15015

State of Nebraska

DEPARTMENT OF HEALTH

BUREAU OF EXAMINING BOARDS

APPLICATION FOR LICENSE TO PRACTICE MEDICINE

To State Board of Medical Examiners:

I hereby apply for certificate of registration to practice Medicine and Surgery in the State of Nebraska, and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

1. Name KNOLLA (LAST NAME) MICHELLE (FIRST NAME) SUE (MIDDLE NAME) (Print name in full, including middle name)
   Permanent address 123½ No. 61 OMAHA, NE 68132 (Zip Code)
2. Place and date of birth OMAHA, NE 3/30/50 Age 28
3. Present residence OMAHA, NE 68132 (Zip Code) Intended residence SAME
4. Are you a citizen of the United States? YES
5. Preliminary and Pre-medical Education:

   Give name and location of institutions attended, beginning with high school, with concise statement of period of study, giving date of diplomas or certificates received

   NORTH HIGH SCHOOL (OMAHA, NE) 9/65 - 6/68 → H.S. DIPLOMA
   UNIV. OF NEBRASKA (LINCOLN, NE) 9/68 - 5/69 }
   UNIV. OF NEBRASKA (OMAHA, NE) 9/69 - 12/75 } → B.A.

6. Medical Education:

   I have spent 3 years in the study of medicine in the institutions named below:

From (Day, Month, Year)	to (Day, Month, Year)	Name of School	Location
6 July 76	26 June 77	UNIV OF NEBR. COLLEGE OF MED	OMAHA
5 July 77	25 June 78	" "	"
5 July 78	20 MAY 79	" "	"
From	to		

I received the degree of M.D. from the UNIV. OF NEBRASKA MEDICAL College located at OMAHA, NE on the 20TH day of MAY 19 79

CERTIFICATE OF MEDICAL EDUCATION

It is hereby certified that Michelle Sue Knolla of Omaha, Nebraska matriculated in U. Nebr. Col. Medicine at Omaha, Nebraska Date July 6, 1976 attended three course of lectures of eleven months each, and received a diploma from U. Nebr. Col. Medicine conferring the degree of Doctor of Medicine (date) May 20, 1979

(SEAL)

Michael J. Larsen XXXX Ph.D.
(President, Secretary or Dean)
Assistant Dean, Student Affairs

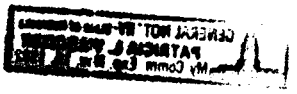
CERTIFICATE OF INTERN SERVICE

This certifies that Dr. ..... has rendered satisfactory and continuous service as an intern in the ..... Hospital at ..... from ..... to .....

Dated .....

.....
Superintendent of Hospital

Examination Fee $100.00



RECIPROCITY AND NATIONAL BOARD

If this application is for reciprocity, the following must be completed and notarized.

1. Upon what license or certificate do you base this application?.....

.....
(Give name of board issuing certificate)

2. Have you been a resident of such state for a period of one year subsequent (following) the date of issuance of said license?.....from..... 19..... to..... 19.....
(Yes or no) (Month, day, year) (Exact dates--month, day, year)

3. Have you ever filed an application in Nebraska?.....
(Yes or no)

4. Have you ever failed in a written examination in Nebraska?..... Give particulars.....
(Yes or no)

.....

5. How long since you have ceased the active practice of medicine and surgery?.....

6. What has been your pursuit since you ceased practice?.....

7. In what other states have you applied for license?.....

8. In what states do you hold a license?.....

9. Have you ever been denied a certificate or the right to take an examination?.....
(Yes or no)

10. Has any state medical examining board or other state agency revoked or suspended a license issued to you?

....
(Yes or no) (Give particulars)

.....

11. Do you now or have you ever had a personal problem with narcotics, drugs, or alcohol?.....
(Yes or no)

.....
(Give particulars)

12. Have you ever been notified or reprimanded by any agency or any complaint relative to the practice of medicine?..... .....
(Yes or no) (Give particulars)

13. Have you ever been charged with the violation of any law relative to the practice of medicine or relative to any crime?..... .....
(Yes or no) (Give particulars)

14. Give brief record of military service.....

.....

