Maine.gov

REGAN N. THEILER, MD

10/25/2012 7:28:26 AM

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BOARD OF LICENSURE IN MEDICINE

MEDICAL DOCTOR

License Number: **MD18899**
Status: **Active**
First Licensure: **08/03/2011**
Expiration Date: **10/31/2013**

History

Detailed license history prior to November 14, 2011 is unavailable online.

License Type	Start Date	End Date
MEDICAL DOCTOR	08/03/2011	10/31/2013

Supervised PA (2 records) hide

Name	Issue Date	License Number
ERIN L. HAYNES, PA-C	09/01/2011	PA736
Practice Name: **Planned Parenthood**		
SARAH L. HURLEY, PA-C	09/01/2011	PA1138
Practice Name: **Planned Parenthood**		

Specialty (1 record) hide

The Board does not verify current specialties. To determine if a physician has been board certified by the American Board of Medical Specialties please visit www.abms.org.

Description	Origin
Obstetrics and Gynecology	ABMS Board Member certified

License/Disciplinary Action

No Records.

GENERAL INFORMATION

Gender: **Female**

Other Addresses (1 record) hide

Address	Type
183 TALCOTT RD STE 101 WILLISTON, VT 05495-2075	Business

Other Phone Numbers (1 record) hide

Phone Number	Type
+1 (409) 370-9644	Work

Education (1 record) hide

Type	Completion Date	Provider
MD	06/01/2003	UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

Education and Training Note: Information up to the date of initial licensure is verified by the Board. Information provided by the licensee after this date is not verified by the Board.

Please Note: Despite our efforts to be accurate, these pages may contain errors. We present this website to you with a good-faith representation that the information it contains is generally reliable. Information on this site should not be relied upon for legal purposes. The information may not show a complete history. If you need further information, we would encourage you to contact us directly (207-287-3601) or seek the advice of a professional.

018899

We are pleased to provide you with this certificate of registration of your Maine medical doctor license, which is to be displayed in your primary place of practice with your Maine license certificate. We are also providing you with a wallet card evidencing the continuing validity of your Maine license.

Please write to the Board at 137 State House Station, Augusta, ME 04333-0137 if your address changes, if your professional activities alter the basis upon which your Maine license has been registered, or if you have any question about your Maine license record.

Maine Board of Licensure in Medicine
Medical Doctor License

Licensee Name:
Regan N Theiler, M.D.
Maine License #: 018899
Expiration Date: October 31, 2013

Maine Board of Licensure in Medicine
Medical Doctor License

This is to certify that the physician named below is licensed for the practice of medicine and surgery in the State of Maine and that the license is validly registered for the period August 03, 2011 through October 31, 2013 pursuant to Title 32, Maine Revised Statues of 1964, Chapter 48, as amended. If this registration certificate is marked "Inactive", the licensee may not lawfully provide professional services within the borders of the State of Maine.

LICENSEE NAME: Theiler, Regan N, M.D.
MAINE LICENSE No. 018899

Issue Date: August 03, 2011 **Expiration Date: October 31, 2013**

Maroulla S. Gleaton, M.D. Secretary
Maine Board of Licensure in Medicine

I Maroulla S. Gleaton, M.D. have reviewed the application for licensure in the State of Maine for: **Regan N. Theiler, M.D.** on **DATE 8/2/11**

I have initialed my decision below:

LIST A ___X___ LIST B _____ LIST C _____ LIC COM _____

COMMENTS:

Maroulla S Gleaton, M.D.
Board Secretary

Maroulla S Gleaton MD

9-11

PERMANENT

LIC #:

ISSUED:
EXPIRES:

DATE APP REC'D: 6/16/11 APP FEE PD: $700 REC'D: 6/16/11

NAME: THEILER, REGAN N. SS#: [redacted]

PLACE OF BIRTH: OSSEO, WI DOB: [redacted]

MEDICAL SCHOOL: UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

LOCATION: MADISON, WI YEAR GRAD: 2003

SPECIALTY: OBSTETRICS & GYNECOLOGY AM BD CERT (Y) N

LICENSE EXAM:	BASED ON	ON FILE	NUMBER/PLACE
☑ USMLE	1, 2, 3	☑	5-041-870-6
☐ NBME	I, II, III	☐	
☐ FLEX		☐	

MALPRACTICE N/R OTHER PERSONAL DATA 15 ☑ NPDB 6/17/11

☑ FCVS 7-5-11 ☑ LICENSES [redacted], TX ☑ REFERENCES (2)

COMMENTS:

APPROVAL

D. SPRAGUE DATE 8-2-11 GARY R HATFIELD, MD ____ DATE ____

LIST A ✓ LIST B ____ LIST C ____ LIC COM ____

COMMENTS:

BOARD APPROVED - YES ☐ NO ☐ APPROVAL DATE ____

WRITTEN EXAM SENT: E-XAM REC'D 7/18/11 SCORE 100 %

1220992

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.

RECEIVED
V#283
JUN 16 2011
$700
BOARD OF LICENSURE IN MEDICINE

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)

Theiler
Applicant's Printed Last Name

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

6/15/11
Date of Signature

PAMELA A. SIMMONS
NOTARY PUBLIC STATE OF TEXAS
COMMISSION EXPIRES:
01-25-2013

NOTARY

Dated 6/15/11 Signed Pamela A Simmons

State of Texas County of Galveston

SUBSCRIBED AND SWORN TO before me this 15th day of, June 20 11.

My commission expires: 1-25-2013 (NOTARY PUBLIC SIGNATURE & SEAL)

ADDENDUM 1

1. SPECIALTY

Please list any specialties or subspecialties, and if you are ABMS board certified in any specialty, check the box.

Primary Specialty: Obstetrics and Gynecology ☒ Specialty2: _____ ☐

Specialty3: _____ ☐ Specialty4: _____ ☐

2. MEDICAL LICENSURE

List all countries **outside the U.S. or Canada** where you have held, now hold, or have applied for a medical license.

Country	Cert. #	Status	Date Expires	Country	Cert. #	Status	Date Expires

3. LIABILITY INSURANCE DATA

Information you supply here is required for the Maine Rural Health Access Program {24-A MRSA, Ch. 75, §6304, (3)}. The information will be reported to the Maine Superintendent of Insurance for administration of this program as provided in that law. Maintenance of professional liability insurance is not a requirement to maintain a Maine medical license in force. Please select 'Self Insured' if you have no professional liability insurance, or if you only pay a portion of the premium.

Please check the appropriate box to indicate the method you employ to secure professional medical malpractice liability insurance.

☐ Self Insured ☐ Physician Paid ☒ Employer Paid

If you checked off "Employer Paid", please enter the name of the employer who or which paid your premiums here: University of Texas

Insurance Company (Name/Address):
Self-Insured, State of Texas

Policy #: _____

4. ADDITIONAL INFORMATION

Will you practice in Maine within the next year? ☒ Yes ☐ No If yes, in what community? Portland

5. HOSPITAL AFFILIATIONS

List **in chronological order** all hospitals where you have held or now hold privileges. Include all periods of time (Month and Year) from the date of completion of residency to the present. Be certain to report **COMPLETE ADDRESSES.** Failure to do so will delay the application process. You may photocopy this page, if necessary.

From Mo./Yr.	To Mo./Yr.	Name of Hospital, Institution, or Practice	Complete Address (Street, City, State, Zip)	Nature of Experience	Office Use Only S	Office Use Only R
8/2007	6/2011	UTMB John Sealy Hospital	301 University Blvd Galveston, TX 77555	Ob/Gyn Faculty	6/20	7/5
9/2009	6/2011	Mainland Medical Center	6801 Emmett F Lowry Expressway Texas City, TX 77591	Courtesy privileges	6/20	7/11

ADDENDUM 2

PERSONAL DATA

Check off (X) each appropriate response. Every 'YES' response must be fully explained by written statement on a separate 8.5" x 11" sheet of white paper. Each such explanation must be cross-referenced with the question number, and must be signed, dated, and submitted to the Board.

YES NO

☐ ☒ 1. Have you EVER had ANY licensing authority (INCLUDING MAINE) deny your application for any type of license, or take any disciplinary action against the license issued to you in that jurisdiction, including but not limited to warning, reprimand, fine, suspension, revocation, restrictions in permitted practice, probation with or without monitoring?

☐ ☒ 2. Have you EVER been notified of the existence of allegations involving you, filed with or by ANY licensing authority (INCLUDING MAINE), which allegations remain open as of the date of this application?

☐ ☒ 3. Have you EVER left a medical licensing jurisdiction (INCLUDING MAINE) while a complaint or allegation was pending?

