APPLICATION TO PRACTICE MEDICINE

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 400
MINNEAPOLIS, MINNESOTA 55414-3246
(612) 617-2130
Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

APR 18 1998
MN BOARD OF MED PRACTICE

FOR BOARD USE ONLY

APPLICATION #: 67575
CHECK /RECEIPT #:
AMT PAID:
TEMP PERMIT #: 7636
BOARD ACTION:
BOARD DATE: 7-11-98
LICENSE #: 40822

DATE OF APPLICATION:

DAY	MONTH	YEAR
03	18	98

INSTRUCTIONS TO APPLICANT

1. Answer all questions completely and accurately 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 Day, Month, and Year. Attach a separate sheet if necessary. 309
5. Enter all dates as DAY-MONTH-YEAR. For example, January 1, 1989 should be entered as 01-JAN-89.
6. The application fee is not refundable.
7. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
8. Incomplete applications will be destroyed after six months of inactivity.

FOR BOARD USE ONLY

	SOURCE CODE	AMOUNT
3	5200	168.00
5	5201	200.00
7	5203	60.00

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
Terrell	Carrie	Ann

STREET ADDRESS:

CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:
Minneapolis	MN	55406	USA

HOME PHONE:	OTHER PHONE:	GENDER	MAIDEN NAME:
		☐ MALE ☒ FEMALE	

SOCIAL SECURITY OR ALIEN REGISTRATION NO.

BASIS FOR APPLICATION (CHECK ONE) *

- ☐ FEDERATION LICENSING EXAMINATION (FLEX)
- ☐ NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINATION (NBME)
- ☐ NATIONAL BOARD OF OSTEOPATHIC EXAMINERS EXAMINATION (NBOE)
- ☐ LICENTIATE OF MEDICAL COUNCIL OF CANADA EXAMINATION (LMCC)
- ☐ STATE BOARD EXAMINATION (STATE)
- ☒ UNITED STATES MEDICAL LICENSING EXAM (USMLE)
- ☐ COMBINATION FLEX, NBME, USMLE

ECFMG CERTIFICATION (FOREIGN)

NUMBER:

DATE ISSUED:

DRIVERS LICENSE

STATE:

NUMBER:

ADDRESS OF NEAREST RELATIVE		
NAME OF RELATIVE:		
STREET ADDRESS:		
CITY:	STATE OR PROVINCE:	
ZIP CODE:	COUNTRY: USA	RELATIONSHIP:

YOUR INTENDED ADDRESS		
STREET ADDRESS:		
CITY:	STATE OR PROVINCE:	
ZIP CODE:	COUNTRY:	EFFECTIVE DATE:
PHONE:		

RECORD OF BIRTH			
BIRTHDATE (DD-MMM-YY)	CITY OF BIRTH: Wichita Falls	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH: Texas
FULL NAME OF FATHER:	MOTHER'S MAIDEN NAME:	COUNTRY OF BIRTH: USA	

IDENTIFYING CHARACTERISTICS				
HEIGHT (ft./in.): 5' 8"	WEIGHT (lbs): 180	COLOR HAIR: brown	COLOR EYES: blue	
IDENTIFYING MARKS:				

PRELIMINARY EDUCATION					
NAME OF HIGH SCHOOL: Fridley	CITY: Fridley	STATE OR PROVINCE: MN		FROM DATE: 1983	TO DATE: 1986
NAME OF COLLEGE: Moorhead State	CITY: Moorhead	STATE OR PROVINCE: MN	DEGREE: BA	FROM DATE (DD-MMM-YY): 01-09-86	TO DATE (DD-MMM-YY): 06-06-90
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	DEGREE:	FROM DATE (DD-MMM-YY):	TO DATE (DD-MMM-YY):

MEDICAL EDUCATION (MEDICAL SCHOOLS ONLY)					
INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE (DD-MMM-YY	TO DATE (DD-MMM-YY)
University of Minnesota	Minneapolis	MN	55455	01-09-91	01-06-95

ACCOUNTING OF TIME NOT NOTED ELSEWHERE ON THIS APPLICATION		
ACTIVITY (ATTACH SEPARATE SHEET, IF NECESSARY)	FROM DATE (DD-MMM-YY)	TO DATE (DD-MMM-YY)
Inorganic chemist @ Pace Inc, Mpls MN	06/06/90	01-01-92

