ICE Wisconsin DSPS
Integrated Credentialing and Enforcement DRL-WORLD\Kmh

Home Site Map Logout

Clients Credentialing Enforcement Boards A/R Maintenance

Home » Clients » Search by Individual » Search by Individual Results

**Search by Individual Results**
View, add, edit, and delete a person's contact information by browsing to the desired tab.

Summary | Name | Relationships | Address | Phone/Fax | Email/Web | Protection | Skills

**Name:** HOPE FRISCH [redacted]
**Gender:** female [redacted]

[redacted]

**Applications**

Add New Application

| Profession | Application ID | Method | Specialty | Sub Profession | Kind | Action |
|---|---|---|---|---|---|---|
| 875 (Special Permits) | 312918 | CAMP OR RECREATIONAL | | 21 (Medicine and Surgery) | 36 (CAMP OR RECREATIONAL FACILITY PHYSICIAN) | ✖ |
| 21 (Medicine and Surgery) | 339562 | ENDORSEMEN | | | | ✖ |

**Total Applications : 2**

**Credentials**

Add An Old Credential

| Credential Number | Granted | Renewal By | Status |
|---|---|---|---|
| 53322-21 | 07/02/2009 | 02/29/2016 | ACTIVE |
| 191-875 | 07/18/2008 | 10/15/2008 | EXPIRED |

