49517

CERTIFICATE OF ETHICAL AND MORAL CHARACTER

THIS CERTIFICATE MUST BE SIGNED BY TWO LICENSED PHYSICIANS WHO ARE PERSONALLY ACQUAINTED WITH THE APPLICANT.

I certify that the photograph attached is a recent one and likeness of Dr. Frisch

And that s/he is a person of good ethical and moral character.

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Mark L. Tarr MD	1/30/07	022265	MN

Mark L. Tarr MD
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

State: Minnesota County: Hennepin

I certify that on the date set forth below, 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. Sworn to before me by the applicant on this 30th day of January, 2007.

Notary Public Signature

Expiration Date 1 / 31 / 2011
Month Day Year

Applicant Signature

I certify that the photograph attached is a recent one and likeness of Dr. Frisch

And that s/he is a person of good ethical and moral character.

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Stefanie Swanson Galecich	1/30/07	405522	MN

Stefanie Swanson Galecich
PRINT OR TYPE FULL NAME

49517

APPLICATION TO PRACTICE MEDICINE

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 500
MINNEAPOLIS, MINNESOTA 55414-3246
612-617-2130 or www.bmp.state.mn.us

Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

392

MN BOARD OF MEDICAL PRACTICE
FEB - 8 2007

FOR BOARD USE ONLY

APPLICATION #: 87942
CHECK/RECEIPT #: 326-3
AMT PAID: _____
TEMP PERMIT #: _____
BOARD ACTION: _____
BOARD DATE: 3-12-2007
LICENSE #: 49517

SOURCE CODE	AMOUNT
5200 lic	192 00
5201 app	200 00
5203 tp	

DATE OF APPLICATION:

MONTH	DAY	YEAR
9	1	2006

INSTRUCTIONS TO APPLICANT

1. Answer all questions completely, accurately, and legibly or the application will be returned.
2. The name you enter must exactly match the name on your medical diploma, or documentation of formal name change must be submitted.
3. All addresses must include zip code if requested on the application.
4. Account for all time from the beginning of high school, whether spent in school, practice, or otherwise. Dates must include Month, Day, and Year. Attach a separate sheet if necessary.
5. Enter all dates as MONTH-DAY-YEAR.
6. The application fee is not refundable.
7. Failure to answer all questions completely and accurately, omission or falsification of material facts, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
8. Incomplete applications may be destroyed after six months of inactivity.

TO: The Minnesota Board of Medical Practice:

I hereby make application for a license to practice medicine and surgery in the State Of Minnesota and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME: LAST	FIRST	MIDDLE
Frisch	Hope	Elizabeth

STREET ADDRESS: 1924 Garfield Street Northeast

CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:
Minneapolis	Minnesota	55418	USA

HOME PHONE:	OTHER PHONE:	OTHER NAMES:
612-781-3074	612-964-6650	

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER:

GENDER ☐ MALE ☑ FEMALE

BASIS FOR APPLICATION (CHECK ONE)

- ☐ FEDERATION LICENSING EXAMINATION (FLEX)
- ☐ NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINATION (NBME)
- ☐ NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS EXAMINATION (NBOME)
- ☐ COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION (COMLEX-USA)
- ☐ LICENTIATE OF MEDICAL COUNCIL OF CANADA EXAMINATION (LMCC)
- ☐ STATE BOARD EXAMINATION (STATE)
- ☑ UNITED STATES MEDICAL LICENSING EXAM (USMLE)
- ☐ COMBINATION FLEX, NBME, USMLE (MUST BE COMPLETED BY YEAR 2000)

ECFMG CERTIFICATION (FOREIGN ONLY)

NUMBER:

DATE ISSUED:

DRIVER'S LICENSE

STATE: Minnesota

NUMBER:

49517

ADDRESS OF NEAREST RELATIVE		
NAME OF RELATIVE: ...sch		
STREET ADDRESS: ...s. So.		
CITY: Minneapolis	STATE OR PROVINCE: MN	
ZIP CODE: 55418	COUNTRY: USA	RELATIONSHIP: ...

