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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: Eggleston
First Name: Kathryn
Middle Name: Louise
Suffix:
Maiden Name:
M.D. ☒ D.O. ☐

Kathryn Eggleston Anzalone
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: SWWC
5107 E. Kellogg
City: Witchita State/Province: KS ZIP Code: 67218
Telephone: 316-425-3215 Fax:
E-mail address: ~~eggleston~~
Alternate Phone (e.g. pager or cell phone):

Home Address
☐ Public Access
☒ Mailing

Street: PO Box 14826
City: Minneapolis State/Province: MN ZIP Code: 55414
Telephone: Confidential
E-mail address:
Alternate Phone (e.g. pager or cell phone):

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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	69	St. Louis Park	MN	USA
Date of Birth (mm/dd/yyyy)		Birth City	Birth State/Province	Birth Country

F	Confidential	1780689539	Are you a U.S. Citizen? ☑ Yes ☐ No
Gender	Social Security Number	NPI Number	

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: Medical College of ~~Wisc~~ Wisconsin
   Address: 8701 Watertown Plank Road
   City: Milwaukee State/Province: WI ZIP Code: 53226
   Country: USA
   Attendance Dates (From – To): 8/1992 – 5/18/1996
   Graduation Date: 5/18/1996 Degree: MD

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

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.

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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: Eau Claire Family Medicine Residency
Hospital Address: 617 W. Clairmont
City: Eau Claire
State/Province: WI
ZIP Code: 54701
Country: USA

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☑ Residency ☐ Fellowship ☐ Research ☐ Other
Accredited by: ☑ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other
Department/Specialty: University of Wisconsin Department of Family Medicine

From: 7 / 1996 To: 7 / 1999 Successfully Completed? Yes☑ No☐ In Progress☐
Month Year Month Year

2.Hospital Name:
Hospital Address:
City:
State/Province: N/A
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

Applicant Name: Kathryn Louise Eggleston Date: 12/12/12

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.

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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	MD	43137	Active	11/2000
2.	ND	MD	9588	Active	3/2004
3.	SD	MD	7969	Active	11/2011
4.	WI	MD	39038	Active	7/1997
5.	AK	MD	5094	Exp	11/06 - 12/10
6.					
7.					
8.					
9.					
10.					

verified ✓ verified ✓ mail ✓ verified ✓

Applicant Name: Kathryn Louise Eggleston Date: 12/14/12

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

1. State/Province N/A	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: 6 Year: 1999 To: Month: 8 Year: 1999	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 Vacation
2. From: Month: 8 Year: 1999 To: Month: 10/31/ Year: 2000	Practice/Employment Name Marshfield Clinic (or list non-working time as indicated above) Practice/Employment Address 2116 Craig Road City Eau Claire State/Province WI ZIP Code 54701 Country USA Position and Department Family Medicine % Clinical 100 % Administrative Employment ☑ Staff Privileges ☐ Affiliation ☐ Other

Applicant Name: Kathryn L. Eggleston Date: 12/15/12

Dates: From/To	Practice/Employment
3. From: Month: 11/1 Year: 2000 To: Month: 7/31 Year: 2003	Practice/Employment Name Robbinsdale Clinic (or list non-working time as indicated above) Practice/Employment Address 3819 W. Broadway City Robbinsdale State/Province MN ZIP Code 55442 Country USA Position and Department Family Medicine % Clinical 100 % Administrative Employment ☑ Staff Privileges ☐ Affiliation ☐ Other
4. From: Month: 1/1 Year: 2003 To: Month: 2 Year: 2012	Practice/Employment Name Midwest Health Center for Women (or list non-working time as indicated above) Practice/Employment Address 33 South 5th Street, 4th Floor City Minneapolis State/Province MN ZIP Code 55402 Country USA Position and Department Family Medicine % Clinical 100 % Administrative Employment ☑ Staff Privileges ☐ Affiliation ☐ Other Clinic closed 2/2012
5. From: Month: 10 Year: 2003 To: Month: current Year:	Practice/Employment Name Red River Womens Clinic (or list non-working time as indicated above) Practice/Employment Address 512 First Avenue North City Fargo State/Province ND ZIP Code 58102 Country USA Position and Department Medical Director % Clinical 95 % Administrative 5 Employment ☑ Staff Privileges ☐ Affiliation ☐ Other
6. From: Month: 11 Year: 2003 To: Month: current Year:	Practice/Employment Name Womens Health Center (or list non-working time as indicated above) Practice/Employment Address 32 East First Street Suite 300 City Duluth State/Province MN ZIP Code 55802 Country USA Position and Department Family Medicine % Clinical 100 % Administrative Employment ☑ Staff Privileges ☐ Affiliation ☐ Other