**Total Credentials : 2**

**Orders (ICE)**

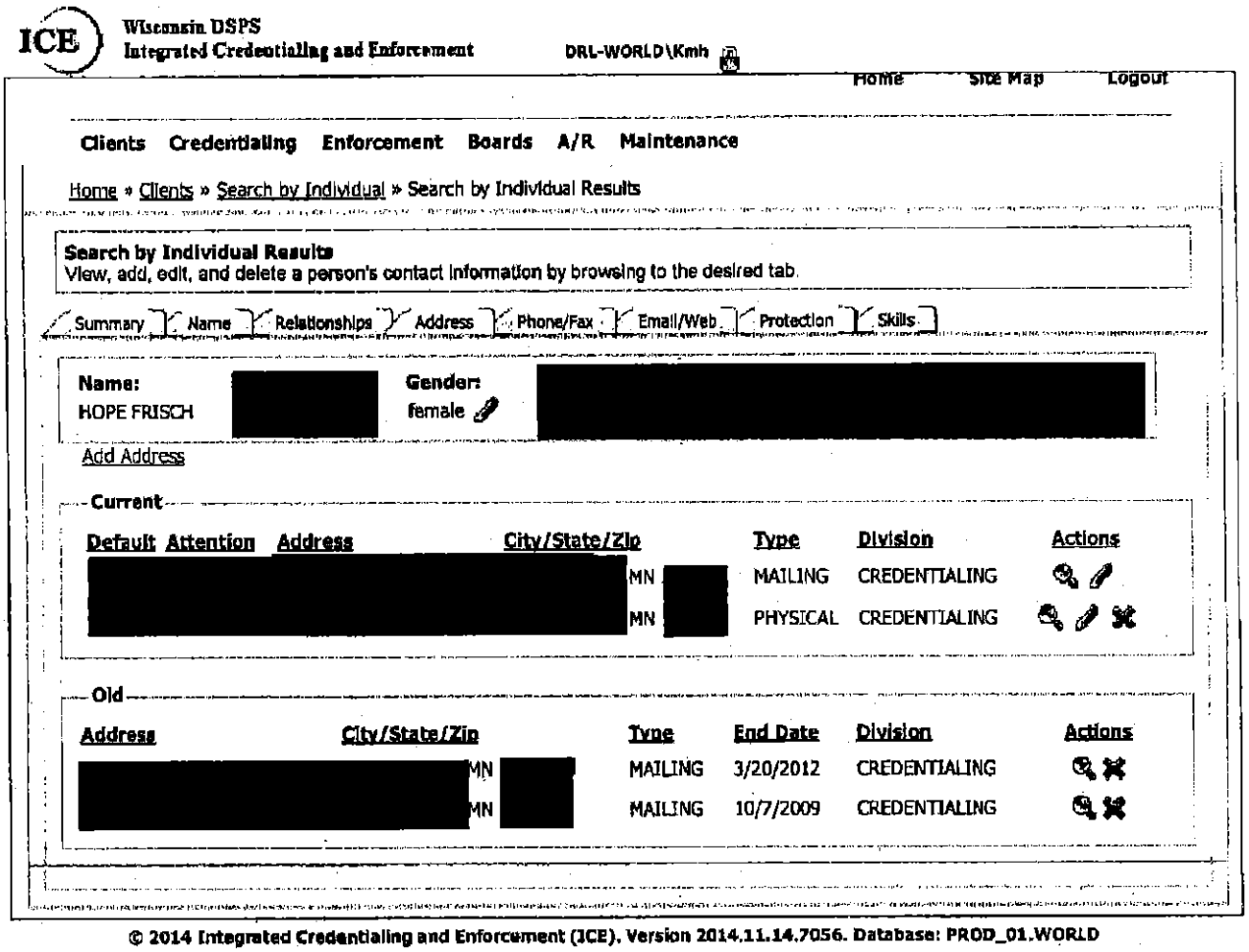
**No orders found.**

**Intake Cases (ICE)**

**No cases found.**

**Respondent Report**

View Consolidated Case Notes Summary



**Credential Holder**
Enter renewal information and click Save.

Credential | Xref | Insurance | Firearms | Details | Letters | Holds | History | Notes | Cred: 1 of 1 > »

Renew | Hot Print Renewal Letter | Wall Cert | Labels | Hot Print DRN | Renewal Notice | Expanded Details | **Save**

**Credential:** 53322-21 (Medicine and Surgery)
**Renewal:** 2014
**Name:** FRISCH, HOPE
**Status:** REGULAR - CURRENT(ACTIVE)
**Granted:** 07/02/2009 **Renew By:** 02/29/2016 OtherDate
**First Fee:** 07/22/2014

**Detail Payments/Refunds**

| Batch Date | Code | Batch Type | Batch# | Batch Location | Amt. Paid |
|---|---|---|---|---|---|
| 07/22/2014 | P | E | 0 | 430 | 166 |

**Requirements**

Add Requirement | Confirm Requirements

| Code | Complied | Complied Date | Printed | Comments | Actions |
|---|---|---|---|---|---|
| SIG | Met | 07/22/2014 | | status set to Met 07/22/2014 14:30 via online re | |
| FEE | Met | 07/22/2014 | | added by CRP SR 01/02/2014 10:16 | |
| CLS | Met | 07/22/2014 | | status set to Met 07/22/2014 14:29 via online re | |
| LFN | Met | 07/22/2014 | | added by CRP 07/23/2014 08:10 | |
| STA | Met | 07/23/2014 | | added by CRP 07/22/2014 14:28 | |

**License Type:** REGULAR
**Status:** ACTIVE
Show SSN
View/Edit Continuing Education

**Specialty Code:** (12) OBSTETRICS AND GYNECOLOGY
--Select One--

**Working State:** --Select--
**Residency:** --Select--

[redacted]

**Name and Address Change**
Click on expand/collapse to view/hide information.

**More Details:**
Click on expand/collapse to view/hide information.
**Credential Initial:**
**Credentialing Method Group: ENDORSEMENT (Endorsement)**
**PDMP Status:**

**Credential Holder**
Enter renewal information and click Save.

Credential | Xref | Insurance | Firearms | Details | Letters | Holds | History | Notes | Cred: 1 of 1