15. Affidavit: MICHELLE SUE KNOLLA....., being duly sworn, deposes and says that the foregoing
(Applicant)
statements are true.

I further solemnly swear upon my honor that if granted a license to practice within the State of Nebraska, that I shall abide by the laws of the State and adhere strictly to the ethics of the profession.

Dated MARCH 19, 1979 Signed Michelle Sue Knolla
(Signature of applicant)

State of Nebraska }
County of Douglas } ss.

In Omaha in said county on this 19 day of March

A. D. 19 79, personally appeared before me, and being duly sworn, deposes and says that he has carefully and truthfully complied with the above.

(SEAL) GENERAL NOTARY-State of Nebraska PATRICIA L. WAGONER My Comm. Exp. Nov. 16, 1982

Patricia L. Wagoner
Notary Public

CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE
OR ATTACH CERTIFICATION OF NATIONAL BOARD SCORES

I, ..., Secretary of the.....

certify that.....was granted Certificate No.....

to practice medicine in the State of.....on the.....day of.....

based on written examination, and that said certificate has never been revoked.

(Note:—If by written examination for re-registration Secretary should so state.)

I further certify that the aforesaid.....

in his written examination before this Board, obtained a general average of.....in the following branches:

Subject	Per Cent	Subject	Per Cent
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

I hereby certify to the reputability of Dr.....and, based on the records in this office, recommend him to the Department of Health as a fit and proper person to receive Nebraska Reciprocity License.

I also certify that the photograph, as appears on this application, is a likeness of the said Dr.....

.....and the person named in the above statement, and our records show he received the following diplomas from medical schools:

Name of School	Date of Issue
.....	.....
.....	.....

(SEAL OF STATE BOARD) .....
Secretary

Place..... ..... Date.....

RECOMMENDATION OF SECRETARY OF ☐ LOCAL ☐ COUNTY MEDICAL SOCIETY

I, ...Secretary of the.....

Medical Society, certify that.....
(Full name of applicant)

is personally known to me, and that he is an ethical practitioner and is of good moral and professional character.

I further certify that the said Dr.....

has been engaged in the reputable practice of medicine in the state of.....for..... years immediately preceding the date of this application and that he has never been an itinerant or advertising doctor during the period he has practiced in this state. We have carefully reviewed all the statements made by the applicant herein and believe them to be true in every respect.

(Note:—If licensee has not been engaged in practice continually, fix the time when he was out of practice

.....)

I also certify that the above photograph is a likeness of the said Dr.....

I hereby recommend said applicant for a license to practice medicine in the State of Nebraska.

.....
Secretary

SEAL OF SOCIETY

(Note:—If Society has no seal the signature must be acknowledged before a notary public.)

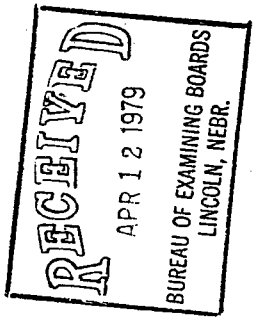
CERTIFICATE FROM THE SECRETARY OF THE STATE SOCIETY

I hereby certify that the records of my office show that Dr.....

has been a member and in good standing of the.....State Medical

.....for the past.....years, and that he is now in good standing. Given under my hand and the seal of.....State Medical.....

this.....day of.....19..... .....
Secretary



THIS SPACE FOR PHOTOGRAPH

This is to certify that the above is a correct likeness of

Michelle S Knolla

Helen L Cox

~~Dean~~ of School (for examination)

Registrar

Secretary of Board (for reciprocity)

Date.....

License No.....

Date.....

STATE OF NEBRASKA
Department of Health

Practice of Medicine

For Use of Department Only

Name.....

Address.....

.....

Application received.....

Fee.....$ 100.00..... Paid 4-12-79 # 3035

High School credits filed.....

Photo of applicant.....

Photo of diploma.....

Approved.....

Passed.....