YOUR INTENDED ADDRESS (IF KNOWN)		
STREET ADDRESS: same as address above		
CITY:	STATE OR PROVINCE:	
ZIP CODE:	COUNTRY:	EFFECTIVE DATE:
PHONE:		

RECORD OF BIRTH			
BIRTHDATE (MO/DAY/YEAR) / 1974	CITY OF BIRTH: Minneapolis	COUNTY OF BIRTH: USA	STATE/PROVINCE OF BIRTH: Minnesota
FULL NAME OF FATHER: Melvin Julius Frisch		MOTHER'S MADEN NAME: Patti Widdes	COUNTRY OF BIRTH: USA

IDENTIFYING CHARACTERISTICS			
HEIGHT (ft./in.): 5/5	WEIGHT (lbs): 155	COLOR HAIR: Red	COLOR EYES: Green
IDENTIFYING MARKS:			

PRELIMINARY EDUCATION					
NAME OF HIGH SCHOOL: Minneapolis South	CITY: Minneapolis	STATE OR PROVINCE: MN		FROM DATE: (Mo/Day/Year) 9 / / 1988	TO DATE: (Mo/Day/Year) 6 / 10 / 1992
NAME OF COLLEGE: Brandeis University	CITY: Waltham	STATE OR PROVINCE: MA	DEGREE BA	FROM DATE: (Mo/Day/Year) 8 / / 1992	TO DATE: (Mo/Day/Year) 5 / 19 / 1996
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	DEGREE	FROM DATE: (Mo/Day/Year) / /	TO DATE: (Mo/Day/Year) / /

MEDICAL EDUCATION (MEDICAL COLLEGES MUST BE RECOGNIZED BY THE BOARD)					
INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
University of Health Sciences-College of Osteopathic Medicine (now called KCUMB)	Kansas City	MO	64106	8/1999	5/18/2003

ACCOUNTING OF TIME NOT NOTED ELSEWHERE ON THIS APPLICATION		
ACTIVITY (ATTACH SEPARATE SHEET, IF NECESSARY)	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
Employment at Meadowbrook Women's Clinic	8/1996	5/1999

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MEDICAL DIPLOMAS

	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE Mo/Day/Year
BACHELOR OF: ☐ MEDICINE ☐ OSTEOPATHY						
DOCTOR OF OF: ☐ MEDICINE ☑ OSTEOPATHY	University of Health Sciences-College of Osteopathic Medicine (now called KCUMB)	Kansas City	MO	64106	USA	5/19/2003

US/CANADIAN ACCREDITED GRADUATE CLINICAL MEDICAL INTERNSHIP, RESIDENCY, FELLOWSHIP

NAME OF HOSPITAL:			FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
University of Minnesota Medical School			6/2003	6/8/2007
STREET ADDRESS: 515 Delaware Street SE	CITY: Minneapolis	STATE OR PROVINCE: Minnesota	COUNTRY: USA	ZIP CODE: ~~55405~~ 55455
TYPE OF TRAINING: (BE SPECIFIC) Obstetrics, Gynecology and Women's Health				
NAME OF HOSPITAL:			FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:			FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:			FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:			FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				

MILITARY SERVICE

BRANCH OF SERVICE:	ENTRY DATE (Mo/Day/Year)	RELEASE DATE (Mo/Day/Year)	RANK AT DISCHARGE:	TYPE OF DISCHARGE
DUTY ASSIGNMENT:			LOCATION:	

STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE EVER BEEN LICENSED

STATE/PROVINCE/COUNTRY	LICENSE NUMBER	DATE ISSUED (Mo/Day/Year)	HOW OBTAINED(*)

(*) NATIONAL BOARD OF MEDICAL EXAMINERS (NBME)
STATE BOARD EXAM (STATE)
NATIONAL BOARD OF OSTEO MEDICAL EXAMINERS (NBOME)
COMPREHENSIVE OSTEO MEDICAL LICENSING EXAM (COMLEX-USA)
FLEX EXAMINATION (FLEX)
UNITED STATES MEDICAL LICENSING EXAM (USMLE)
COMBINATION FLEX, NBME, USMLE (COMB)
LICENTIATE OF MEDICAL COUNCIL OF CANADA (LMCC)