**Name:** FRISCH, HOPE

**Renewal Due:** 02/29/2016

**Profession:** Medicine and Surgery

**Credential #:** 53322-21

Add History | View Online Activity

**History**

| Date | History Type | History | Actions |
|---|---|---|---|
| 07/23/2014 | RenewedAuto | Cred Holder Renewed - Auto Event | |
| 07/23/2014 | CredHolderStatusChange | Status Change: E to A by DRL-WORLD\straum | |
| 03/03/2014 | CredHolderStatusChange | Status Change: ACTIVE to EXPIRED by DRL-WORLD\straim | |
| 03/22/2012 | RenewedAuto | Cred Holder Renewed - Auto Event | |
| 03/21/2012 | CredHolderStatusChange | Status Change: E to A by DRL-WORLD\Rnl142 | |
| 03/01/2012 | CredHolderStatusChange | Status Change: ACTIVE to EXPIRED by DRL-WORLD\rnl142 | |
| 10/06/2009 | RenewedAuto | From fee rec. year=2009 date printed=10/06/2009 | |
| 09/02/2009 | StandardRequirementAdded | Standard Requirement Added: FEE | |
| 09/02/2009 | StandardRequirementAdded | Standard Requirement Added: SIG | |
| 09/02/2009 | StandardRequirementAdded | Standard Requirement Added: CLS | |
| 07/02/2009 | LicenseGranted | License granted. | |
| 07/02/2009 | FromApplicationMethodInformation | Application 339562 by method ENDORSEMEN | |
| 05/26/2009 | GraduatedFrom | Graduated from University of Health Sciences College of Osteopathic Medicine | |
| 05/22/2009 | EndorsedFrom | Endorsed from USMLE | |
| 05/22/2009 | FromApplicationMethodInformation | Application 339562 by method ENDORSEMEN | |

**Exam History**

**There are no query results.**

Print History

**Credential Expanded Details**
View expanded details on the credential holder. Click the Return link when finished.

**Cred. Holder:** FRISCH, HOPE

**Profession:** 53322-21 (Medicine and Surgery)

**Print Activity List**

| Requested Date | Print Activity | Printed | Printed Date | Renewal Year |
|---|---|---|---|---|
| 7/23/2014 | HEALTHCHK | Yes | 8/5/2014 | 0 |
| 3/3/2014 | HEALTHCHK | Yes | 3/4/2014 | 0 |
| 1/2/2014 | RENEWALDOM | Yes | 1/2/2014 | 2014 |
| 1/2/2014 | RENEWALSEL | Yes | 1/2/2014 | 2014 |
| 3/20/2012 | HEALTHCHK | Yes | 4/3/2012 | 0 |

1 2

**PIN Number**

**PIN: DG7YCD DOB: 05/31/1974 SSN: 9638**

**Renewal Requirements List**

| Code | Renewal Year | Complied | Complied Date | Printed | Printed Date | Insert Date | Comments |
|---|---|---|---|---|---|---|---|
| LFN | 2014 | Met | 07/22/2014 | No | | 07/23/2014 | added by CRP 07/23/2014 08:10 |
| FEE | 2014 | Met | 07/22/2014 | No | | 01/02/2014 | added by CRP SR 01/02/2014 10:16 |
| STA | 2014 | Met | 07/23/2014 | No | | 07/22/2014 | added by CRP 07/22/2014 14:28 |
| SIG | 2014 | Met | 07/22/2014 | No | | 01/02/2014 | status set to Met 07/22/2014 14:30 via online renewal |
| CLS | 2014 | Met | 07/22/2014 | No | | 01/02/2014 | status set to Met 07/22/2014 14:29 via online renewal |
| STA | 2012 | Met | 03/21/2012 | No | | 03/20/2012 | added by CRP 03/20/2012 12:18 |
| SIG | 2012 | Met | 03/20/2012 | No | | 01/03/2012 | status set to Met 03/20/2012 12:20 via online renewal |
| LFN | 2012 | Met | 03/20/2012 | No | | 03/21/2012 | added by CRP 03/21/2012 07:50 |
| CLS | 2012 | Met | 03/20/2012 | No | | 01/03/2012 | status set to Met 03/20/2012 12:19 via online renewal |
| FEE | 2012 | Met | 03/20/2012 | No | | 01/03/2012 | added by CRP SR 01/03/2012 09:58 |
| FEE | 2009 | Met | 10/06/2009 | No | | 09/02/2009 | Met thru online renewal |
| SIG | 2009 | Met | 10/06/2009 | No | | 09/02/2009 | Met thru online renewal |
| CLS | 2009 | Met | 10/06/2009 | No | | 09/02/2009 | Met thru online renewal |

