1. Read the questionnaire to familiarize yourself before completing. 2. Type or print legibly. 3. It possible, keep a copy of your completed questionnaire for your future reference. 4. You will receive a proof of your data prior to publication for final approval. Name as you wish it to appear in the directory. Berry Leondas H. 1. Last Name First Middle AMA ME number (not for publication Any member whose dues have been paid in advance for life is designated Life Member (LM). Are you a Life Member? Yess No. 3. Place of Birth: City Woodsdale N.C. State/Province/Country Month Vol. Day 2.0 Year 1902. 4. Married to Entra FORD BERRY 5. Subspecialty: Indicate your 3 major subspecialties by first, second and third preference (Limited to the subspecialties listed below). Allergy Administration Family Practice Neuropsychiatry Aerosposychiatry Proctology Ammistration General Medicine Nutrition Nutrition Heading Heading Heading Proctology Physicial Heading Headi	0	BIOGRAPHICA	L DIRECTO	RY OF TH	E AMERICAN COL	LEGE OF I	PHYSICIAN	VS
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18.	Type of work: Indicate P(rimar						
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	center, college, industr	tional setting (HMO, clinic or l	health	Administration (Se CON	V#.1)		
	Teaching/training (of ot			Other, please specify			
19.	Work Site: Indicate P(rimary)	or S(econdary)					
	Solo private office pract	tice	* 1111111111111111111111111111111111111	Medical school (including pare	nt university and		
		ctice (including multispecialty		associated facilities)			
	groups) Military (U.S. or Canadi	an)		Other General Hospital Prison or correctional facility			
	U.S. or Canadian Govern	nment, non-military		Publicly sponsored clinic (alco	hol, drug, mental health, etc)		
	(including Veterans Ad			Other private, for profit non-ho xinstitution (including industry			
	provincial/local)	Jilai (i.e. State/		Other Private, non-profit, non-h	nospital organization/institution		
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	Full-time private practic	ours/week) in essentially one	position	Part-time (5 to 35 hours/week) Not working or working less th	an 5 hours/week but not retired		
	Full-time (35 or more h			Not working or working less th			
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22.	Military Record: Active duty in	n the Medical Corps; include t	oranch of service, dates a	and final rank at discharge			
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23	ACP Activities: List of offices	and committees held					
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24.	offices held with term of office		I, state and local societies	s. Indicate membership status, pas	t presidencies as well as current		
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25.	Professional Interests: Brief C	rescription. Not t	o exceed 30 words.			
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26.	Publications: List the number of most recent title.	of your profession	onally significant books and	articles. Indicate if Auth	or, Coauthor, Contributor,	Editor or Coeditor. Give year
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27.	Community Health: List part	icipation in volur	ntary health organizations a	nd community planning	activities which relate to	your profession.
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28.	Geographical Location: You visame city and state of your	will be listed und mailing address.	ler the city and state of you Only ONE listing will be e	r preference. The city a stered. Cross references State	nd state of your geograph will not be used.	ical location need not be the
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