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PRACTICE REFERENCES

STATE BELOW WHERE YOU HAVE PRACTICED OUTSIDE OF A TRAINING PROGRAM, AND LIST TWO REFERENCES FROM EACH FACILITY

NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:

NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:

NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:

NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATECNTRY	ZIP CODE:

NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATECNTRY	ZIP CODE:

PROPOSED PRACTICE PLANS IN MINNESOTA (IF ANY)

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE
American College of Obstetrics and Gynecology	6/2003	present

Are you currently* certified by a specialty board of the (check one):

- ☐ American Board of Medical Specialties
- ☐ Royal College of Physicians and Surgeons of Canada
- ☐ College of Family Physicians of Canada
- ☐ American Osteopathic Assn Bureau of Professional Education
- ☑ None of the above

Specialty: ____________

Issue Date: ____________

Expiration Date: ____________

* If it has been more than 10 years since your initial licensing exam, the SPEX exam is required unless currently specialty board certified.

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CIRCLE "Y" FOR YES OR "N" FOR NO. ATTACH ADDITIONAL SHEETS TO PROVIDE SUFFICIENT DETAIL. FOR QUESTIONS 1 AND 2 BELOW, THE TERMS "IMPAIRED" AND "LIMITED" INCLUDE BUT ARE NOT LIMITED TO IMPAIRMENTS OR LIMITATIONS RELATED TO PHYSICAL, PSYCHOLOGICAL, OR EMOTIONAL DISORDERS OR CONDITIONS, OR CHEMICAL DEPENDENCY OR CHEMICAL ABUSE. NOTE: IF YOU ARE CURRENTLY PARTICIPATING IN HEALTH PROFESSIONALS SERVICES PROGRAM (HPSP) FOR A CONDITION COVERED BY QUESTIONS 1-4 OR IF YOU DO NOT HAVE THAT CONDITION, YOU MAY LEAVE THE QUESTION UNANSWERED AS TO THAT CONDITION. IF RESPONSES TO QUESTIONS CHANGE DURING THE TIME YOUR APPLICATION IS PENDING, YOU MUST MAKE THE BOARD AWARE OF THE NEW INFOFORMATION.

Y	1. Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.
	Y ✓ 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe. _____
	Y ✓ 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe. _____
Y	2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety? Please describe. No
Y	3. Are you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider). Please describe. _____
	Y ✓ 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe. _____
	Y ✓ 3b. If yes, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe. _____
Y	4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? If you answer this question 'yes", please answer the following:
	Y ✓ 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?
	Y ✓ 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?
	Y ✓ 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?
	4d. Please explain._____
	4e. Identify your treating physician._____
Y ✓	5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe. No _____ _____

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Y ✓	6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.
Y ✓	7. Have you ever been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If so, give particulars.
Y ✓	8. Has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by Medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If so, give particulars.
Y ✓	9. Have you ever been notified of any investigations by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board? If so, give particulars.
Y ✓	10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents).
Y ✓	11. Have your hospital privileges been restricted or revoked? If so, give particulars.
Y ✓	12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Y ✓	13. Have there ever been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed.
Y ✓	14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.
Y ✓	15. Have you ever applied for licensure in Minnesota before? If so, please give license # and issue date or withdrawal/denial date.
✓ N	16. Have you ever had a residency permit in Minnesota? If so, please give residency permit number. (Residents are required to have residency permits as of 1993 unless licensed in Minnesota). 16944

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[redacted]

THIS CERTIFICATE MUST BE SIGNED BY TWO LICENSED PHYSICIANS WHO ARE PERSONALLY ACQUAINTED WITH THE APPLICANT.

I certify that the photograph attached is a recent one and likeness of Dr. Frisch

And that s/he is a person of good ethical and moral character.