Return

**Credential Expanded Details**
View expanded details on the credential holder. Click the Return link when finished.

**Cred. Holder:** FRISCH, HOPE
**Profession:** 53322-21 (Medicine and Surgery)

**Print Activity List**

| Requested Date | Print Activity | Printed | Printed Date | Renewal Year |
|---|---|---|---|---|
| 3/1/2012 | HEALTHCHK | Yes | 3/8/2012 | 0 |
| 10/8/2009 | HEALTHCHK | Yes | 4/2/2010 | 0 |
| 7/2/2009 | HEALTHCHK | Yes | 4/2/2010 | 0 |
| 3/2/2010 | HEALTHCHK | Yes | 3/16/2010 | 0 |

1 2

**PIN Number**

**PIN: DG7YCD DOB: 05/31/1974 SSN: 9638**

**Renewal Requirements List**

| Code | Renewal Year | Complied | Complied Date | Printed | Printed Date | Insert Date | Comments |
|---|---|---|---|---|---|---|---|
| LFN | 2014 | Met | 07/22/2014 | No | | 07/23/2014 | added by CRP 07/23/2014 08:10 |
| FEE | 2014 | Met | 07/22/2014 | No | | 01/02/2014 | added by CRP SR 01/02/2014 10:16 |
| STA | 2014 | Met | 07/23/2014 | No | | 07/22/2014 | added by CRP 07/22/2014 14:28 |
| SIG | 2014 | Met | 07/22/2014 | No | | 01/02/2014 | status set to Met 07/22/2014 14:30 via online renewal |
| CLS | 2014 | Met | 07/22/2014 | No | | 01/02/2014 | status set to Met 07/22/2014 14:29 via online renewal |
| STA | 2012 | Met | 03/21/2012 | No | | 03/20/2012 | added by CRP 03/20/2012 12:18 |
| SIG | 2012 | Met | 03/20/2012 | No | | 01/03/2012 | status set to Met 03/20/2012 12:20 via online renewal |
| LFN | 2012 | Met | 03/20/2012 | No | | 03/21/2012 | added by CRP 03/21/2012 07:50 |
| CLS | 2012 | Met | 03/20/2012 | No | | 01/03/2012 | status set to Met 03/20/2012 12:19 via online renewal |
| FEE | 2012 | Met | 03/20/2012 | No | | 01/03/2012 | added by CRP SR 01/03/2012 09:58 |
| FEE | 2009 | Met | 10/06/2009 | No | | 09/02/2009 | Met thru online renewal |
| SIG | 2009 | Met | 10/06/2009 | No | | 09/02/2009 | Met thru online renewal |
| CLS | 2009 | Met | 10/06/2009 | No | | 09/02/2009 | Met thru online renewal |

Return

2012 ①



**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery)
**Name:** FRISCH, HOPE
**Granted:** 07/02/2009 **Renew By:** 02/29/2016

**Renewal:** 2014
**Status:** REGULAR - CURRENT(ACTIVE)
**First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Credential

Renewal Year: 2012

**Log**

| Time | Step # | Step Title | Message | |
|---|---|---|---|---|
| 3/20/2012 12:19:13 PM | 1 | Update Contact Info | Step completed, advancing to next step in renewal process... | |
| 3/20/2012 12:19:19 PM | 2 | Certification Of Legal Status | Step completed, advancing to next step in renewal process... | Survey Answers |
| 3/20/2012 12:19:25 PM | 3 | Affidavit of Credential Holder | Step completed, advancing to next step in renewal process... | Survey Answers |
| 3/20/2012 12:19:52 PM | 4 | DWD Survey | Step completed, advancing to next step in renewal process... | |
| 3/20/2012 12:20:23 PM | 4 | Verify Professional Specialties | Step completed, advancing to next step in renewal process... | |
| 3/20/2012 12:20:29 PM | 5 | Expert Witness Participation | Step completed, advancing to next step in renewal process... | Survey Answers |
| 3/20/2012 12:20:46 PM | 7 | Important Information Regarding Your Credential | Step completed, advancing to next step in renewal process... | |
| 3/20/2012 12:20:57 PM | 6 | Continuing Education Requirement (DO) | Step completed, advancing to next step in renewal process... | Survey Answers |
| 3/20/2012 12:21:07 PM | 7 | List Opt-Out | Step completed, advancing to next step in renewal process... | Survey Answers |
| 3/20/2012 12:25:12 PM | 9 | Pay Renewal Fee | Step completed, advancing to next step in renewal process... | |
| 3/20/2012 12:25:17 PM | 10 | Workforce Survey | Step completed, advancing to next step in renewal process... | |

