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Application for Physician Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Bresette
First Name Robin
Middle Name Jean Kutil
Suffix
Maiden Name Kutil
M.D. ☒ D.O. ☐
Robin Jean Kutil
All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore, you should consider what your preferred address is for these purposes.

Practice Address
☒ Public Access
☒ Mailing

Street 5107 E. Kellogg Dr
City Wichita State/Province KS ZIP Code 67218
Telephone 316.425.3215 Fax 316.425.345
E-mail address jburkhart@itrustwomen.org
Alternate Phone (e.g. pager or cell phone)

Home Address
☐ Public Access
☐ Mailing

Street
City State/Province ZIP Code
Telephone Fax
E-mail address
Alternate Phone (e.g. pager or cell phone)

Applicant Name: Robin Bresette Date: 8/2/13

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3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

Confidential 1977 — Date of Birth (mm/dd/yyyy)
West Allis — Birth City
WI — Birth State/Province
USA — Birth Country

F — Gender
Confidential — Social Security Number
1194757419 — NPI Number

Are you a U.S. Citizen? ☒ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI , please go to http://www.cms.hhs.gov/NationalProvIdentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School (attach additional pages if necessary)

1. School Name University of WI School of Medicine & Public Health
Address 750 University Ave
City Madison State/Province WI ZIP Code 53706
Country USA
Attendance Dates (From – To) 8·1·1999 – 5·15·2003
Graduation Date 5·15·2003 Degree M.D.

2. School Name
Address
City State/Province ZIP Code
Country
Attendance Dates (From – To)
Graduation Date Degree

Applicant Name: Robin Bresette Date: 8·2·13

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5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable) N/A

1. Medical School Name ______
Address ______
City ______ State/Province ______ ZIP Code ______
Country ______
Attendance Dates (From – To) ______
Graduation Date ______ Degree ______

2. Medical School Name ______
Address ______
City ______ State/Province ______ ZIP Code ______
Country ______
Attendance Dates (From – To) ______
Graduation Date ______ Degree ______

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6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name University of MN / St. Joseph's Hospital Family Medicine

Hospital Address 580 Rice St.

City St. Paul

State/Province MN

ZIP Code 55103

Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☒ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other

Department/Specialty: Family Medicine

From: 07 / 2003 To: 06 / 2006 Successfully Completed? Yes ☒ No ☐ In Progress ☐

Month Year Month Year

2.Hospital Name

Hospital Address

City

State/Province

ZIP Code

Country

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PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other

Department/Specialty:

From: / To: / Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

Applicant Name: Robin Bresette Date: 8.2.13

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6. Postgraduate Training (continued) N/A

3.Hospital Name__________

Hospital Address__________

City__________

State/Province__________

ZIP Code__________

Country__________

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other__________

Department/Specialty:__________

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

4.Hospital Name__________

Hospital Address__________

City__________

State/Province__________

ZIP Code__________

Country__________

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other__________

Department/Specialty:__________

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

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7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)	Number of attempts
		☐ P ☐ F	
State Board Exam State			
FLEX Pre-1985		☐ P ☐ F	
FLEX Component 1		☐ P ☐ F	
FLEX Component 2		☐ P ☐ F	
LMCC – Single		☐ P ☐ F	
LMCC – Part I		☐ P ☐ F	
LMCC – Part II		☐ P ☐ F	
NBME Part I		☐ P ☐ F	
NBME Part II		☐ P ☐ F	
NBME Part III		☐ P ☐ F	
SPEX		☐ P ☐ F	
NBOME Part I		☐ P ☐ F	
NBOME Part II		☐ P ☐ F	
NBOME Part III		☐ P ☐ F	
COMLEX-USA Level 1		☐ P ☐ F	
COMLEX-USA Level 2, CE		☐ P ☐ F	
COMLEX-USA Level 2, PE		☐ P ☐ F	
COMLEX-USA Level 3		☐ P ☐ F	
COMVEX		☐ P ☐ F	
USMLE Step I	06 · 14 · 2001	☒ P ☐ F	1
USMLE Step II, ~~CS~~	02 · 19 · 2003	☒ P ☐ F	1
USMLE Step II, ~~CK~~		☐ P ☐ F	
USMLE Step III	03 · 12 · 2004	☒ P ☐ F	1

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8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG website at www.ecfmg.org.

8. ECFMG (if applicable) N/A

Certificate Number ______ Issue Date ______ Valid Through Date ______

9. State/Province Professional Licensure whether temporary or permanent: List all states and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license or certification. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states or provinces in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure – MD or DO only – attach additional pages if necessary

#	State/Province	Type (MD, DO)	License Number	Status	Issue Date
1.	MN	M.D.	47029	active	2004
2.	SD	M.D.	7050	expired	2007
3.	ND	M.D.	1136	active	2009
4.					
5.					
6.					
7.					
8.					
9.					
10.					