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BACHELOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE DD-MMM-YY
☐ MEDICINE ☐ OSTEOPATHY						
DOCTOR OF:	**NAME OF SCHOOL:**	**CITY:**	**STATE OR PROVINCE**	**ZIP:**	**COUNTRY:**	**DATE : DD-MMM-YY**
☒ MEDICINE ☐ OSTEOPATHY	University of MN	Minneapolis	MN	55455	USA	01.06.95

NAME OF HOSPITAL:			FROM DATE(DD-MMM-YY)	TO DATE (DD-MMM-YY)
University of Minnesota			01.07.95	Current
STREET ADDRESS:	**CITY:**	**STATE OR PROVINCE:**	**COUNTRY:**	**ZIP CODE:**
BOX 395 425 Delaware St. SE	Minneapolis	MN	USA	55455
TYPE OF TRAINING: (BE SPECIFIC)				
Obstetrics and Gynecology				

NAME OF HOSPITAL:			FROM DATE (DD-MMM-YY)	TO DATE (DD-MMM-YY)
STREET ADDRESS:	**CITY:**	**STATE OR PROVINCE:**	**COUNTRY:**	**ZIP CODE:**
TYPE OF TRAINING: (BE SPECIFIC)				

NAME OF HOSPITAL:			FROM DATE(DD-MMM-YY)	TO DATE (DD-MMM-YY)
STREET ADDRESS:	**CITY:**	**STATE OR PROVINCE:**	**COUNTRY:**	**ZIP CODE:**
TYPE OF TRAINING: (BE SPECIFIC)				

POST GRADUATE NON-CLINICAL MEDICAL EDUCATION/TRAINING

FACILITY NAME:			FROM DATE(DD-MMM-YY)	TO DATE (DD-MMM-YY)
N/A				
STREET ADDRESS:	**CITY:**	**STATE OR PROVINCE:**	**COUNTRY:**	**ZIP CODE:**
FACILITY NAME:			**FROM DATE (DD-MMM-YY)**	**TO DATE (DD-MMM-YY)**
STREET ADDRESS:	**CITY:**	**STATE OR PROVINCE:**	**COUNTRY:**	**ZIP CODE:**

MILITARY SERVICE

BRANCH OF SERVICE:	ENTRY DATE (DD-MMM-YY)	RELEASE DATE (DD-MMM-YY)	RANK AT DISCHARGE:	TYPE OF DISCHARGE:
DUTY ASSIGNMENT:			**LOCATION:**	
N/A				

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

STATE/PROVINCE/COUNTRY	LICENSE NUMBER	DATE ISSUED (DD-MMM-YY)	HOW OBTAINED (*)
N/A			

(*) NATIONAL BOARD OF MEDICAL EXAMINERS (NBME)
STATE BOARD EXAM (STATE)
NATIONAL BOARD OF OSTEOPATHIC EXAMINERS (NBOE)
LICENTIATE OF MEDICAL COUNCIL OF CANADA (LMCC)
FLEX EXAMINATION (FLEX)
UNITED STATES MEDICAL LICENSING EXAM (USMLE)
COMBINATION FLEX, NBME, USMLE

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PRACTICE REFERENCES

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

NAME OF FACILITY	FROM DATE: (DD-MMM-YY)	TO DATE: (DD-MMM-YY)			
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: (DD-MMM-YY)	TO DATE: (DD-MMM-YY)			
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: (DD-MMM-YY)	TO DATE: (DD-MMM-YY)			
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: (DD-MMM-YY)	TO DATE: (DD-MMM-YY)			
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: (DD-MMM-YY)	TO DATE: (DD-MMM-YY)			
NAME OF REFERENCE:	STREET ADDRESS:		CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE:	STREET ADDRESS:		CITY:	STATE/CNTRY:	ZIP CODE:

PROPOSED PRACTICE PLANS IN MINNESOTA (IF ANY)

"Moonlighting" until completion of residency (6/99) followed by practice in MN

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE
American College of Obstetrics and Gynecology	7/95	current

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

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

Specialty: ______________

Expiration Date: ____________

*If is 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 THROUGH 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. IF YOU ARE CURRENTLY PARTICIPATING IN HEALTH PROFESSIONAL SERVICES PROGRAM (HPSP) FOR A CONDITION COVERED BY QUESTIONS 1-4, YOU MAY ANSWER "NO" 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 INFORMATION.

Y (N) 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 N 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 N 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 (N) 2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine or surgery with reasonable skill and safety? Please describe.