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Mark J. Yang MD	1/30/07	022265	MN

Mark L. Tone MD
PRINT OR TYPE FULL NAME

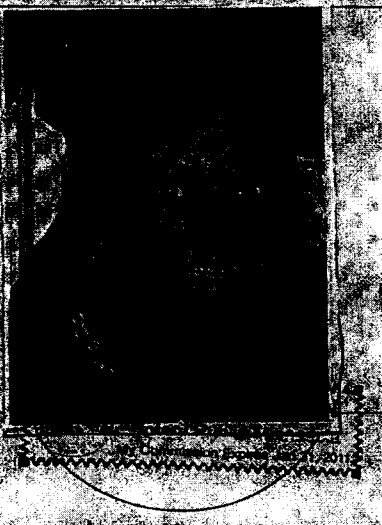
CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

State Minnesota County: Hennepin

I certify that on the date set forth below, 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. Sworn to before me by the applicant on this 30th day of January, 2007

Notary Public Signature

Expiration Date: 1 / 31 / 2011
Month Day Year



Applicant Signature

I certify that the photograph attached is a recent one and likeness of Dr. Frisch

And that s/he is a person of good ethical and moral character.

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Stefanie Swanson Gabrecht	1/30/07	405522	MN

Stefanie Swanson Gabrecht
PRINT OR TYPE FULL NAME

49517 -

AFFIDAVIT OF APPLICANT:

STATE OF: Minnesota

COUNTY OF: Hennepin

I, Hope Elizabeth Frisch, swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota: that I am the person named in the diploma, which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this 30th day of January, 2007

Signature of Notary Public

ROSEMOND S. O[illegible]
Notary Public-Minnesota
My Commission Expires Jan 31, 2011

Signature of Applicant

My Commission Expires: 1-31-11

RIGHTS OF SUBJECTS OF DATA

This information is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, omission or falsification of material facts, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Wednesday, November 12, 2014

minnesota north star

Log In

Search

Home | Online Services

User Admin

Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name: Hope Frisch Start Date: 5/23/2012 2:22:13 PM

Service Name: License Renewal - PY Complete Date: 5/23/2012 2:30:53 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	5/23/2012 2:22:43 PM	
2	Verify Information	5/23/2012 2:23:25 PM	• Designated phone must be entered
2	Verify Information	5/23/2012 2:23:47 PM	
3	Privileges & Continuing Medical Education	5/23/2012 2:24:01 PM	
4	Practice Questions	5/23/2012 2:25:07 PM	
5	Profiling - Practice Addresses	5/23/2012 2:25:15 PM	
5	Profiling - Post Graduate Training	5/23/2012 2:25:20 PM	
5	Profiling - Post Graduate Training	5/23/2012 2:25:20 PM	
5	Profiling - ABMS/AOA	5/23/2012 2:25:30 PM	
5	Profiling - ABMS/AOA	5/23/2012 2:25:30 PM	
5	Profiling - Criminal Convictions	5/23/2012 2:25:48 PM	
6	Review	5/23/2012 2:26:46 PM	
7	Questionnaire	5/23/2012 2:28:18 PM	
		1	

Verification Page

The following is a copy of the verification page that was presented to the user upon completion of the Online Service

The information you have submitted in the previous steps is provided below.

If any information is incomplete or incorrect, return to the appropriate step to make additions or corrections by clicking the Previous button located at the end of this section. Note: Do not use the Back button on your browser.

Use your browser's Print command to print this summary for your records.

Application for License Renewal

License Number: PY 49517
Name: Hope Elizabeth Frisch

Drivers License: MN
Is license current? Yes

Designated Address: 801 Nicollet Mall
Suite 400
Minneapolis, MN 55402

Phone: (612) 333-2503
Email Address:
Web Site: www

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Abbott Northwestern	Minneapolis	MN	physician
Fairview Southdale	Edina	MN	physician

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 05/31/2013.

Practice Questions

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. **If you are currently participating in Health Professionals Services Program (HPSP) for a condition covered by questions 1-4 or if you do not have that condition, leave the question unanswered as to that condition.** For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse.

The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling.