**Continuing Education Log**

No Continuing Education log information recorded for this renewal year

2013 ?



**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery)
**Name:** FRISCH, HOPE
**Granted:** 07/02/2009 **Renew By:** 02/29/2016

**Renewal:** 2014
**Status:** REGULAR - CURRENT(ACTIVE)
**First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Log

**Answers**

I declare under penalty of law that I am: (check one)

○ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

◉ a citizen or national of the United States

2014



**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery)
**Name:** FRISCH, HOPE
**Granted:** 07/02/2009 **Renew By:** 02/29/2016

**Renewal:** 2014
**Status:** REGULAR - CURRENT(ACTIVE)
**First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Log

**Answers**

☑ I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery) **Renewal:** 2014
**Name:** FRISCH, HOPE **Status:** REGULAR - CURRENT(ACTIVE)
**Granted:** 07/02/2009 **Renew By:** 02/29/2016 **First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Log

**Answers**

☐ Please check here if you are willing to serve as an expert witness in disciplinary proceedings.

2014 (5



**Online Activity**
View credential holder renewal log, Activity Information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery)
**Name:** FRISCH, HOPE
**Granted:** 07/02/2009 **Renew By:** 02/29/2016

**Renewal:** 2014
**Status:** REGULAR - CURRENT(ACTIVE)
**First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Log

**Answers**

(●) I plan to complete the required Continuing Education. I understand that no credential will be issued until I meet this requirement. I also understand that my credential may expire if the required Continuing Education is not completed by the renewal deadline.

(●) I have or will have completed *30 hours of AMA or AOA Category I continuing education beginning March 1, 2012 and ending February 28, 2014, and I have or will have evidence of this which I will furnish to the Medical Examining Board upon request.

2012 (6



**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery)
**Name:** FRISCH, HOPE
**Granted:** 07/02/2009 **Renew By:** 02/29/2016

**Renewal:** 2014
**Status:** REGULAR - CURRENT(ACTIVE)
**First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Log

**Answers**

Per Wis. Stat. § 440.14, if you are an individual or a sole proprietor, you may declare that your street address and/or PO Box # not be disclosed on any list of ten or more credential holders that the department furnishes to another person. Please check the box below to make this declaration.

☒ **Please do not disclose my street address and/or PO Box # on lists**

RC 14 (3



**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery)
**Name:** FRISCH, HOPE
**Granted:** 07/02/2009 **Renew By:** 02/29/2016

**Renewal:** 2014
**Status:** REGULAR - CURRENT(ACTIVE)
**First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Credential

Renewal Year: 2014

Log

| Time | Step # | Step Title | Message | |
|---|---|---|---|---|
| 7/22/2014 2:29:25 PM | 1 | Update Contact Info | Step completed, advancing to next step in renewal process... | |
| 7/22/2014 2:29:36 PM | 2 | Certification Of Legal Status | Step completed, advancing to next step in renewal process... | Survey Answers |
| 7/22/2014 2:29:41 PM | 3 | Affidavit of Credential Holder | Step completed, advancing to next step in renewal process... | Survey Answers |
| 7/22/2014 2:29:47 PM | 4 | Verify Professional Specialties | Step completed, advancing to next step in renewal process... | |
| 7/22/2014 2:29:51 PM | 5 | Expert Witness Participation | Step completed, advancing to next step in renewal process... | Survey Answers |
| 7/22/2014 2:30:10 PM | 6 | Continuing Education Requirement (DO) | Step completed, advancing to next step in renewal process... | Survey Answers |
| 7/22/2014 2:30:18 PM | 7 | List Opt-Out | Step completed, advancing to next step in renewal process... | Survey Answers |
| 7/22/2014 2:30:33 PM | 8 | US Bank Payment Site Information | Step completed, advancing to next step in renewal process... | |