Failed.....

.....

State of Nebraska

Department of Health

Lincoln, Nebraska

This is to Certify That MICHELLE SUE KNOLLA, M.D.

Having submitted satisfactory evidence of compliance with the laws of the State of Nebraska is hereby granted

License No. 15015 *to practice*

Medicine and Surgery

Board of Examiners in Medicine and Surgery

President

Vice-President

Secretary

Given under the name and Seal of the Department of Health of the State of Nebraska, at Lincoln,

on the 27TH *day of* AUGUST,

in the year one thousand nine hundred and 79,

M. D.
Director of Health

Governor

This license shall be kept on display in the place where the licensee practices.

The University of Nebraska

MEDICAL CENTER
COLLEGE OF MEDICINE

THIS DIPLOMA MAKES KNOWN THAT THE BOARD OF REGENTS OF THE UNIVERSITY OF NEBRASKA UPON THE RECOMMENDATION OF THE FACULTY AND BY AUTHORITY OF THE STATUTES OF THE STATE HAS BY ITS OFFICERS SPECIALLY AUTHORIZED HERETO CONFERRED THE DEGREE

DOCTOR OF MEDICINE

UPON

MICHELLE SUE THOMAS KNOLLA

WHO IS ENTITLED TO ENJOY ALL THE RIGHTS, HONORS AND PRIVILEGES PERTAINING TO THAT DEGREE

IN TESTIMONY WHEREOF WE HAVE HEREUNTO SUBSCRIBED OUR NAMES AND CAUSED THE SEAL OF THE SAID BOARD TO BE AFFIXED AT LINCOLN THIS TWENTIETH DAY OF MAY, NINETEEN HUNDRED SEVENTY-NINE.

UNIVERSITAS NEBRASKENSIS · FEB. 15, 1869

ATTEST:

William V. Swanson
CORPORATION SECRETARY OF THE BOARD

Robert Reference
CHAIRMAN OF THE BOARD

Neal A. Vanselow
CHANCELLOR

Ronald W. Roskens
PRESIDENT OF THE UNIVERSITY

NEBRASKA DEPARTMENT OF HEALTH & HUMAN SERVICES

Reports Home Page

POWERED BY MyLicense

Renewal Questions for License Number 15015

License Type	Sort Name	Question	Answer	Date
Physician	Knolla, Michelle Sue, MD	**(1) Inactive:** Have you selected Inactive Status? Inactive means you cannot practice your profession after the expiration date of your credential, but may represent yourself as having an inactive credential.	N	9/4/2012
Physician	Knolla, Michelle Sue, MD	**(2) Name Change:** Are you requesting a name change or correction to your name?LL	N	9/4/2012
Physician	Knolla, Michelle Sue, MD	**(3) Were you convicted** a misdemeanor or felony in any jurisdiction between 10/2/10 and 10/1/12?	N	9/4/2012
Physician	Knolla, Michelle Sue, MD	**(4a) Have you held a credential** that was issued by another jurisdiction(s) to provide health services, health-related services, or environmental services? (If you answer "No" to 4a, answer "No" to 4b)	N	9/4/2012
Physician	Knolla, Michelle Sue, MD	**(4b) Has such credential been denied,** refused renewal, or disciplined between 10/2/10 and 10/1/12? (If NOT credentialed in another jurisdiction answer "No")ULL	N	9/4/2012
Physician	Knolla, Michelle Sue, MD	**(5a) I am a citizen** of the United States. (Neb. Rev. Stat. 38-129) NOTE: If you are a US citizen please answer "No" to 5b and c.	Y	9/4/2012
Physician	Knolla, Michelle Sue, MD	**(5b) I am an alien** lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act. (Neb. Rev. Stat. 38-129)	N	9/4/2012
Physician	Knolla, Michelle Sue, MD	**(5c) I am a non immigrant** lawfully present in the United States and who is eligible for a credential under the Uniform Credentialing Act. (Neb. Rev. Stat. 38-129)	N	9/4/2012
Physician	Knolla, Michelle Sue, MD	**(6) Continuing Competency Waiver-Military:** I have served full-time duty in the active military service of the United States, or a National Guard call to active service for more than 30 consecutive days, or active service as a commissioned officer of the Public Health Service or the National Oceanic and Atmospheric Administration during part of the 24 months immediately preceding the biennial licensure renewal date (10/2/10 and 10/1/12). If you meet this exemption, you are not required to	N	9/4/2012