☐ ☒ 4. Have you EVER been denied registration, or had your ability to prescribe or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended by, or surrendered to

☐ ☒ a) The U. S. Drug Enforcement Administration (US DEA)?

☐ ☒ b) Any state/territory of the U. S., INCLUDING MAINE?

☐ ☒ 5. Have you EVER received a sanction from Medicare or from any state Medicaid program?

6. The purpose of the following questions is to determine the current fitness of the applicant to practice medicine. The following inquiries concern medical, mental health, and addiction issues. This information is treated confidentially by the Board. The mere fact of treatment for medical, mental health or addiction(s) is not, in itself, a basis on which an applicant is ordinarily denied licensure when he/she has demonstrated personal responsibility and maturity in dealing with these issues. The Board encourages applicants who may benefit from such treatment to seek it. The Board may deny a license to applicants whose ability to function in the practice of medicine or whose behavior, judgment, and understanding is impaired by a medical, mental health or addictive condition.

☐ ☒ a. Since becoming a medical student, have you been diagnosed with or treated for a medical, mental health, or addictive condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?

☐ ☒ b. Within the last five (5) years have you been diagnosed with or treated for any medical, mental health, or addictive disorder that impaired your behavior, judgment, understanding, or ability to function in school, work or other important life activities?

☐ ☒ c. Are you now, or have you during the past five (5) years been dependent upon alcohol or habituating drugs or undergone treatment for such?

Yes No N/A

☐ ☐ ☒ d. If any of your answers to questions 6(a-c) is "Yes," are the limitations or impairments caused by your medical, mental health, or addictive condition reduced or improved because you receive ongoing professional treatment (with or without medication) or because you participate in a professional monitoring program?

☐ ☒ e. Within the last five (5) years have you ever raised the issue of consumption of drugs or alcohol or the issue of a medical, mental health or addictive disorder as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority?

☐ ☒ f. Are you currently engaged in the illegal use of drugs or misuse of any drugs?

☐ ☒ g. Have you ever been diagnosed with or treated for any type of sexual behavior disorder?

☐ ☒ 7. Have you EVER been charged, summonsed, indicted, arrested, or convicted of any criminal offense, including when those events have been deferred, set aside, dismissed, expunged or issued a stay of execution? Please include motor vehicle offenses but not minor traffic or parking violations.

YES NO

☐ ☒ 8. Have you EVER applied for hospital, HMO or other health care entity privileges which were denied?

☐ ☒ 9. Have you EVER had your staff privileges or employment at any hospital, nursing home, HMO, or other health care entity terminated, revoked, reduced, restricted in any way, suspended, made subject to probation, limited in any way, or withdrawn involuntarily?

☐ ☒ 10. Have you EVER voluntarily surrendered privileges or resigned from staff membership during peer review or investigation or to avoid peer review or investigation?

☐ ☒ 11. Have you EVER been deselected from a managed care organization physician panel?

☐ ☒ 12. Have you EVER been disciplined by a professional society or resigned while accusation was pending?

☐ ☒ 13. Have you EVER been named as a party or a defendant, or as an employee of a party or a defendant, in a medical malpractice liability claim or lawsuit, including nuisance suits settled, adjudicated by a court in favor of the other party, or settled by your insurance company/representatives without your express consent?

☐ ☒ 14. Do you have any open malpractice claims?

☒ ☐ 15. Do you intend to practice medicine within the State of Maine without active medical staff privileges at a Maine hospital?

ADDENDUM 3

Maine Board of Licensure in Medicine

Professional (Malpractice) Liability Claims Experience

Duplicate For Multiple Claims

My Name:

Identity of Case:

Date and Place of Original Occurrence:

Malpractice Alleged By Claimant:

Summary of My Defense:

Current Status of Case (Include payment amounts):

Name and Address of Insurance Company and/or Attorney Defending the Case:

Friday, June 10, 2011

Question 15:

I am planning to work as medical director of Planned Parenthood outpatient clinics in Maine, but not to actively practice obstetrics or gynecologic surgery at any hospitals in Maine. I do not at this time have plans to apply for hospital privileges.

Regan Theiler, MD, PhD

Uniform Application for Physician Licensure

UA Username rtheiler **Date Submitted** 6/1/2011
FCVS Status Applicant has an FCVS Packet

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 Theiler
First Name Regan Nell
Middle Name
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

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.

2. Address/Phone

Business
[X] **Public Access**
[X] **Mailing**

Street Planned Parenthood Northern New England
Talcott Rd
City Williston **State/Province** VT **Zip Code** 05495
Country USA
Telephone 4093709644
Fax
Email rtheiler2000@yahoo.com
Alternate Phone

Home
[ ] **Public Access**
[X] **Mailing**

Street Planned Parenthood Northern New England
Talcott Rd
City Williston **State/Province** VT **Zip Code** 05495
Country USA
Telephone 4093709644
Fax
Email rtheiler2000@yahoo.com
Alternate Phone

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

[redacted]	Osseo	Wisconsin	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	[redacted]			
Gender	Social Security Number	NPI	Are you a U.S. Citizen?	[X] 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

1

School Name University of Wisconsin Medical School
Address 750 Highland Drive
Room 2141G HLSC

City Madison
State/Province WI
ZIP Code 53705
Country USA
Attendance Dates **From (mm/yyyy)** 08/1996 **To (mm/yyyy)** 05/2003
Graduation Date 5/15/2003
Degree MD

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)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	From (mm/yyyy)	To (mm/yyyy)	In Progress
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	From (mm/yyyy)	To (mm/yyyy)	In Progress
Certification Date			

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

1 **Hospital Name** Emory University School of Medicine
Hospital Address 69 Jesse Hill Jr Drive

City Atlanta
State/Province Georgia
ZIP Code 30303
Country USA

PGY: (e.g., 1, 2, 3, etc.) [ ] **Internship** [X] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Obstetrics and Gynecology

From: 07 /2005 **To:** 06 /2006 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]

Month Year Month Year

2 **Hospital Name** Emory University School of Medicine
Hospital Address 69 Jesse Hill Jr Drive

City Atlanta
State/Province Georgia
ZIP Code 30303
Country USA

PGY: (e.g., 1, 2, 3, etc.) [ ] **Internship** [ ] **Residency** [ ] **Fellowship** [ ] **Research** [X] **Other**

Department/Specialty Obstetrics and Gynecology

From: 07 /2006 **To:** 06 /2007 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]

Month Year Month Year

3 **Hospital Name** Emory University School of Medicine
Hospital Address 69 Jesse Hill Jr Drive

City Atlanta
State/Province Georgia
ZIP Code 30303
Country USA

PGY: (e.g., 1, 2, 3, etc.) [X] **Internship** [ ] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Obstetrics and Gynecology

From: 07 /2003 **To:** 06 /2004 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]

Month Year Month Year

4 **Hospital Name** Emory University School of Medicine
Hospital Address 69 Jesse Hill Jr Drive

City Atlanta
State/Province Georgia
ZIP Code 30303
Country USA

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

Department/Specialty Obstetrics and Gynecology

From: 07 /2004 **To:** 06 /2005 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

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	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		10/1998	☐ P	☐ F	1
USMLE Step 2		04/2003	☐ P	☐ F	1
USMLE Step 3		10/2004	☐ P	☐ F	1

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 web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states 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

1. **State/Province** TX **Practitioner Type (MD, DO, etc.)** MD **Type of License (Full, Temporary, etc.)**
   License Number M6911 **Status** Inactive **Issue Date** 7/25/2007
2. **State/Province** GA **Practitioner Type (MD, DO, etc.)** OTHER **Type of License (Full, Temporary, etc.)**
   License Number 000305 **Status** Inactive **Issue Date** 7/1/2003

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

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2007 To: Month: Year: In Progress [X]	**Practice/Employment Name** University of Texas Medical Branch (or list non-working time as indicated above) **Practice/Employment Address** 301 University Blvd **City** Galveston **State/Province** Texas **ZIP Code** 77555 **Country** USA **Position and Department** Assistant Professor-Obstetrics and Gynecology **% Clinical** 25 **% Administrative** 75 **Employment** [X] **Staff Privileges** [ ] **Affiliation** [ ] **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

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 judgement 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:

Federation of State Medical Boards

UA Summary of Reported Board Actions

Physician Identification

Name: **Regan Nell Theiler**

Alternate Names:

DOB: [redacted]

Medical School: **University of Wisconsin Medical School**

Year of Graduation: 2003

Summary of Reported Board Actions

No Reportable Board Actions Found

Reportable Actions as of UA Submission Date : 06/01/2011

UA Submission ID : 33,648

UA User Name : rtheiler

Federation of State Medical Boards
UA Licensure History

Physician Identification

Name:	Regan Nell Theiler
Alternate Names:	
DOB:	[redacted]
Medical School:	University of Wisconsin Medical School
Year of Graduation:	2003

Licensure History

State Board/Licensing Entity	License Number	Issue Date	Expiration Date
Texas Medical Board	M6911	06/08/2007	02/28/2013

HCA

July 11, 2011

Yolanda Crutcher
Mainland Medical Center
6801 Emmett F. Lowry Expressway
Texas City, Tx 77591

RE: **Regan Nell Theiler, MD**

This letter acknowledges the receipt of your on line request for verification of the above provider's affiliation with the below hospitals. The information about the provider displayed below is current as of the last Board Meeting.