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Applicant Name: [signature] Date: 12/15/12

Dates: From/To	Practice/Employment
7 From: Month: 2 Year: 2004 To: Month: 8 Year: 2007	Practice/Employment Name Indian Health Board (or list non-working time as indicated above) Practice/Employment Address 1315 East 24th Street City Minneapolis State/Province MN ZIP Code 55404 Country USA Position and Department Family Medicine % Clinical 100 % Administrative Employment ☑ Staff Privileges ☐ Affiliation ☐ Other
8 From: Month: 8 Year: 2007 To: Month: ~~10/5~~ 4/29 Year: 2010	Practice/Employment Name Fremont/Sheridan Clinic (or list non-working time as indicated above) Practice/Employment Address 314 13th Ave NE City Minneapolis State/Province MN ZIP Code 55413 Country USA Position and Department Family Medicine % Clinical 100 % Administrative Employment ☑ Staff Privileges ☐ Affiliation ☐ Other
9 From: Month: 9 Year: 2010 To: Month: Current Year:	Practice/Employment Name Planned Parenthood MN, ND, SD (or list non-working time as indicated above) Practice/Employment Address 671 Vandalia Street City St. Paul State/Province MN ZIP Code 55114 Country USA Position and Department Associate Medical Director % Clinical 60 % Administrative 40 Employment ☑ Staff Privileges ☐ Affiliation ☐ Other
10 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: Kathryn L. Eggleston Date: 12/15/12

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

Confidential

Name of patient involved: _____

In which state did the action take place? WI Mediation case No.: 97-MMP-1217 Case number (if applicable) 30104

Which court? Eau Claire, WI

(If private compromise or settled before initiation of civil action, state here)

Current status of claim: file closed with no further action 8/13/1998

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

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

Month and year of event precipitating claim: 2/18/1997 to 7/3/1997

Month and year of lawsuit: 11/1997

Insurance carrier at time: ~~Ohio Hospital~~ State of Wisconsin liability Program

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:

Complaint brought by patient's husband: unnecessary, expensive procedures completed on wife including colposcopy and endometrial biopsy.

Our position: evaluation, treatment and follow-up of DUB and abnormal pap smear was excellent and appropriate.

Mediation panel review stated care was optimal and exemplary.

No further action.

Case closed 8/25/1999.

Applicant Name: Kathryn L. Eggleston Date: 12/15/12

Kansas State Board of Healing Arts
Addendum 1

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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 Wichita, KS
3. Primary Specialty Family Medicine

   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): [signature] Date: 12/13/12

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~~ KE See attached
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

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

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?

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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): Kellyn Arnold Date: 12/13/12

STATE OF WISCONSIN
DEPARTMENT OF JUSTICE

JAMES E. DOYLE
ATTORNEY GENERAL

Burneatta L. Bridge
Deputy Attorney General

123 West Washington Avenue
P.O. Box 7857
Madison, WI 53707-7857

Mark Smith
Assistant Attorney General
smithme@doj.state.wi.us
608/266-3968
FAX 608/267-2223
TTY 608/267-8902

August 25, 1999

Helen Madsen
University of Wisconsin
Bascom Hall, Room 361
Madison, WI

Re: Platt, et al. v. Augusta Family Medicine Clinic, et al.
Mediation No. 97-MMP-1217

Dear Ms. Madsen:

Our office has called the Medical Mediation Panel to find out the status of the above-entitled action. A mediation session was held, but did not settle. There is no further information on this matter that a case has been filed. Therefore, we are closing our mediation file.

If you have any questions on this matter, please give me a call. Thank you.