		pay the renewal fee.		
Physician	Knolla, Michelle Sue, MD	**(7) Continuing Competency Waiver-Initial License:** I was first licensed in Nebraska within the 24 months immediately preceding the licensure renewal date (10/2/10 and 10/1/12).	N	9/4/2012
Physician	Knolla, Michelle Sue, MD	**(8) Continuing Competency:** Have you completed one of the following immediately preceding the licensure renewal date (October 2, 2010 through October 1, 2012): • 50 hours of Category 1 continuing education approved by the Accreditation Council for Continuing Medical Education (ACCME) or the American Osteopathic Association (AOA). A licensee who has earned more than the 50 hours required for license renewal for the previous 24 month renewal period is allowed to carry over up to 25 hours to the next 24 month renewal period; OR • One year of participation in an approved graduate medical education program; OR • The AMA Physician's Recognition Award or the AOA CME certification (awarded within the 24 months immediately preceding the expiration date of your license). NOTE: If you answer "Yes" to question 8, you should answer "No" to the CE Waiver questions 6 or 7. If you answer "No" to question 8, you MUST answer "Yes" to at least one of the CE Waiver questions 6 or 7.	Y	9/4/2012
Physician	Knolla, Michelle Sue, MD	**1.** Are you Board Certified through an American Board of Medical Specialties (ABMS) board or an American Osteopathic Association (AOA) specialty board? (If No, skip to question 5)	Y	9/4/2012
Physician	Knolla, Michelle Sue, MD	**2.** If Yes to question 1, please select your primary board certification from the drop-down list of ABMS and AOA specialty boards.	AOA - Obstetrics and Gynecology	9/4/2012
Physician	Knolla, Michelle Sue, MD	**3.** Do you participate in Maintenance of Certification through your ABMS specialty board or in Osteopathic Continuous Certification through your AOA specialty board? (If Yes, skip to question 5)	N	9/4/2012
Physician	Knolla, Michelle Sue, MD	**4.** If No to question 3, do you have a lifetime certificate?	Y	9/4/2012
Physician	Knolla, Michelle Sue, MD	**5.** How many more years do you plan to actively practice medicine?	1-5 years	9/4/2012
Physician	Knolla, Michelle Sue, MD	**6.** How would you describe your primary practice setting?	Clinical, office based	9/4/2012
Physician	Knolla, Michelle	**7.** What is the zip code of your primary practice	68022	9/4/2012

Sue, MD location?

Please reply to: Licensure Unit
PO Box 94986, Lincoln, NE 68509-4986
Phone (402) 471-2118
FAX (402) 471-3577

DHHS
Division of Public Health
Nebraska Department of Health and Human Services

State of Nebraska
Dave Heineman, Governor

April 18, 2008

Michelle Sue Knolla, MD
Methodist Physicians Clinic -Women's Center
8901 W Dodge Road
Omaha NE 681143301

Dear Dr. Knolla:

We are pleased to advise you that your application has been approved to serve as a supervising physician for Leanne Renee Hill, PA

Enclosed please find your small-sized certification card number 2265. The issuance date is 04/16/2008 and it will expire on 10/01/2009. You will be sent written notification of the need to renew your certificate at least 30 days prior to expiration.

The primary practice site is:

Methodist Physicians Clinic -Women's Center
8901 W Dodge Road
Omaha NE 681143301

Should you discontinue your supervisory relationship with this physician assistant, you are statutorily required to notify this office of such termination.