1. Since your last renewal, has your cognitive, communicative, or physical ability to engage in the practice of medicine or surgery with reasonable skill and safety been impaired or limited in any way?
Response: Unanswered

2. Since your last renewal, has your use of alcohol or chemical substance(s), including prescription medications, in any way impaired or limited your ability to practice medicine with reasonable skill and safety?
Response: Unanswered

3. Since your last renewal, have you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)?
Response: Unanswered

4. Since your last renewal, have you been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety?
Response: Unanswered

5. Since your last renewal, have you been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders?
Response: No

6. Since your last renewal, have you been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances?
Response: No

7. Since your last renewal, have you been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority?
Response: No

8. Since your last renewal, has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by Medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority?
Response: No

9. Since your last renewal, have you been notified of any investigations by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board?
Response: No

10. Since your last renewal, have your hospital privileges been restricted or revoked?
Response: No

11. Since your last renewal, have there been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon or state district court judges. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Response: No

12. Since your last renewal, have there been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed.
Response: No

13. Since your last renewal, have you voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances?
Response: No

Do you dispense for profit legend drugs that are to be administered orally, are ordinarily dispensed by a pharmacist, and are not a vaccine? This information is classified as public. It is unlawful to dispense these legend drugs for profit after July 1, 1990 unless a statement has been filed with the Board of Medical Practice.
Response: No

Profile - Practice Addresses

Primary: John A. Haugen Associates P.A.
801 Nicollet Mall
Suite 400
Minneapolis, MN 55402

Phone: (612) 333-2503

Secondary: (None)

Profile - Education-Post Graduate

Program	Specialty	Start Date	End Date	Completed

University of Minnesota	Obstetrics and gynecology	06/18/2003	06/08/2007	Y

Profile - ABMS/AOA Specialty Certification

Source	Board/Certificate	Sub Certificate	Effective	Expire	Verify
ABMS	Obstetrics and Gynecology/Obstetrics & Gynecology		12/2009	12/2015	☑
ABMS	Obstetrics and Gynecology/Obstetrics & Gynecology		12/2010	12/2015	☑

Profile - Criminal Convictions

Since your last renewal, have you been convicted of a crime? A person shall be deemed to be convicted of a misdemeanor if he or she pleads guilty, was found guilty by a court of competent jurisdiction or entered a plea of nolo contendere. All felony level convictions and any gross misdemeanor or misdemeanor convictions involving crimes against persons or violations of public health and safety laws (except those related to personal substance abuse and/or addiction, or other illnesses eligible for inclusion in Health Professionals Services Program) are to be reported. All convictions for assault and/or sexual misconduct shall be included. All felony convictions must be reported, even those that are subsequently reduced to misdemeanor or gross misdemeanor convictions pursuant to a stay of imposition of sentence. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.
Response: No

Certification by Licensee

*Indicates required field

* ☑ **I certify that all information provided is complete, accurate and true.**

Submission of this online application does not automatically result in approval of your license. If all requirements are satisfied, a license will be mailed within 2 weeks. If additional information is needed, the Board will contact you.

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Click the Next button to submit this application and proceed to credit card processing.

< Previous Next >

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Wednesday, November 12, 2014

minnesota northstar

Log In

Search

Home | Online Services

User Admin

Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name: Hope Frisch Start Date: 4/15/2013 3:52:52 PM

Service Name: License Renewal - PY Complete Date: 4/15/2013 4:00:06 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	4/15/2013 3:52:59 PM	
2	Verify Information	4/15/2013 3:53:21 PM	
3	Privileges & Continuing Medical Education	4/15/2013 3:56:18 PM	
4	Practice Questions	4/15/2013 3:57:07 PM	
5	Profiling - Practice Addresses	4/15/2013 3:57:16 PM	
5	Profiling - Post Graduate Training	4/15/2013 3:57:22 PM	
5	Profiling - Post Graduate Training	4/15/2013 3:57:22 PM	
5	Profiling - ABMS/AOA	4/15/2013 3:57:29 PM	
5	Profiling - ABMS/AOA	4/15/2013 3:57:29 PM	
5	Profiling - Criminal Convictions	4/15/2013 3:57:44 PM	
6	Review	4/15/2013 3:58:04 PM	
7	Questionnaire	4/15/2013 3:58:37 PM	

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Verification Page

The following is a copy of the verification page that was presented to the user upon completion of the Online Service

The information you have submitted in the previous steps is provided below.