Hospital Facility	Specialty	Category	Last Board Meeting Date	Status	Original Appt. Date	Appt. End Date
Mainland Medical Center	Obstetrics & Gynecology	Consulting	2/28/2011	No Issues Noted	10/1/2008	3/31/2011

The Last Board Meeting Date above indicates the last date on which the Hospital's Board met to consider credentialing issues. If actions are being processed after that date, Hospitals are instructed to remove this Practitioner from this automated response. If you have further questions, please feel free to call the appropriate Medical Staff Office (MSO):

Mainland Medical Center
6801 Emmett F. Lowry Expwy
Texas City, TX 77591
(409)938-5122

Response

HCA Corporate

Welcome TRACY

Please select Search for Provider to enter criteria for data results. The search will include all providers that are in the HCA enterprise-wide database.

Last Name THEILER

NPI Number

profile search

Regan Nell Theiler, MD (H1000006660)

Clear Lake Regional Medical Center - Inactive Practitioner

Status Withdrawn

Mainland Medical Center - Inactive Practitioner

Status Inactive

Category Consulting

DOB [redacted]

NPI

Specialties Obstetrics & Gynecology

Clear Lake Regional
MEDICAL CENTER
MAINLAND MEDICAL CENTER
A Campus of Clear Lake Regional Medical Center-An HCA Affiliated Facility

Date: July 11, 2011

To: Tracy A. Morrison, State of Maine Board of Licensure in Medicine

Fax: **207-287-6590**

Re: **Regan N. Theiler - See Attached Letter.**

Notice: ***Effective April 1, 2011 Mainland Medical Center was merged with Clear Lake Regional Medical Center (also an HCA-Affiliated Hospital). Current providers for Mainland Medical Center will show an ending date of 3/31/2011, as a result of this merger.***

MEMO

This is to inform you that we have received your request for information in regards to a physician affiliated with Mainland Medical Center.

For Future Verifications — We are part of a centralized credentialing process for all HCA facilities and this information is accessible through the following website:

http://www.mainlandmedical.com/about-us/accreditations-affiliates.html

This will provide current credentialing information. Please contact our office if you need assistance.

Mainland Medical Center Medical Staff Office
(409) 938-5095 or (409) 938-5122

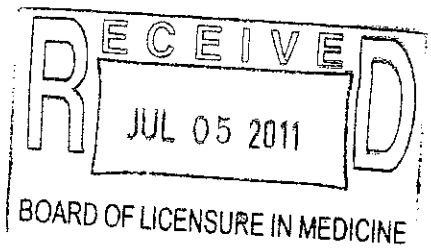
UTMB®
The University of Texas Medical Branch

SCHOOL OF MEDICINE

DEPARTMENT OF OBSTETRICS & GYNECOLOGY
Thomas J. McDougall, FACHE
Administrator

June 30, 2011

State of Maine
Board of Licensure in Medicine
137 State House Station
Augusta, ME 04333-0137



Re: Letter of Recommendation for Regan Theiler, MD

Dear Board Members;

I recommend Regan Theiler, MD, PhD for a medical license in New Hampshire.

She is a highly skilled OB/GYN physician who was a valuable member of our faculty. Dr. Theiler possesses the highest moral character and her professional abilities are outstanding.

Please let me know if I can provide any additional information.

Sincerely,

Thomas J. McDougall, FACHE
Senior Administrator
Departments of Ob/Gyn and Anesthesiology
University of Texas Medical Branch

TJM/ps

301 UNIVERSITY BOULEVARD • GALVESTON, TEXAS 77555-0587 • (409) 747-4996 • FAX (409) 772-0974
tjmcdoug@utmb.edu

GEORGIA COMPOSITE MEDICAL BOARD

EXECUTIVE DIRECTOR
LaSharn Hughes, MBA

BOARD CHAIRPERSON
Alexander S. Gross, MD

2 Peachtree St., N.W., 36th Floor • Atlanta, Georgia 30303 • Tel: 404.656.3913 • Fax 404.656.9723
http://www.medicalboard.georgia.gov E-Mail: Medbd@dch.ga.gov

Wednesday, June 15, 2011

RE: **Regan Theiler, MD**

TO WHOM IT MAY CONCERN:

This is to certify that the above has been issued a license by the Georgia Composite Medical Board.

It is further certified that:

The license number is **305** and was issued on **July 2, 2004**

The current license status is **Lapsed**

The license expiration date is **June 30, 2007.**

Board Actions A review of public records indicates that no public board orders have been docketed.

Certified this day Wednesday, June 15, 2011.

Georgia Composite Medical Board

LaSharn Hughes
Executive Director

LLH/

Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

MAINE STATE BOARD OF REGISTRATION IN MEDICINE
137 STATE HOUSE STATION
161 CAPTIOL ST
AUGUSTA, ME 04333-0137

July 25, 2011

For: MAINE STATE BOARD OF REGISTRATION IN MEDICINE

In response to a recent request, we verify the following information:

****

Physician:	REGAN NELL THEILER, MD
License:	M6911
Date Issued:	06/08/2007
Licensed by:	
Date of Birth:	1973
Medical School:	UNIV OF WISCONSIN MED SCH, MADISON
Graduation Year:	2003
Permit Expires:	02/28/2013

Registration Status:

This is to certify that the above-named physician is licensed to practice medicine in Texas.

Disciplinary Status:

The board has not filed any formal complaints or statements of charges against this physician.

Investigation Status:

Not applicable.

****

If you have any further questions, please contact the Hearings division

Sincerely,

Customer Information Center

BOARD SEAL

ABMS MOC℠ Certification Matters™

You are logged in as: tracy.a.morrison@maine.gov Change Profile Sign out

Enter the doctor's information below or you can search by location and specialty. If you are unsure of any of the fields, leave it blank.

Last Name	theiler	First Name	regan
City		State/Provinc	[Select]
Zip Code		Specialty	[Select]

SEARCH CLEAR

View Search FAQs

Back To Results

Physician Certification

Name
Regan Nell Theiler

Education
MD
PhD

Location (First city and state listed is the last known location)
Galveston, TX (United States)

Certification (For a definition of a specialty or subspecialty click here)
American Board of Obstetrics & Gynecology

Obstetrics & Gynecology - General (General indicates Primary Certificate)

Important notice: Reports provided by this service are not accepted by The Joint Commission, NCQA or URAC to verify physician credentials because no dates are supplied.

For professional credentialing use, please complete this form and an ABMS Official Display Agent will be in touch to discuss your needs.

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039
Telephone: (817) 868-5000
Fax: (817) 868-5099

Physician Information Profile

This report is compiled exclusively for:

Name: **Regan Nell Theiler**
SSN: [redacted]
DOB:
Packet ID: **70920**
Recipient: **Maine Board of Licensure in Medicine**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

This FCVS Physician Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Regan Nell Theiler**	
Other Name Used:	**N/A**	
Gender:	**Female**	
Date of Birth:	[redacted]	
Place of Birth:	**Osseo, WI USA**	
SSN:	[redacted]	
Current Address:	**747 Ormewood Avenue South East** **Atlanta, GA 30312**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**409-772-7590**
	Fax:	**409-772-2261**
	Home:	[redacted]
	Other:	**409-643-1636**
Physical Description:	Height:	**5' 06"**
	Weight:	**165 lbs**
	Eye Color:	**Brown**
	Hair Color:	**Brown**
Physical Marks:	Description:	**Tattoo**
	Location:	**Left Upper Arm**
	Description:	**Tattoo**
	Location:	**Right Shoulder Blade**

Premedical Education (Reported by physician. Not verified by FCVS):

Institution:	**DePaul University, Chicago, IL 60604**
Dates of Attendance:	**09/1992 - 06/1996**
Degree Conferred/Issued:	**Bachelor of Science**

Medical Education:

Medical School:	**University of Wisconsin Medical School** **Transcripts and Certification** **333 East Campus Mall, #10101** **Madison, WI 53715**
Dates of Attendance:	**08/19/1996 - 05/18/2003**
Date Degree Conferred/Issued:	**05/18/2003**
Degree Conferred/Issued:	**Doctor of Medicine**

Unusual Circumstance:	**Leave** **See Form**

Graduate Medical Education:

Institution:	**Emory University School of Medicine** **Department of Obstetrics and Gynecology** **69 Jesse Hill Jr Drive** **Atlanta, GA 30303**
Training Level:	**1**
Program Type:	**Internship**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2003 - 06/30/2004**
Completion:	**Yes**
Accreditation:	**ACGME**
Training Level:	**2-4**
Program Type:	**Residency/Chief Residency**
Specialty/Subspecialty:	**Obstetrics and Gynecology**
Dates of Attendance:	**07/01/2004 - 06/30/2007**
Completion:	**Yes**
Accreditation:	**ACGME**
Unusual Circumstance:	**None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations:	**USMLE Step 1** **USMLE Step 2** **USMLE Step 3**

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name:	Regan Nell Theiler
DOB:	[redacted]
SSN:	
Packet ID:	70920
Request ID:	23697497

OMISSIONS

There are none identified.