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All Other Health Care Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary. N/A

1. State/Province ______ Type ______ License Number ______ Status ______ Issue Date ______
2. State/Province ______ Type ______ License Number ______ Status ______ Issue Date ______
3. State/Province ______ Type ______ License Number ______ Status ______ Issue Date ______
4. State/Province ______ Type ______ License Number ______ Status ______ Issue Date ______
5. State/Province ______ Type ______ License Number ______ Status ______ Issue Date ______

10. Chronology of Activities: List ALL activities (medical, non-medical and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: 07 Year: 2003 To: Month: 06 Year: 2006	Practice/Employment Name U of MN / St. Joseph's Family Med. (or list non-working time as indicated above) Practice/Employment Address 580 Rice St City St Paul State/Province MN ZIP Code 55103 Country USA Position and Department Resident % Clinical 100 % Administrative ______ Employment ☒ Staff Privileges ☐ Affiliation ☐ Other ______
2. From: Month: 08 Year: 2006 To: Month: 11 Year: 2008	Practice/Employment Name Planned Parenthood MN, SD & ND (or list non-working time as indicated above) Practice/Employment Address 671 Vandalia St City St. Paul State/Province MN ZIP Code 55114 Country USA Position and Department Staff MD % Clinical 100 % Administrative ______ Employment ☒ Staff Privileges ☐ Affiliation ☐ Other ______

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Dates: From/To	Practice/Employment
3. From: Month: 08 Year: 2006 To: Month: 02 Year: 2012	Practice/Employment Name Midwest Health Center for Women (or list non-working time as indicated above) Practice/Employment Address 33 S. 5th St., Fourth Floor City Minneapolis State/Province MN ZIP Code 55402 Country USA Position and Department Staff MD % Clinical 100 % Administrative Employment ☒ Staff Privileges ☐ Affiliation ☐ Other
4. From: Month: 11 Year: 2006 To: Month: 03 Year: 2008	Practice/Employment Name Health Partners (or list non-working time as indicated above) Practice/Employment Address 8600 Nicollet Ave S. City Bloomington State/Province MN ZIP Code 55420 Country USA Position and Department Staff - Urgent Care % Clinical 100 % Administrative Employment ☒ Staff Privileges ☐ Affiliation ☐ Other
5. From: Month: 06 Year: 2009 To: Month: 09 Year: 2010	Practice/Employment Name Twin Cities Medical Clinic (or list non-working time as indicated above) Practice/Employment Address 3264 W. Lake St City Minneapolis State/Province MN ZIP Code 55416 Country USA Position and Department Urgent Care % Clinical 100 % Administrative Employment ☒ Staff Privileges ☐ Affiliation ☐ Other
6. From: Month: 09 Year: 2009 To: Month: current Year:	Practice/Employment Name Red River Women's Clinic (or list non-working time as indicated above) Practice/Employment Address 512 1st Ave N City Fargo State/Province ND ZIP Code 58102 Country USA Position and Department Staff MD % Clinical 100 % Administrative Employment ☒ Staff Privileges ☐ Affiliation ☐ Other

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Dates: From/To	Practice/Employment
7. From: Month: 05 Year: 2009 To: Month: current Year:	Practice/Employment Name Neighborhood Health Source (or list non-working time as indicated above) Practice/Employment Address 3300 Fremont Ave N City Minneapolis State/Province MN ZIP Code 55412 Country USA Position and Department Staff - Fam. Medicine % Clinical 100 % Administrative Employment ☒ Staff Privileges ☐ Affiliation ☐ Other
8. From: Month: 02 Year: 2012 To: Month: current Year:	Practice/Employment Name Whole Womans Health (or list non-working time as indicated above) Practice/Employment Address 825 S. 8th St, #1018 City Minneapolis State/Province MN ZIP Code 55404 Country USA Position and Department staff % Clinical 100 % Administrative Employment ☒ Staff Privileges ☐ Affiliation ☐ Other
5. From: Month: Year: To: Month: Year:	Practice/Employment Name (or list non-working time as indicated above) Practice/Employment Address City State/Province ZIP Code Country Position and Department % Clinical % Administrative Employment ☐ Staff Privileges ☐ Affiliation ☐ Other
6. From: Month: Year: To: Month: Year:	Practice/Employment Name (or list non-working time as indicated above) Practice/Employment Address City State/Province ZIP Code Country Position and Department % Clinical % Administrative Employment ☐ Staff Privileges ☐ Affiliation ☐ Other

Applicant Name: Robin Bresette Date: 8.2.13

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11. Malpractice Liability Claims Information (copy this form to report multiple claims) N/A

Name of patient involved: ____________________

In which state did the action take place? __________ Case number (if applicable) __________

Which court? ____________________
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: ____________________

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out)
☐ Other ____________________

Amount of judgment or settlement $ __________ Amount paid on your behalf $ __________