**Continuing Education Log**

No Continuing Education log information recorded for this renewal year

2014 (2



**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery)
**Name:** FRISCH, HOPE
**Granted:** 07/02/2009 **Renew By:** 02/29/2016

**Renewal:** 2014
**Status:** REGULAR - CURRENT(ACTIVE)
**First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Log

**Answers**

I declare under penalty of law that I am: (check one)

- a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.
- a citizen or national of the United States

2014 (3)



**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery) **Renewal:** 2014
**Name:** FRISCH, HOPE **Status:** REGULAR - CURRENT(ACTIVE)
**Granted:** 07/02/2009 **Renew By:** 02/29/2016 **First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Log

**Answers**

☒ I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

2014 (4



**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery) **Renewal:** 2014
**Name:** FRISCH, HOPE **Status:** REGULAR - CURRENT(ACTIVE)
**Granted:** 07/02/2009 **Renew By:** 02/29/2016 **First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Log

**Answers**

☑ Please check here if you are willing to serve as an expert witness in disciplinary proceedings.

2014 (5



**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery) **Renewal:** 2014
**Name:** FRISCH, HOPE **Status:** REGULAR - CURRENT(ACTIVE)
**Granted:** 07/02/2009 **Renew By:** 02/29/2016 **First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Log

**Answers**

☑ I plan to complete the required Continuing Education. I understand that no credential will be issued until I meet this requirement. I also understand that my credential may expire if the required Continuing Education is not completed by the renewal deadline.

☑ I have or will have completed *30 hours of AMA or AOA Category I continuing education beginning March 1, 2012 and ending February 28, 2014, and I have or will have evidence of this which I will furnish to the Medical Examining Board upon request.

**Online Activity**
View credential holder renewal log, Activity information (online login info), Continuing education log

**Credential:** 53322-21 (Medicine and Surgery) **Renewal:** 2014
**Name:** FRISCH, HOPE **Status:** REGULAR - CURRENT(ACTIVE)
**Granted:** 07/02/2009 **Renew By:** 02/29/2016 **First Fee:** 07/22/2014

**Online Renewal Log**

< Back To Log

**Answers**

Per Wis. Stat. § 440.14, if you are an individual or a sole proprietor, you may declare that your street address and/or PO Box # not be disclosed on any list of ten or more credential holders that the department furnishes to another person. Please check the box below to make this declaration.

☒ **Please do not disclose my street address and/or PO Box # on lists**

Credentialing | Ind. Cred. Search | Org. Cred. Search | Manage Credentials | Home | Site Map | Logout

DRL-WORLD\Kmh

**Credential Holder**
Enter renewal information and click Save.

Credential | Xref | Insurance | Firearms | Details | Letters | Holds | History | Notes | Cred: 1 of 1 > »

Reinstate | Extend Temporary | Make Permanent | Hot Print Renewal Letter | Wall Cert | Labels | Hot Print DRN | Renewal Notice | Expanded Details | Save

**Credential:** 191-875 (Special Permits)
**Renewal:** 0
**Name:** FRISCH, HOPE
**Status:** TEMPORARY - NOT CURRENT (EXPIRED)
**Granted:** 07/18/2008 **Renew By:** 10/15/2008 OtherDate
**First Fee:**

**Detail Payments/Refunds**
**There are no query results.**

**Requirements**
Add Requirement | Confirm Requirements
**There are no query results.**

**License Type:** TEMPORARY
**Specialty Code:**
**Working State:** --Select--
**Status:** EXPIRED
**Residency:** --Select--
Show SSN
View/Edit Continuing Education
--Select One--

[redacted]

