUNE NINETEEN HUNDRED EIGHTY-TWO

C. Peter Magrath
PRESIDENT

Duane C. Wilson
SECRETARY

Susan L. Lowe
May 16, 1984

Family Practice Center

OF ST. JOSEPH MERCY HOSPITAL
IN AFFILIATION WITH THE UNIVERSITY OF IOWA
101 SOUTH TAYLOR • MASON CITY, IOWA 50401 • PHONE (515) 424-7766

May 16, 1984

Mr. Ronald V. Saf
Iowa State Board of Medical Examiners
State Capitol Complex
Executive Hills West
Des Moines, Iowa 50319

Dear Mr. Saf:

This letter is to certify that Joseph M. Freund, M.D. successfully completed one year of Family Practice residency in the St. Joseph Mercy Hospital Family Practice Residency Program in Mason City, Iowa from July 1, 1982, to June 30, 1983. Dr. Freund is presently a second-year resident in our program.

Sincerely,

Richard E. Munns, M.D.
Director
Family Practice Residency

REM:sa

National Board of Medical Examiners

of the

United States of America

Joseph Michael Freund, 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

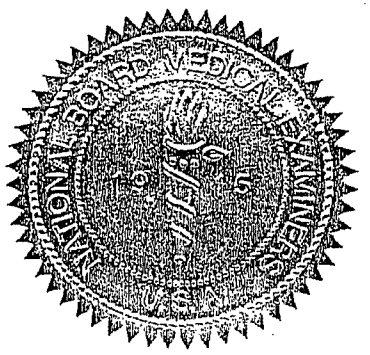
Chas Doescher, Jr.
Chairman of the Board

Edithe J. Levis
President of the Board

Philadelphia, Pa.

July 1, 1983

Susan J. Ives
May 16, 1984



Certificate No.

266304

No. R-2561

RECEIVED
MAY 29 1984
BD. OF MED. EXAM.

State of Iowa

CERTIFICATE OF LICENSE

TO PRACTICE AS A RESIDENT PHYSICIAN

THIS IS TO CERTIFY *that* JOSEPH MICHAEL FREUND *residing at* Mason City

County of Cerro Gordo *State of* Iowa *has given evidence of having received a diploma from*

University of Minnesota

in the State of Minnesota *on the* 12 *day of* June *19* 82, *and further complied with all the requirements of the Iowa law,*

THE STATE BOARD OF MEDICAL EXAMINERS

Under the provisions of an Act regulating the practice of Medicine and Surgery, hereby certifies that --he is legally authorized to practice as a Resident Physician in the State of Iowa. This certificate shall be limited to one year and may be renewed from year to year.

Dated at Des Moines, Iowa this

1 *day of* July *19* 82.

Ronald V. Saf

RONALD V. SAF
EXECUTIVE DIRECTOR

Susan J. Ames
May 24, 1984
Cerro Gordo Co. Iowa

IOWA STATE BOARD OF MEDICAL EXAMINERS

RESIDENT PHYSICIAN'S APPLICATION FOR LICENSURE

READ INSTRUCTIONS ON PAGE 3.
COMPLETE CENTER PORTION OF PAGE 4.

04/25/82
(Date)

To the Iowa State Board of Medical Examiners:

I hereby make application for a license to practice as a Resident Physician in the State of Iowa and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

(Name must coincide with medical diploma)

THIS APPLICATION MUST BE TYPEWRITTEN!

1. Name Joseph (First) Michael (Middle) Freund (Last)
2. Addresses [redacted] (Home address)
3. Place of Birth [redacted] (Place) Date of Birth [redacted] (Month Day Year) Age [redacted] County
4. Name and address (Father) [redacted]
5. Name and address (Mother) [redacted]
6. Are you a citizen of the United States? Yes If not, give particulars
7. Identification: Height [redacted] Weight [redacted] Color of Hair [redacted]
   Color of Eyes [redacted] Identifying marks [redacted]

8. PRELIMINARY EDUCATION (Beginning with High School. Give name of institutions attended and location, with concise statement of periods of study.)

   High School Brooklyn Center H.S., Mpls, MN from 09/69 to 06/73
   (Name, location, dates of attendance)
   College University-MN-Morris, Morris, MN. from 09/73 to 06/77
   (Name, location, dates of attendance)
   Academic Degree of B.A. from University of Minnesota on 06/77 (Date)

9. MEDICAL EDUCATION

   I have spent four years in the study of medicine, each year comprising ten (Months) each, in the following institutions.