Y (N) 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 N 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 N 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 (N) 4. Within the last ten years, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? Please describe.

Y (N) 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.

Y (N) 6. Have you ever been diagnosed as having or have you ever been treated for compulsive gambling or kleptomania? Please describe.

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Y (N)	7. 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 (N)	8. Have you ever been denied a license by, or the privilege of taking an examination before any medical examining board, or has a conditioned license ever been issued to you by any state medical board or licensing authority? If so, give particulars.
Y (N)	9. Has your license to practice medicine in any state or country ever 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 (N)	10. 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 ever been reprimanded or censured by any medical society or licensing board? If so, give particulars.
Y (N)	11. 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 (N)	12. Have your hospital privileges ever been restricted or revoked? If so, give particulars.
Y (N)	13. 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 (N)	14. 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 (N)	15. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.
Y (N)	16. Have you ever applied for licensure in Minnesota before? If so, please give license # and issue date or withdrawal/denial date.
(Y) N	17. Have you ever had a residency permit in Minnesota? If so, please give residency permit number.

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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. Terrell

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
[signature]	3.18.98	32301	MN

SARAH ARCHER
PRINT OR TYPE FULL NAME

OK

This is a true likeness.
Sandra R. Nanti
4/17/98

SANDRA R. NANTI
NOTARY PUBLIC - MINNESOTA
My Commission Expires Jan. 31, 2000

[illegible]

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Tracy Prosen	4-3-98	40331	MN

TRACY PROSEN
PRINT OR TYPE FULL NAME

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AFFIDAVIT OF APPLICANT:

STATE OF: Minnesota

COUNTY OF: Hennepin

I, Carrie Ann Terrell, 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 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 17 day of April, 19 98

Sandra R. Santi

Signature of Notary Public

My Commission Expires: January 31, 2000

SANDRA R. SANTI
NOTARY PUBLIC-MINNESOTA
My Commission Expires Jan. 31, 2000

Carrie Ann Terrell

Signature Of Applicant

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, and/or omission or falsification of material facts 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

Tuesday, October 28, 2014

minnesota northstar

Welcome Wendy Boswell! | 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:	Carrie Terrell	Start Date:	3/19/2014 8:08:00 AM
Service Name:	License Renewal - PY	Complete Date:	3/19/2014 8:14:00 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	3/19/2014 8:08:15 AM	
2	Verify Information	3/19/2014 8:08:23 AM	
3	Privileges & Continuing Medical Education	3/19/2014 8:11:33 AM	
4	Practice Questions	3/19/2014 8:12:20 AM	
5	Profiling - Practice Addresses	3/19/2014 8:12:32 AM	
5	Profiling - Post Graduate Training	3/19/2014 8:12:39 AM	
5	Profiling - Post Graduate Training	3/19/2014 8:12:39 AM	
5	Profiling - ABMS/AOA	3/19/2014 8:12:49 AM	
5	Profiling - Criminal Convictions	3/19/2014 8:12:55 AM	
6	Review	3/19/2014 8:13:07 AM	
7	Questionnaire	3/19/2014 8:13:13 AM	

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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 40822
Name: Carrie Ann Terrell

Drivers License:
Is license current? Yes

Designated Address: Riverside Prof Bldg
606 24th Ave S #300
Minneapolis, MN 55454

Phone: (612) 273-7111
Email Address: terre010@umn.edu
Web Site: umphysicians.umn.edu

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
University of Minnesota Medical Center, Fairview	Minneapolis	MN	full

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: 146
Category 1 Equivalent Course Hours: 0

Total Reported Hours: 146

You were not 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: UNIVERSITY SPECIALISTS
606 24TH AVE S #300
MINNEAPOLIS, MN 55455

Phone: (612) 273-7111

Secondary: (None)

Military Status: No

Profile - Education-Post Graduate

Program	Specialty	Start Date	End Date	Completed
University Of Minnesota	Obstetrics and Gynecology	06/00/1995	06/00/1999	Y
University of MN	ob-gyn	06/08/1995	06/08/1999	Y

Profile - ABMS/AOA Specialty Certification

Source	Board/Certificate	Sub Certificate	Verify
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

* ☑ **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.

All information provided is private until your application has been approved. Once it has been approved, all information is public except as noted in the application. Public information is available to any person upon request.