DISCREPANCIES

Discrepancy 1:

Section of Profile:	**Medical Education**
Discrepancy:	The applicant reports the degree/diploma was issued/conferred/awarded by Univ Wisconsin Med Sch on 05/15/2003. The institution reports 05/18/2003.
Follow-Up:	FCVS has defined "graduation date" as the date the diploma was issued to the applicant by the medical school.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

8/98 - 11/01 Ph.D

Section of Profile:	**Medical Education**
Issue:	The applicant and Univ Wisconsin Med Sch report Leave in the Unusual Circumstances sections of the application and the verification form, respectively during attendance at this institution.
Follow-Up:	Both the applicant and the institution provided an explanation on the verification form for the Leave of Absence/Break in Training.

End of report for Regan Nell Theiler

DS

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

June 30, 2011

Attn: Tracy Bevers
FCVS
Tracy Bevers
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: June 30, 2011
Your Reference Number: fcvs-jyw
FSMB Batch Number: BQ1931662

The following is a final report of the search results from the Board Action Data Bank as of June 30, 2011 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of June 30, 2011

Item	Name	DOB	School	Yr/Grad	Request ID
10	Theiler, Regan Nell	[redacted]	050020	2003	23908158

LICENSE HISTORY
State Board
TEXAS

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 6/30/2011

State Queried For:	Maine Board of Licensure in Medicine
Physician Name:	Regan Nell Theiler
Date of Birth:	[redacted]
Year of Graduation:	(Doctor of Medicine)
Social Security Number:	[redacted]
ABMSU ID:	914455

Certification:

Board:	Obstetrics and Gynecology
Specialty:	Obstetrics and Gynecology
Status:	ACTIVE
Initial Certification:	01/16/2009

All information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

Section II

Identity

Affidavit and Release

and

Authorization for Release of Information, Documents and Records

I, the undersigned (name as shown), hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor 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 wholly true in every respect.

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" 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 me being prosecuted under appropriate federal and state laws.

I waive confidentiality, 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 Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints (both against me, formal or informal, pending or closed), my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, 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 FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

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

Theiler

Applicant's Printed Last Name

Regan Nell

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

1/16/07

Date of Signature

[redacted]

Date of Birth

[redacted]

Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

Dated 1/16/07

State of Georgia County of DeKalb

SUBSCRIBED AND SWORN TO before me this 16 day of January, 2007

My commission expires: Notary Public, DeKalb County, Georgia
My Commission Expires Feb. 8, 2009

Notary Public, DeKalb County, Georgia
My Commission Expires Feb. 8, 2009

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature Carole West

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify this applicant by (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

STATE OF WISCONSIN } ss.
Trempealeau County }

IS ILLEGAL TO MAKE COPIES OF T RECORD UNLESS SPECIFICALLY AUTHORIZED BY LAW. (WIS. STAT. 69.24)

I, JANET PETERSON, Register of Deeds of the said County of Trempealeau, State of Wisconsin, do hereby certify that the annexed is a true copy of the record of Birth

which is in my legal custody and was received for record in this office on the 14th day of December, 19 73, and is recorded in Volume 67 of Births on Page 85 as No. -----

WITNESS MY HAND AND SEAL AT MY OFFICE THIS 13th day of April, 19 95

Janet Peterson
Register of Deeds

(S E A L)

Deputy

FORM NO. VS-3
300M-REV.-1-68

85

STATE OF WISCONSIN
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH

14055
LOCAL FILE NUMBER

CERTIFICATE OF LIVE BIRTH

CHILD

1. CHILD—NAME: First: Regan; Middle: Nell; Last: Theiler
2a. DATE OF BIRTH: Month Day Year: [redacted] HOUR: 4:00P M.
3. SEX: ☐ Male ☒ Female
4a. THIS BIRTH, Single, Twin, Triplet, Etc.: Single (Specify)
4b. IF NOT SINGLE BIRTH, Born First, Second, Etc. (Specify)
5a. COUNTY OF B[redacted]: Trempealeau
5b. NAME OF CITY OR VILLAGE (If Neither, Name Township): Osseo
5c. Inside City or Village Limits: ☒ Yes ☐ No
5d. HOSPITAL—NAME (If Not in Hospital, Give Street and Number or Location): ~~Osseo Area Municipal~~

MOTHER

6a. MOTHER—MAIDEN NAME: First: Karol; Middle: Lynne; Last: Luer
6b. AGE: 26
6c. STATE OF BIRTH (If not in U.S.A., Name of Country): Wisconsin
7a. RESIDENCE—STATE: Wisconsin
7b. COUNTY: Trempealeau
7c. NAME OF CITY, VILLAGE (If Neither, Name Township): Osseo,
7d. Inside City or Village Limits: ☒ Yes ☐ No
7e. MAILING ADDRESS: Box 413, Osseo, Wisconsin

FATHER

8a. FATHER—NAME: First: Dennis; Middle: Allen; Last: Theiler
8b. AGE: 23
8c. STATE OF BIRTH (If not in U.S.A., Name of Country): Wisconsin

9a. INFORMANT—SIGNATURE: Karol Lynne Theiler
9b. RELATION TO CHILD: Mother

I Certify That The Above Named Child Was Born Alive at The Place and Time on The Date Stated Above
10a. Signature: Richard D. Garber, M.D.
10b. DATE SIGNED: 11-30-73
ATTENDANT (Specify): ☒ M.D. ☐ Midwife ☐ D.O. ☐ Other

10d. CERTIFIER—NAME Type or Print: R. D. Garber, M.D.
10e. MAILING ADDRESS Street or R.F.D. No., City or Village, State, Zip: Osseo, Wisconsin 54758

11a. REGISTRAR—SIGNATURE: Richard D. Garber
11b. DATE RECEIVED BY LOCAL REGISTRAR Month Day Year: 11-30-73

SEAL VERIFIED

Section III

Medical Education

FE RATION CREDENTIALS VERIFICATION SERVIC FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Wisconsin Medical School (Now School of MEdicine and Public Health)

Complete Address: Room 2141 HSLC, 750 Highland Ave.

Street Address: 750 Highland Ave., Room 2141H

City: Madison **State:** WI **ZIP Code (Postal Code):** 53704-2221

If name of institution was different when this individual attended, please note this name below:

University of Wisconsin School of Medicine

Premedical Education:

Years of education required for admission to your medical school: 4

Credential/degree presented by the applicant for admission to your medical school: BS Chemistry

Enrollment and Participation: Our records indicate that Theiler, Regan Nell
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 148 weeks of medical education on the following dates (mm/dd/yy):

From 08 (Month) / 19 (Date) / 1996 (Year) **To** 05 (Month) / 18 (Date) / 2003 (Year)

This individual (check one):

Was awarded the degree of Doctor of Medicine, M.D. on 05 (Month) / 18 (Date) /2003 (Year)

Was NOT awarded a degree because:
(please explain - attach additional pages if necessary)

Certification: By my signature, I, Sharon J. Greuel (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

Affix Institutional Seal Here. If no seal is available, this form must be notarized.

SEAL VERIFIED

Signature: Sharon J Greuel

Title: Certification Officer

Date of Signature: February 16, 2007

Phone: (608) 263-4920 **Fax:** (608-263-1187

Email: greuel@wisc.edu

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☒ NO ☐

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☒	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☒

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
   Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
400 Fuller Wiser Road, Suite 300
Euless, TX 76039
Telephone (817) 868-5000

PLEASE FAX YOUR RESPONSE TO 817-868-4106 BEFORE MAILING THE SEALED / NOTARIZED ORIGINAL

May 13, 2011

Transcripts and Certification
333 East Campus Mall, #10101
Madison WI 53715

Re: Packet ID 70920
USMLE ID 50418706

The form you recently submitted to FCVS for **Dr. Regan Nell Theiler** was either incomplete or requires further clarification. Please address these items listed below and return by fax to the above number.