Yours truly,

Mark E. Smith
Assistant Attorney General

MES:jlb

c: John W. Beasley, M.D.
Kathryn L. Eggleston, M.D.
Nola R. Westphal, M.D.

Helen Madsen
University of Wisconsin
Bascom Hall, Room 361
Madison, WI

Re: Platt, et al. v. Augusta Family Medicine Clinic, et al.
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Yours truly,

Mark E. Smith
Assistant Attorney General

MES:jlb

c: John W. Beasley, M.D.
Kathryn L. Eggleston, M.D.
Nola R. Westphal, M.D.

Kathryn L Eggleston
12/13/12

Addendum 2

Question 7. Yes. I voluntarily let my Alaska Medical License expire. There was the possibility of my spouse transferring to AK. This did not occur. No plans to move to AK, so let license expire.

K L Eggleston MD

K. L. Eggleston MD

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)

Kathryn L Eggleston MD Eggleston
Applicant's Printed Last Name

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

12/14/12
Date of Signature

NOTARY

Dated 12-14-12 Signed Mary Ahlen

State of Minnesota County of Washington

SUBSCRIBED AND SWORN TO before me this 14th day of, December 2012.

My commission expires: 1-31-13

(NOTARY PUBLIC SIGNATURE & SEAL)

MARY L. AHLEN
Notary Public
Minnesota
My Commission Expires January 31, 2013

Applicant Name: Kathryn L. Eggleston Date: 12/14/12

STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Sean Parnell, Governor
Emil Notti, Commissioner
Lynne Smith, Director

Division of Corporations, Business and Professional Licensing

Alaska State Medical Board

VERIFICATION OF LICENSE

This is to certify that the records of the Alaska State Medical Board indicate the following with regard to the physician named below:

Name:	**KATHRYN LOUISE EGGLESTON**
License Type:	**MD**
Description of License:	**IS A LICENSED PHYSICIAN**
License Number:	**S-5094**
Current Status:	**INACTIVE**
Date First Issued:	**04/11/2003**
Expiration Date:	**12/31/2010**
School Name:	**MEDICAL COLLEGE OF WISCONSIN**
Year of Graduation:	**1996**
Date of Birth:	Confident 69
Gender:	**F**
Board Actions:	**No actions on file, license in good standing**

This license information was last updated on: 12/11/2012

Debora Stovern
Executive Administrator
Alaska State Medical Board

Date: December 12, 2012

550 West Seventh Avenue - Suite 1500, Anchorage AK 99501-3567
Telephone: (907) 269-8163 Fax: (907) 269-8196 Website: www.commerce.state.ak.us/occ/pmed.htm

STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Sean Parnell, Governor
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Lynne Smith, Director

Division of Corporations, Business and Professional Licensing

Alaska State Medical Board

VERIFICATION OF LICENSE

This is to certify that the records of the Alaska State Medical Board indicate the following with regard to the physician named below:

Name:	**KATHRYN LOUISE EGGLESTON**
License Type:	**MD**
Description of License:	**IS A PHYSICIAN WITH A TEMPORARY PERMIT TO PRACTICE MEDICINE**
License Number:	**T-2516**
Current Status:	**ACTIVE**
Date First Issued:	**02/26/2003**
Expiration Date:	**08/26/2003**
School Name:	
Year of Graduation:	
Date of Birth:	Confident)69
Gender:	**F**
Board Actions:	**No actions on file, license in good standing**

Debora Stovern
Executive Administrator
Alaska State Medical Board

Date: December 12, 2012

550 West Seventh Avenue - Suite 1500, Anchorage AK 99501-3567
Telephone: (907) 269-8163 Fax: (907) 269-8196 Website: www.commerce.state.ak.us/occ/pmed.htm

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

December 12, 2012

Kansas State Board of Healing Arts
800 SW Jackson
Lower Level-Suite A
Topeka, KS 66612

This is to certify that a standard search of the available records of the Minnesota Board of Medical Practice indicates the following:

Physician:	Kathryn Louise Eggleston
Date of birth:	Confidential 69
Was issued license number:	43137
On:	November 11, 2000
Expiration date is:	July 31, 2013
Status:	Active
Issued on the basis of:	USMLE - United States Med Lic Exam
Corrective action:	None
Disciplinary action:	None

Licensure History:

TP9266 -Temporary Permit Issued:October 18, 2000 Expired: November 11, 2000

RP13100 -Residency Permit Issued:September 02, 1997 Expired: October 03, 1997

This license information was last updated on: 12/12/2012 12:16:04AM

The above format is the standard format prepared for all physicians regulated by this board.