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

< Previous Submit

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Tuesday, October 28, 2014

minnesota northstar

Welcome Wendy Boswell! | 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:	Carrie Terrell	Start Date:	2/27/2013 3:34:02 PM
Service Name:	License Renewal - PY	Complete Date:	2/27/2013 3:37:43 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	2/27/2013 3:34:06 PM	
2	Verify Information	2/27/2013 3:34:13 PM	
3	Privileges & Continuing Medical Education	2/27/2013 3:34:25 PM	
4	Practice Questions	2/27/2013 3:34:55 PM	
5	Profiling - Practice Addresses	2/27/2013 3:35:09 PM	
5	Profiling - Post Graduate Training	2/27/2013 3:35:11 PM	
5	Profiling - Post Graduate Training	2/27/2013 3:35:11 PM	
5	Profiling - ABMS/AOA	2/27/2013 3:35:14 PM	
5	Profiling - ABMS/AOA	2/27/2013 3:35:14 PM	
5	Profiling - ABMS/AOA	2/27/2013 3:35:25 PM	
5	Profiling - ABMS/AOA	2/27/2013 3:35:25 PM	
5	Profiling - Criminal Convictions	2/27/2013 3:35:31 PM	
6	Review	2/27/2013 3:35:43 PM	• You must affirm the statement under Certification by Licensee
6	Review	2/27/2013 3:35:50 PM	
7	Questionnaire	2/27/2013 3:35:54 PM	

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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 40822
Name: Carrie Ann Terrell

Drivers License:
Is license current? Yes

Designated Address:
Riverside Prof Bldg
606 24th Ave S #300
Minneapolis, MN 55454

Phone:(612) 273-7111
Email Address:terre010@umn.edu
Web Site:umphysicians.umn.edu

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
University of Minnesota Medical Center, Fairview	Minneapolis	MN	full

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 03/31/2014.

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: UNIVERSITY SPECIALISTS
606 24TH AVE S #300
MINNEAPOLIS, MN 55455

Phone: (612) 273-7111

Secondary: (None)

Profile - Education-Post Graduate

Program	Specialty	Start Date	End Date	Completed
University Of Minnesota	Obstetrics and Gynecology	06/00/1995	06/00/1999	Y
University of MN	ob-gyn	06/08/1995	06/08/1999	Y

Profile - ABMS/AOA Specialty Certification

Source	Board/Certificate	Sub Certificate	Effective	Expire	Verify
ABMS	Obstetrics and Gynecology/Obstetrics & Gynecology		12/2012	12/2013	☑

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 > **The above items in red need your attention!**

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Tuesday, October 28, 2014

minnesota north star

Welcome Wendy Boswell! | 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:	Carrie Terrell	Start Date:	3/16/2012 12:50:44 PM
Service Name:	License Renewal - PY	Complete Date:	3/16/2012 12:54:14 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	3/16/2012 12:50:46 PM	• Specify credit card type for payment
1	Information	3/16/2012 12:50:49 PM	
2	Verify Information	3/16/2012 12:51:29 PM	
3	Privileges & Continuing Medical Education	3/16/2012 12:51:32 PM	
4	Practice Questions	3/16/2012 12:52:00 PM	
5	Profiling - Practice Addresses	3/16/2012 12:52:09 PM	
5	Profiling - Post Graduate Training	3/16/2012 12:52:10 PM	
5	Profiling - Post Graduate Training	3/16/2012 12:52:11 PM	
5	Profiling - ABMS/AOA	3/16/2012 12:52:20 PM	
5	Profiling - Criminal Convictions	3/16/2012 12:52:25 PM	
6	Review	3/16/2012 12:52:33 PM	
7	Questionnaire	3/16/2012 12:52:42 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 40822

Name: Carrie Ann Terrell

Drivers License:
Is license current? Yes

Designated Address: Riverside Prof Bldg
606 24th Ave S #300
Minneapolis, MN 55454

Phone: (612) 273-7111
Email Address: terre010@umn.edu
Web Site: umphysicians.umn.edu

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
University of Minnesota Medical Center, Fairview	Minneapolis	MN	full

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Response: No

Profile - Practice Addresses

Primary: UNIVERSITY SPECIALISTS
606 24TH AVE S #300
MINNEAPOLIS, MN 55455
Phone: (None)

Secondary: MIDWEST HEALTH CTR FOR WOMEN **Phone:** (None)

33 S 5TH ST
suite 400
MINNEAPOLIS, MN 55401

Profile - Education-Post Graduate

Program	Specialty	Start Date	End Date	Completed
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