If any information is incomplete or incorrect, return to the appropriate step to make additions or corrections by clicking the Previous button located at the end of this section. Note: Do not use the Back button on your browser.

Use your browser's Print command to print this summary for your records.

Application for License Renewal

License Number: PY 49517
Name: Hope Elizabeth Frisch

Drivers License: MN - [redacted]
Is license current? Yes

Designated Address: 801 Nicollet Mall
Suite 400
Minneapolis, MN 55402

Phone: (612) 333-2503
Email Address:
Web Site: www.[redacted]

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Abbott Northwestern	Minneapolis	MN	physician
Fairview Southdale	Edina	MN	physician

Continuing Education

The residency or fellowship program were converted into number of years:

Years	Description
0	Residency Program
0	Fellowship Program

Required Hours: 75

Category 1 Course Hours: 0
Category 1 Equivalent Course Hours: 101
Total Reported Hours: 101

You are certified by an ABMS, AOABPE, RCPSC, CFPC specialty board during your three-year cycle or are currently participating in MOC, OCC, or the RCPSC equivalent?

Practice Questions

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. **If you are currently participating in Health Professionals Services Program (HPSP) for a condition covered by questions 1-4 or if you do not have that condition, leave the question unanswered as to that condition.** For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse.

The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling.

1. Since your last renewal, has your cognitive, communicative, or physical ability to engage in the practice of medicine or surgery with reasonable skill and safety been impaired or limited in any way?
Response: Unanswered

2. Since your last renewal, has your use of alcohol or chemical substance(s), including prescription medications, in any way impaired or limited your ability to practice medicine with reasonable skill and safety?
Response: Unanswered

3. Since your last renewal, have you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)?
Response: Unanswered

4. Since your last renewal, have you been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety?
Response: Unanswered

5. Since your last renewal, have you been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders?
Response: No

6. Since your last renewal, have you been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances?
Response: No

7. Since your last renewal, have you been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority?
Response: No

8. Since your last renewal, has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by Medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority?
Response: No

9. Since your last renewal, have you been notified of any investigations by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board?
Response: No

10. Since your last renewal, have your hospital privileges been restricted or revoked?
Response: No

11. Since your last renewal, have there been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon or state district court judges. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Response: No

12. Since your last renewal, have there been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed.
Response: No

13. Since your last renewal, have you voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances?
Response: No

Do you dispense for profit legend drugs that are to be administered orally, are ordinarily dispensed by a pharmacist, and are not a vaccine? This information is classified as public. It is unlawful to dispense these legend drugs for profit after July 1, 1990 unless a statement has been filed with the Board of Medical Practice.
Response: No

Profile - Practice Addresses

Primary: John A. Haugen Associates P.A.
801 Nicollet Mall
Suite 400
Minneapolis, MN 55402

Phone: (612) 333-2503

Secondary: (None)

Profile - Education-Post Graduate

Program	Specialty	Start Date	End Date	Completed
University of Minnesota	Obstetrics and gynecology	06/18/2003	06/08/2007	Y

Profile - ABMS/AOA Specialty Certification

Source	Board/Certificate	Sub Certificate	Effective	Expire	Verify
ABMS	Obstetrics and Gynecology/Obstetrics & Gynecology		12/2009	12/2015	☑
ABMS	Obstetrics and Gynecology/Obstetrics & Gynecology		12/2010	12/2015	☑