Month and year of event precipitating claim: ____________________

Month and year of lawsuit: ____________________

Insurance carrier at time: ____________________

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other __________

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Applicant Name: Robin Bresette Date: 8.2.13

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Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

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Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

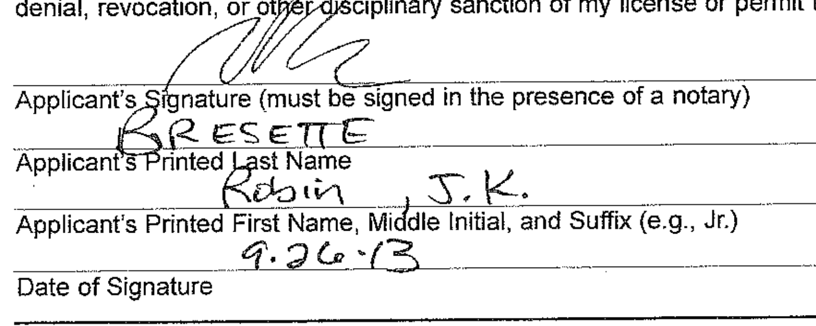
I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.



Applicant's Signature (must be signed in the presence of a notary)

BRESETTE
Applicant's Printed Last Name

Robin, J.K.
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

9.26.13
Date of Signature

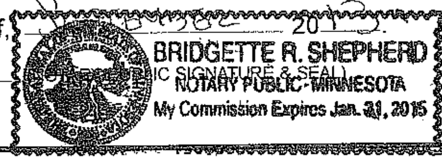
NOTARY

Dated 9-26-2013 Signed Bridgette R. Shepherd

State of MINNESOTA County of HENNEPIN

SUBSCRIBED AND SWORN TO before me this 26th day of, 2013.

My commission expires: JAN 31, 2015



(NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: Robin Bresette Date: 8.2.13

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Kansas State Board of Healing Arts
Addendum 1

Discipline applying for: (Check appropriate item)

☒ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

License Designation: Please select the license designation you are requesting.

☒ Active — A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.

☐ Federal Active — A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.

☐ Inactive — A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.

☐ Exempt — A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect. I acknowledge by marking the exempt check box, that with an exempt license I will not be a health care provider as defined by K.S.A. 40-3401, that I am not required to maintain professional liability insurance in accordance with K.S.A. 40-3401 and that services I render while a holder of an exempt license will not be insured or covered by the Health Care Stabilization Fund. I intend to engage in the following professional activities in Kansas:____________________

Additional Information:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☒ No
2. Give location of intended practice in Kansas 5107 E. Kellogg Dr, Wichita, KS 67218
3. Primary Specialty Family Medicine / Womens Health

   American Board Certified Family Medicine American Board Eligible ____________

Statement of Health:

4. Do you presently have any physical or mental problems or disabilities which could effect your ability to competently practice your particular branch of the healing arts or your particular specialty?

   ☐ Yes ☒ No

   If yes, applicant shall file with this application, a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.

Name (Printed or typed): Robin Bresette Date: 8.2.13

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Kansas State Board of Healing Arts
Addendum 2

Please answer each of the following questions by putting a check (✓) in the appropriate box. All "yes" answers MUST be thoroughly explained in detail in a separate signed page. You are required to furnish complete details including date, place, reason and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant. If you are unsure of your response to a particular question, check (✓) the "yes" box and submit the appropriate form if required. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check (✓) the "no" box.

1. Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training or educational program, including but not limited to medical school, prior to completing the training?
   ☐Yes ☒No
2. Have you ever had any application for any professional license refused or denied by any licensing authority?
   ☐Yes ☒No
3. Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?
   ☐Yes ☒No
4. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?
   ☐Yes ☒No
5. Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?
   ☐Yes ☒No
6. Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?
   ☐Yes ☒No
7. Have you ever voluntarily surrendered any professional license?
   ☐Yes ☒No
8. Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation, or had any other disciplinary action taken against any professional license you have held?
   ☐Yes ☒No
9. Have you ever been notified or requested to appear before a licensing or disciplinary agency?
   ☐Yes ☒No
10. To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility?
   ☐Yes ☒No
11. Has any professional association imposed any disciplinary action against you?
   ☐Yes ☒No
12. Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?
   Confidential
13. Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?
   Confidential

14. Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?
Confidential

15. Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?
Confidential

16. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?
☐ Yes ☒ No

17. Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?
☐ Yes ☒ No

18. Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?
☐ Yes ☒ No

19. Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency?
☐ Yes ☒ No

20. Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.
☐ Yes ☒ No

21. Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.
☐ Yes ☒ No

22. Have you ever been court-martialed or discharged dishonorably from the armed services?
☐ Yes ☒ No

23. Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself?
☐ Yes ☒ No

24. Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company?
☐ Yes ☒ No

25. Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company?
☐ Yes ☒ No

Name (Printed or typed): Robin Bresette Date: 8.3.13

RECEIVED
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