1. Unusual Circumstances:
The Verification Form initially received omitted the following unusual circumstances:

Do this individual's official records reflect (an) interruption(s) or extension in his/her medical education?

X Yes _ No

If "Yes," please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and circle whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	circle one:	
Personal/Family			Approved	Unapproved
Academic remediation			Approved	Unapproved
Health			Approved	Unapproved
Financial			Approved	Unapproved
Participation in joint degree Program (e.g., MD/PhD)	08/98	11/01	(Approved)	Unapproved
Participation in non-research Special study (e.g., fellowship, International experience)			Approved	Unapproved
Participation in non-degree research			Approved	Unapproved
Other (Please specify):			Approved	Unapproved

Completion of the following is certification that the information above is an accurate account of the individual's records and is true and correct. This section MUST be signed by an authorized representative.

Signature Certification officer Title 05/24/2011 Date

Medical Education

School	050020 - University of Wisconsin Medical School
Dates	08/1996 to 05/2003
Grad Date	05/15/2003
Degree	MD

Unusual Circumstances:

Interruptions: Y: I took seven years to finish because I also completed PhD training in the department of Microbiology.

Probation: N

Disciplined: N

Negative Reports: N

Limitations: N

PROVIDED BY APPLICANT

MED..AL STUDENT PERFORMANCE EVALL..ION

Regan N. Theiler

November 2002

IDENTIFYING INFORMATION

Regan Theiler is a fourth year student at the University of Wisconsin Medical School in Madison, Wisconsin.

UNIQUE CHARACTERISTICS

Regan is a student in the Medical Scientist Training Program at the UW Medical School. Her doctoral thesis was in the field of cytomegalovirus infection. She has two papers in press and one published in 2001. For additional details regarding the quality of her research, please refer to letters submitted by her thesis advisor.

ACADEMIC HISTORY

Date of Initial Matriculation in Medical School:	August 1996
Date of Expected Graduation from Medical School:	May 2003
Joint degree student:	
Date of Initial Matriculation in Other Degree Program:	August 1996
Date of Graduation from Other Degree Program:	December 2001
Type of Other Degree Program:	PhD, Microbiology
Was the student required to repeat or otherwise remediate any coursework during his/her medical education:	No
Was the student the recipient of any adverse action(s) by the medical school or its parent institution:	No

ACADEMIC PROGRESS

Basic Science and Introduction to Clinical Medicine Record

Regan did her basic science coursework from 1996 to 1998. Her first year GPA was a 3.51 and her second year GPA was 3.38. She received an A grade in histology, genetics physiology, neuroscience, renal, respiratory, GI, hepatic neoplastic diseases and psychiatry. Her USMLE Step 1 exam score was 239, which is in the 94th percentile nationally, and confirms her excellent preparation in the sciences basic to medicine.

During our Patient, Doctor and Society course that introduces students to clinical medicine, Regan received a satisfactory grade the first semester, a B the second and third semesters and an A the fourth semester. Her clinical instructors found her interview skills to be right on target for this stage in her career. They also noted that she does an excellent job of communicating her findings effectively in written format. Her physical exam skills as revealed by an OSCE were also right on target.

Required Clinical Clerkships and Clinical Elective Record

As a third year student, Regan achieved a 3.23 GPA. Her clinical attributes include outstanding problem-solving skills. She is able to critically analyze patient findings and integrate these with her strong knowledge of pathophysiology in order to construct an appropriate differential. She then logically works through the data to a diagnosis and treatment plan. Regan has a strong motivation and high standards that are apparent in her work ethic and passion for learning. She puts in long hours, reads constantly to expand her knowledge, is always prepared on the status of her patients, is very reliable and meticulous, and she is able to multitask because of her organizational and time-management skills. She is a quiet worker who goes about her business without needing to draw attention to her performance. Regan interacts with her patients and their

UNIVERSITY OF WISCONSIN - MADISON TRANSCRIPT

OFFICIAL COPY
02/19/0
PAGE 1

Theiler,Regan Nell
BIRTHDATE [redacted]
MATRICULATION DATE 09/03/96
DEGREES: BS 06/1996 DePaul University, Chicago, IL
PRELIM EXAMS PASSED 03/31/00 in Microbiology
PHD MINOR COMPLETED 05/15/98 Distributed
PHD MAJOR COMPLETED 05/18/00 Microbiology

		CRS	GR	PTS
Fall 1996-97	**MP5M P1 MED GRM-G Medical**			
	SESSION A1: SEP 03 - DEC 13			
ANATOMY 710	Histology and Organology	5.000	A	20.000
ANATOMY 711	Gross Human Anatomy	8.000	B	24.000
MED SC-M 800	Generalst Physician Partnrs	1.000	S	0.000
BMOLCHEM 704	Comprehensive Human Biochem	6.000	B	18.000
SUM:		20.000		
Spring 1996-97	**MP5M P1 MED GRM-G Medical**			
	SESSION A1: JAN 21 - MAY 09			
MD GENET 721	Medical Genetics	2.000	A	8.000
MED SC-M 731	Neuroscience	7.000	A	28.000
MED SC-M 801	Clin Medicine & Practice I	3.000	B	9.000
PATH 703	General Pathology	2.000	B	6.000
PHYSIOL 720	Prin of Human Physiology	6.000	A	24.000
HIST MED 720	HIST PERSPECTIVES-MEDICINE	1.000	DR	
	COURSE DROPPED 02/20/97			
SUM:		20.000		
Summer 1996-97	**MP5M P2 MED GRM-G Medical**			
	SESSION HD: JUN 16 - AUG 10			
BMOLCHEM 990	Adv Biomoleclr Chem & Rsrch	2.000	P	0.000
SUM:		2.000		
Fall 1997-98	**MP5M P2 MED GRM-G Medical**			
	SESSION A1: SEP 02 - DEC 12			
M M & I 701	Infection and Immunity I	4.000	B	12.000
MED SC-M 703	Hematology	3.000	B	9.000
MED SC-M 715	Respiratory System	3.000	A	12.000
MED SC-M 719	Smr-Contemp Iss:Health Care	1.000	DR	
	COURSE DROPPED 09/03/97			
MED SC-M 802	Clin Medicine & Practice II	4.000	B	12.000
SUM:		14.000		
Spring 1997-98	**MP5M P2 MED GRM-G Medical**			
	SESSION A1: JAN 20 - MAY 07			
MED SC-M 699	Directed Study	1.000	B	3.000
MED SC-M 702	Infection and Immunity II	4.000	B	12.000
MED SC-M 707	Gastrointestinal Tract	2.000	A	8.000
MED SC-M 708	Hepatic	2.000	A	8.000
MED SC-M 711	Male/Female Endocrine Sys	3.000	B	9.000
MED SC-M 716	Psychiatry	2.000	A	8.000
MED SC-M 718	Autopsy Pathology	1.000	S	0.000
MED SC-M 721	Neoplastic Diseases	2.000	A	8.000
MED SC-M 727	Pharmacology II	2.000	B	6.000
MED SC-M 804	Generalist Partners Prgm II	3.000	A	12.000
SUM:		22.000		

		CRS	GR	PTS
Fall 1998-99	**MP5M P2 MED GRM-G Medical**			
	SESSION A1: SEP 02 - DEC 15			
M M & I 900	Journal Club	1.000	S	0.000
M M & I 901	Seminar	1.000	S	0.000
M M & I 990	Research and Thesis	1.000	A	4.000
MED SC-M 706	Cardiovascular System	3.000	B	9.000
MED SC-M 709	Renal	2.000	A	8.000
MED SC-M 717	Pharmacology	3.000	B	9.000
BMOLCHEM 914	Smr-Molecular Biosci (Adv)	1.000	S	0.000
SUM:		12.000		
Spring 1998-99	**MP5M P3 MED GRM-G Medical**			
	SESSION A1: JAN 19 - MAY 06			
H ONCOL 721	Topic: Conduct of Science	1.000	S	0.000
M M & I 900	Journal Club	1.000	S	0.000
M M & I 901	Seminar	1.000	S	0.000
M M & I 914	Smr-Molecular Biosci (Adv)	1.000	S	0.000
M M & I 990	Research and Thesis	2.000	A	8.000
PATH 750	Cellulr & Moleclr Biol/Path	3.000	AB	10.500
BACT 568	MICROBIOL-ATOMIC RESOLUTIO	3.000	DR	
	COURSE DROPPED 03/02/99			
SUM:		9.000		
Summer 1998-99	**MED P3 Med Prof Medical**			
	G677M GR Microbio-M Graduate			
	SESSION DHH: JUN 14 - AUG 08			
M M & I 990	Research and Thesis	2.000	S	0.000
SUM:		2.000		
Fall 1999-2000	**MED P3 Med Prof Medical**			
	PAGE 2 FOLLOWS			