Profile - Criminal Convictions

Since your last renewal, have you been convicted of a crime? A person shall be deemed to be convicted of a misdemeanor if he or she pleads guilty, was found guilty by a court of competent jurisdiction or entered a plea of nolo contendere. All felony level convictions and any gross misdemeanor or misdemeanor convictions involving crimes against persons or violations of public health and safety laws (except those related to personal substance abuse and/or addiction, or other illnesses eligible for inclusion in Health Professionals Services Program) are to be reported. All convictions for assault and/or sexual misconduct shall be included. All felony convictions must be reported, even those that are subsequently reduced to misdemeanor or gross misdemeanor convictions pursuant to a stay of imposition of sentence. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.
Response: No

Certification by Licensee

*Indicates required field

* ☑ **I certify that all information provided is complete, accurate and true.**

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Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Wednesday, November 12, 2014

minnesota north star

Welcome Pat Hayes! | Logoff

Search

Home | Online Services | User Admin

User Admin

Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name: Hope Frisch Start Date: 4/21/2014 10:29:41 AM

Service Name: License Renewal - PY Complete Date: 4/21/2014 10:58:25 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	4/21/2014 10:29:46 AM	
2	Verify Information	4/21/2014 10:30:41 AM	
3	Privileges & Continuing Medical Education	4/21/2014 10:31:00 AM	
4	Practice Questions	4/21/2014 10:32:08 AM	
5	Profiling - Practice Addresses	4/21/2014 10:34:43 AM	
5	Profiling - Post Graduate Training	4/21/2014 10:35:03 AM	
5	Profiling - Post Graduate Training	4/21/2014 10:35:03 AM	
5	Profiling - ABMS/AOA	4/21/2014 10:35:11 AM	
5	Profiling - Criminal Convictions	4/21/2014 10:35:17 AM	
6	Review	4/21/2014 10:35:36 AM	
7	Questionnaire	4/21/2014 10:35:41 AM	

1

Verification Page

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Use your browser's Print command to print this summary for your records.

Application for License Renewal

License Number: PY 49517
Name: Hope Elizabeth Frisch

Drivers License: MN
Is license current? Yes

Designated Address: 801 Nicollet Mall
Suite 400
Minneapolis, MN 55402

Phone: (612) 333-2503
Email Address:
Web Site: www

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Abbott Northwestern	Minneapolis	MN	physician
Fairview Southdale	Edina	MN	physician

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 05/31/2016.

Practice Questions

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. **If you are currently participating in Health Professionals Services Program (HPSP) for a condition covered by questions 1-4 or if you do not have that condition, leave the question unanswered as to that condition.** For

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Response: Unanswered

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Response: Unanswered

3. Since your last renewal, have you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)?
Response: Unanswered

4. Since your last renewal, have you been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety?
Response: Unanswered

5. Since your last renewal, have you been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders?
Response: No

6. Since your last renewal, have you been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances?
Response: No

7. Since your last renewal, have you been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority?
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Response: No

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Response: No

11. Since your last renewal, have there been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon or state district court judges. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Response: No

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Response: No

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Response: No

Do you dispense for profit legend drugs that are to be administered orally, are ordinarily dispensed by a pharmacist, and are not a vaccine? This information is classified as public. It is unlawful to dispense these legend drugs for profit after July 1, 1990 unless a statement has been filed with the Board of Medical Practice.
Response: No

Profile - Practice Addresses

Primary:	John A. Haugen Associates P.A. 801 Nicollet Mall Suite 400 Minneapolis, MN 55402	**Phone:**	(612) 333-2503
Secondary:	John A. Haugen Associates, P.A.	**Phone:**	(952) 927-6561

3400 West 66th Street
Suite 385
Edina, MN 55435

Military Status: No

Profile - Education-Post Graduate

Program	Specialty	Start Date	End Date	Completed
University of Minnesota	Obstetrics and gynecology	06/18/2003	06/08/2007	Y

Profile - ABMS/AOA Specialty Certification

Source	Board/Certificate	Sub Certificate	Verify
ABMS	Obstetrics and Gynecology/Obstetrics & Gynecology		☑
ABMS	Obstetrics and Gynecology/Obstetrics & Gynecology		☑

Profile - Criminal Convictions

Since your last renewal, or on or after July 2013, have you been convicted of a crime?
Response: No

Certification by Licensee

*Indicates required field

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< Previous | Submit