Sincerely,

Joann Schaefer, M.D., Chief Medical Officer
Director, Division of Public Health
Department of Health & Human Services

Helen L. Meeks, Administrator
Licensure Unit

JS/HLM/nc

cc: Leanne Renee Hill, PA

#2265 4/18/08 X

Nebraska Department of Health and Human Services System
Regulation and Licensure
Credentialing Division
301 Centennial Mall South, 3rd Floor
PO Box 94986
Lincoln, NE 68509-4986 Φ (402) 471-2118

Rev. 02-15-06

Fee: $100 (or $25 if certificate issued within 6 months of expiration date)

LICENSURE UNIT

APR 16 2008

RECEIVED

APPLICATION FOR CERTIFICATION OF APPROVAL TO SUPERVISE A PHYSICIAN ASSISTANT

1.	Name of Physician	Last: Knolla	First: Michelle	Middle: S
2.	Name of Physician Assistant	Last: Hill	First: Leanne	Middle: R
3.	Physician's Primary Site of Practice	Name: Methodist Physicians Clinic-Women's Center		
		Street/PO Box/Route: 8901 West Dodge Road		
		City: Omaha	State: NE	Zip: 68114
		County: Douglas	Telephone: 402-354-1700	
4.	Mailing Address of Physician	Street/PO Box/Route: 8901 West Dodge Road		
		City: Omaha	State: NE	Zip: 68114
5.	Other Practice Sites, Including Hospitals: NE Methodist Hospital, Omaha, NE			
6.	Physician's License Number: 15015			
7.	How many years has the physician practiced medicine? 25 -26 years			

8.	Previous locations where physician practiced medicine	Location/City/State	Specialty	Dates
		Clarkson Hosp. Omaha, NE	OB GYN	1953 1954

9. The physician must answer the following questions either yes or no. **If you answer yes to any of the four questions you must attach to this application an explanation of the circumstances and outcome.**

a	Has any disciplinary action ever been taken against you by a state/licensing agency for inappropriate supervision of or inappropriate practice with a physician assistant? Answer Yes or No	No
b	Has any disciplinary action ever been taken against you by a state/licensing agency? Answer Yes or No	No
c	Has the Drug Enforcement Administration ever taken action against you with regard to your controlled substance registration? Answer Yes or No	No

	d	Has the physician assistant named above provided medical services at your practice site(s) when the physician assistant did not have a physician assistant supervisor properly certified by this Department? Answer Yes or No	No
		If yes, how many days did the PA practice without a certified supervisor? Answer Yes or No	

10. List the name(s) of any Nebraska Licensed Physician Assistant(s) you are presently supervising.

Name:	License Number:
NONE	
Name:	License Number:

11. To supervise more than two physician assistants, you must show good cause. For example: temporary loss of a supervising physician through death, serious illness, or other similar causes; part-time employment of physician assistants; practice in a state or federally-designated shortage area. If applying to supervise more than two physician assistants, list reason supporting your request below. NOTE: You must also submit a supplemental application, which can be obtained by contacting the Department at (402) 471-2118.

12 **Weekly Practice Schedule** - List the office hours for physician's primary site of practice. List specific times when physician named in Section 1 will be present at the primary site. List specific times when physician assistant named in Section 2 will be present at the primary site. Provide total hours for each provider. If PA will practice at additional sites, attach schedule for each location to this application.

	Office Hours		Physician's Hours		PA's Hours	
	AM	PM	AM	PM	AM	PM
Monday	7 X	5	1 3C		8	1
Tuesday	5	5	3	4	8	1
Wednesday	1 3C	5	1 3C	4	2	1
Thursday	8	5	8	4	8	1
Friday	5	5	8	4	—	—
Saturday		-	-		—	—
Sunday		-	-	-	—	—
Total	0	0	0	0	0	0

13. The supervising physician and the physician assistant must be together 20% of the time when the physician assistant is providing medical services at any site. Will the supervising physician and the physician assistant be together 20% of the time when the physician assistant is performing medical services at any site? Answer (Yes) or No — Yes