**Name and Address Change**
Click on expand/collapse to view/hide information.

**More Details:**
Click on expand/collapse to view/hide information.
**Credential Initial:**
**Credentialing Method Group: SPECIALPERMIT (Special Permits for 875)**

**Credential Holder**
Enter renewal information and click Save.

Credential | Xref | Insurance | Firearms | Details | Letters | Holds | History | Notes | Cred: 1 of 1 > »

**Name:** FRISCH, HOPE **Renewal Due:** 10/15/2008

**Profession:** Special Permits

**Credential #:** 191-875

Add History | View Online Activity

**History**

| Date | History Type | History | Actions |
|---|---|---|---|
| 10/23/2008 | CredHolderStatusChange | Status Change: ACTIVE to EXPIRED by DRL-WORLD\RnI142 | |
| 07/18/2008 | BlueLicensePrinted | | |
| 07/18/2008 | FromApplicationMethodInformation | Application 312918 by method CAMP OR RECREATIONAL | |
| 07/18/2008 | TemporaryLicenseIssued | Temporty license issued. | |
| 06/16/2008 | FromApplicationMethodInformation | Application 312918 by method CAMP OR RECREATIONAL | |
| 05/19/2003 | GraduatedFrom | Graduated from University of Health Sciences College of Osteopathic Medicine | |

**Exam History**

**There are no query results.**

Print History

ICE Wisconsin DSPS
Integrated Credentialing and Enforcement DRL-WORLD\Kmh

Home Site Map Logout

Clients Credentialing Enforcement Boards A/R Maintenance

Home » Credentialing » Application » Individual Application » Applicant » Add Applicant » Method » List » Application

**Application**
Use the tabs to enter the applicant's information.

Checklist | Applicant | School | Residency | Insurance | Xref | Firearms | Notes | History | Letters

| | | | |
|---|---|---|---|
| **Applicant:** | HOPE FRISCH | **Application ID:** | 312918 |
| **Permit:** | 875 (Special Permits) | **Receipted:** | 6/2/2008 Add Transaction |
| **Sub Profession:** | 021 (Medicine and Surgery) | **Entered:** | 6/16/2008 |
| **Permit Kind:** | 036 (CAMP OR RECREATIONAL FACILITY PHYSICIAN) | **Dept Received:** | |
| **Method:** | CAMP OR RECREATIONAL | **Status:** | Temporary permit issued |
| **Method From:** | | **Permit #:** | 191-875 |
| **Credential Initial:** | | | |

Save **All Tabs Completed:**

Print Folder Label | Print Mailing Label | Print Checklist | | Email Applicant | Email Letter of Notice |

**Enter Checklist**

| Requirement | Status | Met Date | Comments | Exam |
|---|---|---|---|---|
| Wisconsin Statutes & Rules Examination | Met | 06/27/2008 | passed | |
| Application Fee | Met | 06/16/2008 | paid 6/2/08<br>refund request submitted | |
| Is name on all credentials the same? If not, submit copy of marriage certificate, divorce decree, etc. | Not Applica | | | |
| PAGE 1 Applicable blanks completed | Met | 06/16/2008 | | |
| Professional Education-provide school name, location (city, state) and date of graduation. | Met | 06/16/2008 | | |
| Post graduate training and activites from the date of graduation to the present. Provide hospital/clinic name, location and dates (month/year). | Met | 07/01/2008 | | |
| PAGE 3 and 4 All questions answered and relevant copies attached. | Met | 06/16/2008 | | |
| Affidavit of applicant, signed and notarized. | Met | 06/16/2008 | | |
| Social Security Number | Met | 06/16/2008 | | |
| Letter requesting services from camp/facility indicating dates of coverage needed. | Met | 06/16/2008 | | |

| | | | | |
|---|---|---|---|---|
| Photo copy of original wall certificate/license including original date of issuance. | Met | 08/16/2008 | | |
| Photo copy of current registration card. | Met | 08/16/2008 | | |
| Physicians Profile Data Report from AMA or AOA | Met | 07/18/2008 | | |
| Disciplinary Inquiry Report from Federation (Form #1445) | Met | 06/27/2008 | | |
| Copies of court or insurance documents of all malpractice suit(s) | Not Applica | | | |
| CIB Fee for Convictions and Pending Charges Form (this file will need further review once application is completed) | Not Applica | | | |
| OTHER | Not Applica | | | EXAM |

PLEASE NOTE: THIS IS THE ONLY MAILED CHECKLIST THAT YOU WILL RECEIVE. Please go online for future updates at http://dsps.wi.gov and look for the "Application Status" link.