Freshman	Univ. of MN, Mpls, MN (Name and location of college)	from	09 (Month)	19 78 (Year)	to	08 (Month)	19 79 (Year)
Sophomore	same (Name and location of college)	from	09 (Month)	19 79 (Year)	to	08 (Month)	19 80 (Year)
Junior	same (Name and location of college)	from	09 (Month)	19 80 (Year)	to	06 (Month)	19 81 (Year)
Senior	same (Name and location of college)	from	06 (Month)	19 81 (Year)	to	04 (Month)	19 82 (Year)
	(Name and location of college)	from	(Month)	19 (Year)	to	(Month)	19 (Year)

   I was granted the degree of Doctor of Medicine by University of Minnesota (Name of Institution)
   located at Minneapolis, MN., on the fourth day of June, 19 82

   A photostatic copy of my diploma is submitted herewith. (Photostat must not be larger than 8 x 10 in. or smaller than 6 x 8 in.)

10. INTERNSHIP.

    I Will (will or have) serve internship in the following hospital: St. Joseph Mercy Hosp. (Name)
    Mason City, Ia. (Location) from July 1 19 82 to June 30 19 83

    (A photostatic copy of my internship certificate is submitted herewith.)

11. POST-GRADUATE WORK: (Places and dates) none

12. STATES AND COUNTRIES IN WHICH YOU ARE LICENSED: none

    State ..... License No. ..... Date ..... How obtained ..... (Exam. or End.)
    State ..... License No. ..... Date ..... How obtained ..... (Exam. or End.)
    State ..... License No. ..... Date ..... How obtained ..... (Exam. or End.)

CPD-76117

13. REFERENCES:

State below names of three references:

(1) [redacted] (Name) (Position) (Street Address) (City or Town) (State)

(2) [redacted] (Name) (Position) (Street Address) (City or Town) (State)

(3) [redacted] (Name) (Position) (Street Address) (City or Town) (State)

14. GENERAL INFORMATION

Where do you intend to reside in the State of Iowa? [redacted]

What type of resident training do you propose to follow? Family Practice

Where? St. Joseph Mercy Hosp., Mason City (Name and Location of Institution)

Do you now, or have you ever, personally used narcotics or taken treatment for alcoholic or drug habit? No

Have you ever been charged with violation of any Federal, State or Local Statute? NO

Have you ever been an inmate of an institution? no

Have you ever been denied a medical license, or the privilege of taking an examination before any State Medical Examining Board? NO

If so, explain .....

Have you ever been notified by any state medical board or any medical society of any complaint against you relative to the practice of medicine? NO

If so, explain .....

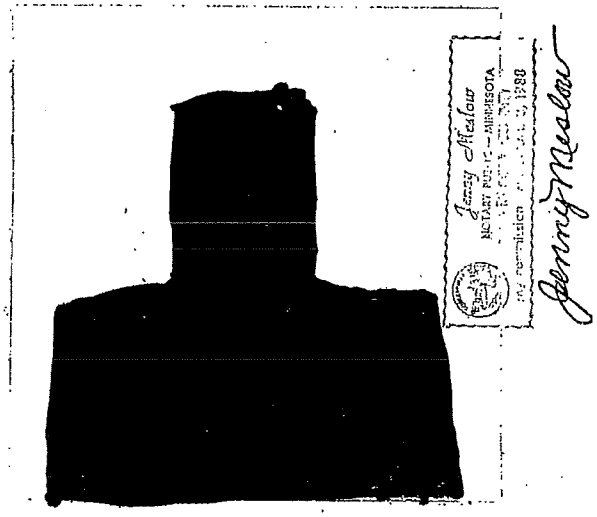
Has any State Medical Examining Board revoked or suspended a license issued to you? NO

AFFIDAVIT OF APPLICANT

State of Minnesota }
County of Hennepin } ss.

I, Joseph Freund being first duly sworn deposes and states that he is the person referred to in the above application and that the photograph of myself hereunto attached, was taken within one year from the date of filing this application.

I further state that I have not previous to this date been denied admission to examination, license or registration by any State examining board; that no certificate issued to me has ever been revoked or suspended, and that the statements herein contained are true in every respect.



Jenny Meslow NOTARY PUBLIC—MINNESOTA HENNEPIN COUNTY My commission expires Oct. 8, 1988

Jenny Meslow

Joseph Michael Freund (Full Name of Applicant)

Sworn to before me this 28th day of April, 1983.

My Commission expires: Oct. 8, 1988

Jenny Meslow NOTARY PUBLIC—MINNESOTA HENNEPIN COUNTY My commission expires Oct. 8, 1988

Jenny Meslow (Notary Public)

RECOMMENDATION OF SUPERINTENDENT OF HOSPITAL

I, Milford S. Grotnes, superintendent of the St. Joseph Mercy hospital, at Mason City, Iowa certify that Doctor Joseph M. Freund will be employed by this institution as a resident physicial beginning July 1, 1982 (Date)

I further certify that Doctor Joseph M. Freund to the best of my knowledge and belief is a person of good moral and professional character and qualified to practice as a resident physician in the State of Iowa. I have carefully examined all the statements made by the applicant and believe them to be true in every respect. I also certify that the photograph attached to this application is a recent one and the likeness of said Doctor Joseph M. Freund.