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			CRS	GR	PTS
		G677M GR Microbio-M Graduate			
		SESSION AMM: SEP 02 - NOV 28			
BIOCHEM	601	Protein&Enzyme Struct&Funct	2.000	B	6.000
		SESSION A1: SEP 02 - DEC 15			
BACT	640	Gen Virology-Multiplication	3.000	A	12.000
BACT	799	Practicum-Bact Teaching	1.000	A	4.000
M M & I	900	Journal Club	1.000	S	0.000
M M & I	914	Smr-Molecular Biosci (Adv)	1.000	S	0.000
M M & I	990	Research and Thesis	4.000	S	0.000
SUM:			12.000		
Spring 1999-2000		MED P3 Med Prof Medical			
		G677M GR Microbio-M Graduate			
		SESSION A1: JAN 24 - MAY 11			
BIOCHEM	603	Eukaryotic Molecular Biol	2.000	C	4.000
M M & I	900	Journal Club	1.000	S	0.000
M M & I	914	Smr-Molecular Biosci (Adv)	1.000	S	0.000
M M & I	990	Research and Thesis	5.000	S	0.000
AHABS	750	Vertebrate Viral Disease	3.000	AB	10.500
SUM:			12.000		
Summer 2000		G677M GR Microbio-M Graduate			
		SESSION DHH: JUN 12 - AUG 06			
M M & I	990	Research and Thesis	2.000	S	0.000
SUM: EARNED CR 2 GPA CR 0 GPA 0.000			2.000		0.000
Fall 2000-2001		G677M GR Microbio-M Graduate			
		MED P3 Med Prof Medical			
		SESSION A1: SEP 05 - DEC 15			
M M & I	720	Topics in Immunology	3.000	A	12.000
M M & I	901	Seminar	1.000	DR	
		COURSE DROPPED 09/17/00			
SUM: EARNED CR 3 GPA CR 3 GPA 4.000			3.000		12.000
Spring 2000-2001		G677M GR Microbio-M Graduate			
		MED P3 Med Prof Medical			
		SESSION A1: JAN 22 - MAY 10			
BACT	990	Research	2.000	S	0.000
ONCOLOGY	675	McArdle Student Seminar	1.000	S	0.000
SUM: EARNED CR 3 GPA CR 0 GPA 0.000			3.000		0.000
Summer 2001		G677M GR Microbio-M Graduate			
		SESSION DHH: JUN 18 - AUG 12			
BACT	990	Research	3.000	S	0.000
SUM: EARNED CR 3 GPA CR 0 GPA 0.000			3.000		0.000
Fall 2001-2002		MED P3 Med Prof Medical			
		G677M GR Microbio-M Graduate			
		SESSION A1: SEP 04 - DEC 14			
BACT	990	Research	3.000	S	0.000
		SESSION 062: OCT 29 - DEC 22			
SR MED	812	3rd Yr Primary Care Clrkshp	8.000	B	24.000
SUM:			11.000		

			CRS	GR	PTS
		Doctor of Philosophy			
		Degree Conferred December 23, 2001			
MAJOR:		Microbiology			
MINOR:		Distributed			
Spring 2001-2002		MED P4 Med Prof Medical			
		SESSION 050: JAN 07 - FEB 17			
OBS&GYN	812	3rd Year Obs & Gynecology	6.000	A	24.000
		SESSION 051: FEB 18 - MAR 31			
PEDIAT	812	3rd Year Pediatrics	6.000	B	18.000
		SESSION 033: APR 01 - APR 21			
NEUROL	812	Third Year Neurology	3.000	B	9.000
		SESSION 004: APR 22 - APR 28			
OPHTHALM	812	Third Year Ophthalmology	1.000	AB	3.500
		SESSION 062: APR 29 - JUN 23			
MEDICINE	812	Prin Int Med-Basic Clrkship	8.000	B	24.000
		SESSION 025: JUN 24 - JUL 07			
ANESTHES	812	Third Year Anesthesia	2.000	B	6.000
SUM:			26.000		
Fall 2002-2003		MED P4 Med Prof Medical			
		SESSION 060: JUL 08 - SEP 01			
SURGERY	812	Third Year Surgery	8.000	B	24.000
		SESSION 042: SEP 03 - SEP 29			
PSYCHIAT	812	Third Year Psychiatry	4.000	A	16.000
		SESSION 043: SEP 30 - OCT 27			
OBS&GYN	925	High Risk Obst Clrk-Meriter	4.000	A	16.000
		SESSION 044: OCT 28 - NOV 24			
MEDICINE	971	Infect Disease Clerkshp-CSC	4.000	AB	14.000
		SESSION 045: NOV 25 - DEC 22			
OBS&GYN	910	Indep Rdg & Rsch-4th Yr Med	8.000	A	32.000
SUM:			28.000		

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Theiler,Regan Nell

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02/19/0

			CRS	GR	PTS
Spring 2002-2003 MED P4 Med Prof Medical					
		SESSION 040: JAN 06 - FEB 02			
SURGERY	923	Gen Surg Clrkshp-St Mary's	4.000	AB	14.000
		SESSION 041: FEB 03 - MAR 02			
MEDICINE	915	Therapeut&Cl Pharmacol-VAH	3.000	S	0.000
		SESSION 051: FEB 17 - MAR 30			
SR MED	856	Preceptorship-Eau Claire	6.000	AB	21.000
		SESSION 043: MAR 31 - APR 27			
MEDICINE	920	Req 4th Yr Med Subintrnshp	4.000	A	16.000
		SESSION 018: APR 28 - MAY 11			
MEDICINE	987	Crit Care/Med ICU-Marshfld	2.000	B	6.000
SUM:			19.000		

Doctor of Medicine
Degree Conferred May 18, 2003

MAJOR: Medicine

END OF RECORD

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Joanne Berg
REGISTRAR

GRADING SYSTEM

All credits are based on semester hours. A 4.000 grading system is used. Prior to 1954-55 a 3.00 grading system was used. Intermediate grades of AB and BC were instituted as of September 1973.

Grades With Associated Grade Points Per Credit

	GRADE	GRADE POINTS
A	Excellent	4
AB	Intermediate Grade	3.5
B	Good	3
BC	Intermediate Grade	2.5
C	Fair	2
D	Poor	1
F	Failure	0
NR	No Report prior to 1999	0

Grades Which Do Not Have Associated Grade Points

CR	Credit	NW	No Work
DEF	Deferred	P	Progress
DR	Dropped	PE	Permanently Excused
EI	Extended Incomplete	PI	Permanent Incomplete
EX	Excused	Q	Question on credits
I	Incomplete	R	Registered
IF	Incomplete - Medical School Courses only	S	Satisfactory
IN	Incomplete in Credit/No Credit Course	U	Unsatisfactory
N	No Credit	W	Withdrew
NR	No Report beginning in 1999		

ABBREVIATIONS AND SYMBOLS

[illegible]	Failed course that has been repeated. Credits are not used to calculate cumulative GPA
#	Course taken On a pass/fail basis
&	Grades of Failure Or No Report - Credits do not count toward degree
& With Name	Full name in body of transcript
? On Credits	Question on credits
[illegible]	Repeat of a failed course
[illegible]	Course does not count toward degree
[illegible]	Credit/No Credit course in progress
ADV STG CRS	Credits not earned on UW-Madison Campus
AU	Course taken for Audit credit
CRS	Number of credits
CUM	Cumulative totals
EARNED CRS	Total credits earned
GPA	Grade Point Average
GPA CR	Credits included in Grade Point Average calculation
GR	Grade Received
H	Course taken for Honors credit
PTS	Grade Points
SUM	Semester/Term totals

YEAR LEVEL DEFINITIONS

1 = FRESHMAN - less than 24 credits and 48 grade points
2 = SOPHOMORE - 24 credits and 48 grade points
3 = JUNIOR - 54 credits and 108 grade points
4 = SENIOR - 86 credits and 172 grade points
5/GR = GRADUATE - A student pursuing a graduate degree
PR = Professional & Year

COURSE NUMBERING SYSTEM

000 - 099 Special Purpose Courses
100 - 299 Undergraduate Courses
300 - 699 Courses Open to Either Undergraduates Or Graduates
700 - 999 Graduate And Professional Courses Including Seminars

A middle digit of 8 (i.e. 181) indicates an honors course. Honors courses are also shown by an H immediately preceding course credit.