14. If you are proposing to be physically present less than 20% of the time when the physician assistant is performing medical services, Board approval must be obtained. The approval process can take 30-90 days. If proposing to be present less than 20% of the time, describe: (attach an additional sheet if necessary)

a) The proposed practice site

b) Percentage of time together

	c) Number of years of experience of physician assistant	
	d) Number of years supervising physician has been supervising physician assistants	
	e) Any previous knowledge the supervising physician has had with the physician assistant's patient care in the community	
	f) Is the site a state or federally designated shortage or underserved area?	
	g) General level of patient complexity	
	h) Any other pertinent/relevant information	
15.	When the supervising physician is absent from the practice, will an approved backup supervising physician accept responsibility for the supervision of the physician assistant? **Answer Yes or No**	Yes
	If no, will the physician assistant cease providing medical services in the absence of the supervising physician? **Answer Yes or No**	
16.	Is there a current scope of practice agreement, pursuant to 172 NAC 90-006, kept at the primary practice site? **Answer Yes or No**	Yes
17	Will the physician assistant and supervising physician comply with the primary and secondary site requirements, pursuant to 172 NAC 90-006? **Answer Yes or No** A physician assistant may not practice at a secondary site without the personal presence of the supervising physician unless approval has been granted by the Board. Secondary sites refer those offices operated by the supervising physician(s) that are not the primary practice sites of said physicians.	Yes

I attest that the statements on this application are true and correct; that I will comply with the primary and secondary site requirements for the supervision of a physician assistant; and that I will supervise the forenamed physician assistant with regard to all items listed in the scope of practice agreement on file at the primary practice site.

Signature of Physician: Michelle J Kruetk Date Signed: 4-3-08

I attest that I will comply with the primary and secondary site requirements for the supervision of a physician assistant, and that I will be bound and limited by the scope of practice agreement on file at the primary practice site.

Signature of Physician Assistant: [signature] Date Signed: 4/3/08

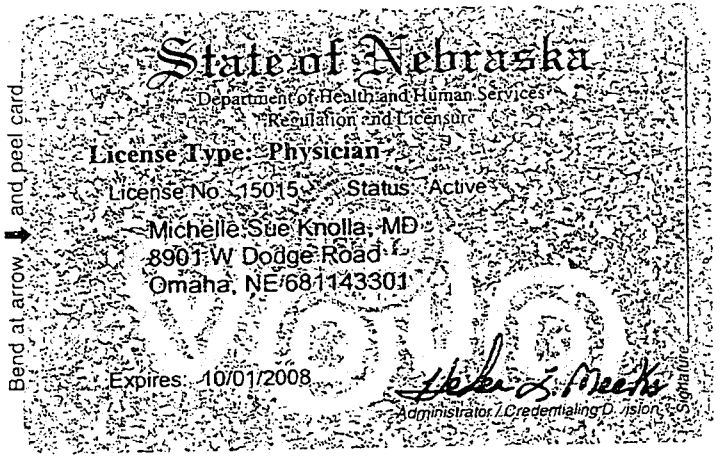
Name _____
First Middle Maiden Last

Old Address _____
Street City State Zip

New Address _____
Street City State Zip

License/Certification/Registration _____ Profession _____

Signature _____



- Please find enclosed your small-sized Licensure/Certification/Registration card. This card shows the expiration date of your Credential.
- You will be sent written notification of the need to renew your Credential in advance of its expiration date.
- Please submit to the Credentialing Division any change of address so that information can promptly reach you.
- If you have a name change or lose the enclosed card, please contact the Credentialing Division at 402-471-2115.

DATE: **04/11/08**

TO: Vonda, NE Supervising Licensure Board

REGARDING: Dr Michelle Knolla

FROM: Jan Lichty-PCI Credentialing

Attached is the Supervising Licensure application from Dr. Knolla. She is applying to supervise Leanne Hill, P.A.

Please contact me if additional information is needed or you have questions or concerns regarding this application.

Jan Lichty, PCI-Credentialing
8601 West Dodge Road.
Ste. 216
Omaha, NE 68114
402-354-5451
Fax: 402-354-5454
Email: Jan.Lichty@nmhs.org

Thank you