I hereby recommend Doctor Joseph M. Freund to the Iowa State Board of Medical Examiners as a fit and proper person to receive a license to practice as a resident physician in the State of Iowa.

Date 5/01/82 Milford S. Grotnes (Superintendent of Hospital)

INSTRUCTIONS

1. Application must be TYPEWRITTEN and filled out in every detail and returned to the Executive Director, Iowa State Board of Medical Examiners, State Capitol Complex, Executive Hills West, Des Moines, Iowa 50319.

2. Application must be accompanied by:

   (a) Fee of $50 (personal checks on United States banks). APPLICATION FEES ARE NOT REFUNDABLE.

   (b) Notarized photostatic copy of medical diploma.

   (c) Notarized photostatic copy of E.C.F.M.G., if foreign medical graduate.

   (d) English translation must accompany foreign credentials.

THIS APPLICATION AND THE DOCUMENTS FILED HEREIN ARE NONTRANSFERRABLE AND CANNOT BE USED FOR ANY OTHER APPLICATION FOR LICENSURE.

DO NOT FILL THE BLANKS BELOW

Certificate No. R-2561

Book No. _____ Page _____

Certificate Issued 7-1, 1982

IOWA STATE BOARD OF
MEDICAL EXAMINERS

RESIDENT PHYSICIAN'S APPLICATION FOR LICENSURE

Name Joseph M. Freund

Residence [redacted]

County of [redacted]

State of [redacted]

Filed 5-5, 1982

Fee Paid 5-10, 1982

Diploma Verified 6-12, 1982

By University of Minnesota

Returned by _____

Examined _____, 19____

General Average _____

Re-examined _____, 19____

General Average _____

APPLICANT MUST FILL FOLLOWING BLANKS

Name Joseph M. Freund

Present Address [redacted]

Age [redacted]

Date - Place of Birth [redacted] Minneapolis

Applicants Social Security

[redacted]

Name of College Issuing Diploma
Univ. of Minnesota

Located at Minneapolis

Date of Graduation 06/04/82, 19____

School of Practice Family Practice

RESIDENT PHYSICIAN'S LICENSE LAW

Any physician, who is a graduate of a medical school and is serving only as a resident physician and who is not licensed to practice medicine and surgery in this state, shall be required to obtain from the medical examiners a license to practice as a resident physician. The license shall be designated "Resident Physician, and shall authorize the licensee to serve as a resident only, under the supervision of a licensed practitioner of medicine and surgery, in an institution approved for this purpose by the medical examiners. Such license shall be valid for one year and may be annually renewed at the discretion of the medical examiners. The fee for this license shall be fifty dollars, and if extended beyond one year, an annual renewal fee of ten dollars per year shall be required. The medical examiners shall determine in each instance those eligible for this license, whether or not examinations shall be given, and the type of examinations. No requirements of the law pertaining to regular permanent licensure shall be mandatory for this resident licensure except as specifically designated by the medical examiners. The granting of a resident physician's license does not in any way indicate that the person so licensed is necessarily eligible for regular licensure, nor are the medical examiners in any way obligated to so license such individual. The medical examiners shall revoke said license at any time they shall determine either that the caliber of work done by a licensee or the type of supervision being given such licensee does not conform to reasonable standards established by the medical examiners.

UNIVERSITY OF MINNESOTA
TWIN CITIES

Office of Admissions and Student Affairs
Medical School
Box 293 Mayo Memorial Building
420 Delaware Street S.E.
Minneapolis, Minnesota 55455
(612) 373-8091
Offices at 3-100 Owre Hall

April 29, 1982

Iowa State Board of Medical Examiners
Executive Hills West
Capitol Complex
Des Moines, IA 50319

RE: Joseph Michael Freund

Dear Sir/Madam:

This will certify that Joseph M. Freund is a regularly enrolled full-time student at the University of Minnesota Medical School. Pending successful completion of Part II of the National Boards and his last quarter of course work, he is scheduled to receive the M.D. degree June 12, 1982.

Sincerely,

Pearl P. Rosenberg

Pearl P. Rosenberg, Ph.D.
Assistant Dean

PPR/lfu

FREUND, JOSEPH MICHAEL, M.D.
St. Joseph Mercy Hospital
84 Beaumont Drive
Mason City, Iowa 50401

R-2561

Issued: 7-1-82

7-1-83 to 7-1-84

24217