INCOMPLETES

The undergraduate student in letter and science must remove the grade of I (Incomplete) by the end of the [illegible] week of classes in the next semester (excluding summer) the student is in attendance. All other [illegible] students and most special students must remove the Incomplete by the end of the next semester they [illegible] attend. Incompletes that are not removed by the deadline dates lapse into a grade of F (failure). The [illegible] removal of Incompletes may be extended with approval of the student's Dean's office. Graduate and [illegible] students are not subject to the above incomplete deadlines. Students who are not in attendance [illegible] period after an Incomplete is received may not remove the Incomplete without permission from the [illegible] Office. These Incompletes remain on the record as Permanent Incompletes and do not lapse into [illegible]

LAW SCHOOL GRADES

The Law School has its own grading scale. Law students entering in 2005 and thereafter are given grades of A+, A, A-, B+, B, B- and so on through F.

Law students entering in 1992 through 2004 were graded on a numerical scale of 65 [illegible] grade equivalents during that time period are as follows:

87-95	A	77-79	C
85-86	AB	70-76	D
83-84	B	65-69	F
80-82	BC		

From 1970 to 1992 the following grading system and letter grade equivalents were used:

87-100	A	70-76	[illegible]
82-86	B	0-69	[illegible]
77-81	C		

Detailed information concerning Law grades is available from the University of Wisconsin Law School [illegible] Office.

MEDICAL SCHOOL GRADES

Detailed information concerning a student's grades, relative class standing and clinical performance [illegible] available upon request of the student from the UW Medical School [illegible] Office. [illegible] to medical students in Medical School Courses.

THE HONORS PROGRAM

Some Schools & Colleges have developed special Honors programs that replace or supplement the [illegible] awards based on grade point average alone. These programs encourage and recognize work of [illegible] depth, scope and originality by undergraduates whose abilities and interests make them eligible. [illegible] of honors courses are open to students who have chosen to do intensive work [illegible] enriched nature in the subject. The programs are [illegible]

TRANSCRIPTS FROM OTHER INSTITUTIONS

The University of Wisconsin - Madison does not issue copies of transcripts or other documents from other institutions, including the University of Wisconsin - Extension.

RECORDING OF UW WORK PRIOR TO JANUARY 1972

Prior to January 1972 all courses and grades for work taken within the former University of Wisconsin System (UW-Madison, UW-Milwaukee, UW-Green Bay, UW-Parkside, UW Centers, and UW Extension) were [illegible] on one record and may appear on this transcript.

Transcripts
Office of the Registrar
University of Wisconsin - Madison
Madison, Wisconsin
608-262-3811
www.registrar.wisc.edu

This is watermarked security paper [illegible] Do not accept as authentic without [illegible] watermark.

ADDITIONAL TESTS: [illegible] this paper is touched [illegible] document is not an original and should not be accepted [illegible] released to a third party without the written consent of the student [illegible] and Privacy Act of 1974. [illegible] ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE.

[illegible]

UNIVERSITY OF WISCONSIN-MADISON

The Board of Regents of the University of Wisconsin System,
on the nomination of the faculty, has conferred upon

REGAN NELL THEILER

The Degree of

DOCTOR OF MEDICINE

Together with all honors, rights, and privileges belonging to that degree.
In witness whereof, this diploma is granted.

Given at Madison in the State of Wisconsin
this eighteenth day of May in the year two thousand and three
and of the University the one hundred fifty-third.

SEAL VERIFIED

Katharine Lyall
President, University of Wisconsin System

Chancellor, University of Wisconsin-Madison

President of the Board of Regents

I certify that this is a true and correct copy of the original diploma of Regan Nell Theiler, M.D.

Sharon J. Greuel
Certification Officer

SEAL
VERIFIED

Section IV

Graduate Medical Education Training

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-6000 Fax: (817) 868-4186

Verification of Postgraduate Medical Education

Institution: Emory University School of Medicine
Address: Department of Obstetrics/Gynecology
Atlanta, GA 30303

Attention: **Program Director**
Affiliated University: ____

Verification For:

Name: **Theiler, Regan Nell**
DOB: [redacted]
Individual's Name on Record (If different from above): ____

Program Participation:

Important: Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1 **Specialty/Subspecialty:** ob/gyn
☒Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research
From: 7/1/2003 **To:** 6/30/2004
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: 2-4 **Specialty/Subspecialty:** ob/gyn
☐Internship ☒Residency ☒Chief Residency ☐Fellowship ☐Research
From: 7/1/2004 **To:** 6/30/2007
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: ____ **Specialty/Subspecialty:** ____
☐Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research
From: __/__/__ **To:** __/__/__
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐Yes ☒No
2. Was this individual ever placed on probation? ☐Yes ☒No
3. Was this individual ever disciplined or placed under investigation? ☐Yes ☒No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐Yes ☒No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐Yes ☒No

Please explain any "Yes" response from above:

____
____

Certification:

ELECTRONIC SEAL VERIFIED

Affix your institutional seal in this space. If

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Carla P. Roberts, MD PhD
Signature: *Carla P. Roberts, MD PhD*
Title: Residency Program Director
Date of Signature: 1/5/2009
Tel: (404) 616-3540 Fax: (404) 521-3589 E-Mail: cputnam@emory.edu

Federation of STATE MEDICAL BOARDS

PROVIDED BY APPLICANT

Full Name: Regan Nell Theiler

Packet ID: 70920

20. Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. **Use one page per institution.**

IMPORTANT:

Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If your postgraduate year is currently in progress, indicate the EXPECTED completion date in the "To" field.

Report internships, residencies, fellowships and research programs separately.

Use one section per department.

(PGY) – Postgraduate years is also known as postgraduate training level.

If a break of six (6) months or more occurred between any of your postgraduate training activities, please provide a written explanation outlining your activities during this period on the "Explanation of Other Activities" form.

Grady Memorial Hospital
Complete name of hospital where training was conducted (Do not abbreviate).
Emory University
Complete name of affiliated university or college (Do not abbreviate).
69 Jesse Hill Jr. Drive
Address line 1

Address line 2
Atlanta — City
GA — State/Province
USA — Country
30303 - _____ — ZIP/Postal Code

PGY:1
- [x] Internship
- [ ] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

ob/gyn — Specialty/Subspecialty
From: 07/03 To: 06/04 — Successfully Completed? [x] Yes [ ] No [ ] In Progress

PGY:2
- [ ] Internship
- [x] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

ob/gyn — Specialty/Subspecialty
From: 07/04 To: 06/05 — Successfully Completed? [x] Yes [ ] No [ ] In Progress

PGY:3
- [ ] Internship
- [x] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

ob/gyn — Specialty/Subspecialty
From: 07/05 To: 06/06 — Successfully Completed? [x] Yes [ ] No [ ] In Progress

PGY:4
- [ ] Internship
- [ ] Residency
- [x] Chief Residency
- [ ] Fellowship
- [ ] Research

ob/gyn — Specialty/Subspecialty
From: 07/06 To: 06/07 — Successfully Completed? [x] Yes [ ] No [ ] In Progress

Unusual Circumstances (check yes or no):

Did you ever take a leave(s) of absence or break(s) from your medical education?	[ ] Yes [x] No
Were you ever placed on probation?	[ ] Yes [x] No
Were you ever disciplined or placed under investigation?	[ ] Yes [x] No
Were any negative reports for behavioral reasons ever filed against you?	[ ] Yes [x] No
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	[ ] Yes [x] No

Please explain any "YES" response from above:

_____

Signature: *Regan Theiler* Date: 5/13/2011

By typing my name above, I certify that I am the individual referenced in the FCVS application and that I agree to the terms and conditions set forth therein. Furthermore, I acknowledge that I have answered all questions and reported all information on this application page truthfully and completely.

Section V

Examination History/Score Transcripts

Unit States Medical Licensing E nination™ (USMLE™)
Certified Transcript of Scores

USMLE United States Medical Licensing Examination™

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4041

Date : 05/27/2011

Recipient:

Federation Credentials Verification Service
ATTN: FCVS3

Euless, TX 76039

Packet ID: 70920

Examinee: Theiler, Regan Nell
Alt Name(s):

Examinee ID#: 5-041-870-6
Date of Birth: [redacted]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	10/20/1998	Pass	239	179	94	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	04/01/2003	Pass	228	174	89	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
GEORGIA	10/28/2004	Pass	235	184	97	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

100%

Maine Board of Licensure in Medicine
State Licensure Examination

Revised 1/23/2008

Applicant: Regan Theiler (please PRINT full name)

Question #1. True or False - Sexual contact between a licensee and a patient is not misconduct if the patient suggests it.