Please be advised that the Board does not release information as to whether there has been a complaint filed or an investigation conducted on individual verifications. All physicians are considered in good standing unless noted otherwise.

Further public records including disciplinary and corrective actions may be available from the Board's website at www.bmp.state.mn.us under professional profile. If other information is needed, please contact the Minnesota Board of Medical Practice at 612-617-2130.

Rob Leach
Executive Director

NORTH DAKOTA STATE BOARD OF MEDICAL EXAMINERS

Duane Houdek
Executive Secretary and Treasurer

Lynette McDonald
Deputy Executive Secretary

Established 1890

Phone (701) 328-6500 - Fax (701) 328-6505
418 E Broadway Ave, Suite 12 - Bismarck, ND 58501-4086

www.ndbomex.com

December 12, 2012

This is to certify that a standard search of the available records of the North Dakota State Board of Medical Examiners indicates the following:

PHYSICIAN:	Kathryn Louise Eggleston, MD
DATE OF BIRTH:	Confidential 69
LICENSE NUMBER:	9588
DATE ISSUED:	03/19/2004
EXPIRATION DATE:	07/01/2013
STATUS:	Active - Unconditioned
BASIS OF ISSUANCE:	USMLE - Step 1, 2, 3
DISCIPLINARY ACTION:	No

PHYSICIAN:	Kathryn Louise Eggleston, MD
DATE OF BIRTH:	07/01/1969
LICENSE NUMBER:	PT 9588
DATE ISSUED:	12/09/2003
EXPIRATION DATE:	03/19/2004
STATUS:	Provisional Temporary
DISCIPLINARY ACTION:	No

This license information was last updated on: 12/12/2012

If our records above show that the license has been disciplined, photocopies from the public file are available upon written request.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this board.

Sincerely,

Duane Houdek
Executive Secretary and Treasurer

South Dakota Board of Medical and Osteopathic Examiners

Primary Source Verification

101 N Main Ave Suite 301
Sioux Falls, SD 57104

Phone: 605-367-7781
Email: sdbmoe@state.sd.us

Name: **Kathryn Louise Eggleston, MD**

Last Reported Address(es):

Confidential
Sioux Falls, SD 57106
UNITED STATES

Licenses, Permits, Registrations, Certificates: As of 12/26/2012

Type	Number	Issue Date	Expiration Date	Status
Medical License (MD/DO)	7969	March 02, 2011	March 01, 2014	Active

Board Actions:

Date	
	No Board Actions on File

To expedite the verification of licensure process, the above is the standard format for all professionals regulated by the Board.

Board Action
If Board Action is indicated please review the board action documents available at http ://www.sdbmoe.gov. If the document is not listed, please email the Board at sdbmoe@state.sd.us.

License verification data is updated daily, and may not reflect changes to licensure occurring within the past 24 hours.

Document Generation Date: 12/26/2012 1:54:13PM

form version 20120223a

Wisconsin Department of Safety and Professional Services
Wisconsin Medical Examining Board

Electronic Licensure Verification

This real-time Licensure Verification page is electronically certified proof of licensure, as requested, and as it appears in the files of the Wisconsin Medical Examining Board as of Wednesday, December 12, 2012 3:55:54 PM - Central Standard Time

License Information

Name	EGGLESTON, KATHRYN L
Credential Type	Medicine and Surgery, MD
Credential Number	39038-20
Location	MINNEAPOLIS, MN
Status	credential license is current (active)
Issue Date	07/25/1997
Expiration Date	10/31/2013
Disciplinary Order(s)	No
Licensee	KATHRYN L EGGLESTON

History

Description	Code	Date
USMLE STEP 3 - 085	EXAM	05/13/1997
MED COL OF WI-MILWAUKEE	GRADUATED FROM	05/18/1996