☐ True ☒ False

Question #2. True or False – A patient is never entitled to a copy of his or her own medical record.

☐ True ☒ False

Question #3. True or False - Habitual rudeness to patients and or colleagues is potential grounds for Board investigation and /or disciplinary action.

☒ True ☐ False

Question #4. True or False – Even if the Licensee (physician or physician assistant) does not belong to the American Medical Association, the AMA code of ethics will be applied to that licensee's behavior.

☒ True ☐ False

Question #5. Which of the following statements about Maine's Letters of Guidance from the Board of Medicine to a licensee is true?

A. Letters of Guidance are reported to the National Data Bank.
B. Letters of Guidance are a type of disciplinary action by the Board of Medicine.
C. Letters of Guidance are a mechanism for the Board to deal with problem licensee behavior that is not serious enough to warrant formal discipline.
D. Letters of Guidance are absolutely confidential.

☐ A ☐ B ☒ C ☐ D

Question #6. True or False - Outbursts of anger from licensees caused by stress or lack of rest will be excused as long as the licensee is otherwise competent.

☐ True ☒ False

Question #7. True or False - Sexual contact with a patient is not deemed misconduct if it occurred outside the office.

☐ True ☒ False

Question #8. True or False -There is little a licensee can do to prevent the diversion of opioids to drug abusers.

☐ True ☒ False

Question #9. True or False - If a patient has not paid a bill, the licensee has no obligation to forward records upon request until the bill is paid.

☐ True ☒ False

Question #10. True or False - If deemed pertinent to the investigation of a complaint, the Board of Medicine has the authority to insist that a licensee undergo a physical, mental, and/or substance abuse evaluation by an evaluator of the Board's choice.

☒ True ☐ False

Question #11. True or False - Licensees do not need to be concerned about rude behavior of their office staff such as the receptionist.

☐ True ☒ False

Question #12. True or False - The Board reports all disciplines and practice restrictions to the National Practitioner Data Bank and the Federation of State Medical Boards discipline databank.

☒ True ☐ False

Question #13. True or False - Licensees should not prescribe controlled substances for themselves or for family members except in emergency situations.

☒ True ☐ False

Question #14. True or False – The sale of goods from the licensee's office raises ethical questions.

☒ True ☐ False

Question #15. True or False – If a patient files a complaint and then withdraws it, the Board may still pursue the complaint.

☒ True ☐ False

Question #16. A 55-year-old man who recently moved to your area is keeping an appointment in your office during business hours to establish care. He says that he has been prescribed oxycontin and oxycodone for his chronic severe osteoarthritis for the last two years by a Boston Physical Medicine & Rehabilitation doctor. He indicates he has less than a one-day supply of pain medication. He also admits that he was jailed 7 years ago briefly for a "minor offense." He is requesting a prescription for a one-month supply of oxycontin and oxycodone.

The best approach here would be:

A. Prescribe a one-month supply and wait to see how it goes.
B. Insist on contact with the most recent prescriber before acceding to his request. Also check the Prescription Monitoring Program data base operated by Maine's Office of Substance Abuse.
C. Explain that osteoarthritis pain is not treated with opioids.
D. Presume addiction/diversion is occurring and refuse to prescribe any opioids.

☐A ☒B ☐C ☐D

Question #17. The most appropriate attitude about managing nonmalignant pain is:

A. The risk of opioid addiction in long-term pain management is not a concern.
B. Use of opioids in long-term pain management requires monitoring for opioid abuse and diversion.
C. Opioid treatment should be reserved for terminal situations.
D. Pain is not a life-threatening problem and therefore does not require urgent attention.

☐A ☒B ☐C ☐D

Question #18. If an addicted licensee seeks help by contacting the Maine Medical Association Physician Health Program:

A. The Board will view this as grounds for automatic discipline.
B. The Physician Health Program will immediately make a report to the Board, whether or not there is potential for patient harm.
C. Appropriate treatment will be offered and monitored confidentially.
D. The Physician Health Program will immediately make a report to the National Data Base

☐A ☐B ☒C ☐D

Question #19. If a Maine licensee is reasonably concerned that a licensed practicing colleague has a substance abuse problem:

A. The concerned licensee has a legal obligation to report the colleague either to the Board of Medicine or to the Maine Medical Association Physician Health Program.
B. The concerned licensee may report the addicted colleague to the Board of Medicine or the Maine Medical Association Physician Health Program, but has no obligation to do so.
C. There is no obligation to report unless the concerned licensee is aware of adverse patient outcomes as a result of the substance abuse.

☒A ☐B ☐C

Question #20. Which of the following situations warrant Board disciplinary action?

A. The licensee exhibits increased tolerance to a narcotic prescribed by his/her health care provider who is treating the licensee for a painful condition.
B. The licensee seeks treatment for depression.
C. The licensee uses a sedative hypnotic or an anxiolytic which is prescribed, documented, and monitored by the licensee's health care provider.
D. None of the above.

☐A ☐B ☐C ☒D

Question #21. If unsure how to answer a question on a licensure application, a prudent course would be to:

A. Answer the question putting yourself in the most favorable light.
B. Call the Board for advice and/or attach an addendum to the application explaining the situation/circumstances.
C. Skip the question
D. Guess

☐A ☒B ☐C ☐D

Question #22. Which of the following is true?

A. A high percentage of chemically dependent physicians and physician assistants respond successfully to treatment and return to full practice.
B. Heavy alcohol use, if restricted to times when the licensee is not practicing medicine, will have no impact on the licensee's fitness for practice.
C. Licensees are too intelligent and too informed about drugs and alcohol to get into trouble with them.
D. The Physician Health Program in Maine is of no assistance in keeping recovering licensees in practice.

☒A ☐B ☐C ☐D

Question #23. You have become concerned that a patient is addicted to, and/or diverting opioids you are prescribing for pain. You have learned that this patient is seeking opioid medication from multiple other providers. Which of the following is NOT true?

A. Opioid abuse /addiction is a potentially life-threatening medical condition.
B. Maine law supports communicating concern about the patient's opioid abuse and/or diversion to other providers and oversight agencies without the patient's consent.
C. Diversion of opioids threatens the health and safety of other Maine citizens.
D. You are obligated to continue prescribing opioids.

☐A ☐B ☐C ☒D

Question #24. Common issues underlying complaints against licensees to the Board of Licensure in Medicine include:

A. Office staff communication style.
B. Lack of communication regarding test results.
C. Poor communication among professionals.
D. Licensee rudeness.
E. All of the above.

☐A ☐B ☐C ☐D ☒E

Question #25. The major focus of the Maine Board of Licensure in Medicine is:

A. To protect the public health and welfare.
B. To provide education for licensees.
C. To provide a readily verifiable source of information for various credentialing bodies.
D. To provide rehabilitation for ill licensees.
E. To promote the public image of medicine.
F. To protect licensees from malpractice suits.

☒A ☐B ☐C ☐D ☐E ☐F

Question #26. If a licensee wishes to renew the license in active status and has failed to obtain adequate CME for license renewal, an acceptable course of action would be to:

A. Delay sending in the application for license renewal until the CME is completed.
B. Claim CME that is planned even if not yet completed.
C. Send in the application on time, including an accurate CME report, explain the circumstances around not having completed CME requirements, and request an extension.
D. Send in your renewal leaving CME information blank.

☐A ☐B ☒C ☐D

Question #27. Primary supervision of a Physician Assistant (PA) involves:

A. Accepting liability for the medical practice delegated to the physician assistant.
B. Developing, cosigning and implementing a detailed "plan of supervision" for each site at which the physician assistant is practicing.
C. Updating the plan of supervision at a minimum every two years with license renewal.
D. Knowledge of the specific competencies of the physician assistant.
E. All of the above.

☐A ☐B ☐C ☐D ☒E

Question #28. True or False – A Physician Assistant must obtain Board approval for schedule II prescribing authority in addition to DEA authority.

☒**True** ☐**False**

Question #29 True or False – A licensee whose license is in inactive status may practice medicine and surgery in Maine.

☐**True** ☒**False**

Question #30 True or False – The Board can assist licensees and/or complainants with medical malpractice issues.

☐**True** ☒**False**

I affirm that the foregoing answers are mine, and that I alone completed this examination.

(Applicant signature) 7/11/11 (Date)

The following are open comment questions to help us evaluate this exam.

Question #31. Through this experience did you learn anything that will be of value in your practice in Maine?

yes

Question #32. If you have suggestions, questions, or other comments regarding the improvement of this examination, please make them here.

Not all material was covered in the reading

Question #33. Did you review the online Law/Rule/Policy review materials before taking this exam, or did you test your current level of knowledge?

X **Read the materials first**

_____ **Did not read the materials first**