# Department of Regulation & Licensing

**STATE OF WISCONSIN**
**Phone: (608) 266-2112**
TTY# (608) 267-2416 } Hearing or Speech
TRS# (800) 947-3529 } Impaired Only

PO Box 8935, Madison, WI 53708-8935
E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov
Fax: (608) 261-7083

Information requested is required for processing your application. This is not a license.

HOPE E FRISCH DO
[redacted]

The following is a list of requirements that need to be met before licensure can be completed. You can check the current status of your application at any time by phone with the Interactive Response System or by the Internet. To check the status by phone, call (608) 261-7925 and follow the prompts. The Interactive Voice Response System will inform you of any requirements not yet met. To check the current status by Internet, key in the following address: http://drl.wi.gov and select the "Application Status" link.

**MEDICINE AND SURGERY**
**CHECK FORM**

[redacted]

| [redacted] | Completed or Date Required | [redacted] | [redacted] |
|---|---|---|---|
| WI Statute & Rules Examination | 07/02/2009 | Met | Passed |
| Application Fee | 05/26/2009 | Met | PD 5/19/09 |
| Pages One and Two - Applicable blanks completed | 05/26/2009 | Met | |
| Pre-Professional and Professional Education | 05/26/2009 | Met | |
| All activities and practice accounted for | 05/26/2009 | Met | |
| Pages Three, Four and Five - Applicable blanks completed | 05/26/2009 | Met | |
| Affidavit of applicant, signed and notarized | 05/26/2009 | Met | |
| National Board Scores, original certification | 05/26/2009 | Met | USMLE |
| Authorization and Waiver, signed and notarized | 05/26/2009 | Met | |
| Copy of Medical diploma | 05/26/2009 | Met | |
| Physicians Profile Data Report from AOA or AMA | 06/04/2009 | Met | Report date 5/28/09 |
| Disciplinary Inquiry Report from Federation (Form #1445) | 05/26/2009 | Met | Report date 5/14/09 |
| Work History (Form #1934) | 05/26/2009 | Met | |
| Certificate of Post-Graduate Training (Form #2165) | 05/26/2009 | Met | |
| Medical Education Verification Form (Form #2164) | 05/26/2009 | Met | Graduated 5/03 |
| Certification of Legal Status Completed. | 05/26/2009 | Met | |
| Hospital Verification-Privileges, Employment or Appointment (Form #2187) | 05/26/2009 | Met | |
| Verification of state license(s) directly from State Board office(s) | 05/26/2009 | Met | Rec'd: MN |
| Completed National Practitioner Data Bank Report/Self-query (both parts of report NPDB and HIPDB) | 06/01/2009 | Met | Report date 5/14/09 |
| Social Security Number Collection Form (#2380) | 05/26/2009 | Met | |

**This is not a license.**

# Department of Regulation & Licensing

STATE OF WISCONSIN
Phone: (608) 266-2112
TTY# (608) 267-2416 } Hearing or Speech
TRS# (800) 947-3529 } Impaired Only

PO Box 8935, Madison, WI 53708-8935
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HOPE E FRISCH DO
[redacted]

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**MEDICINE AND SURGERY**
**CHECK FORM**

[redacted]

| | | | |
|---|---|---|---|
| WI Statute & Rules Examination | | Not Met | [redacted] |
| Application Fee | 05/26/2009 | Met | PD 5/19/09 |
| Pages One and Two - Applicable blanks completed | 05/26/2009 | Met | |
| Pre-Professional and Professional Education | 05/26/2009 | Met | |
| All activities and practice accounted for | 05/26/2009 | Met | |
| Pages Three, Four and Five - Applicable blanks completed | 05/26/2009 | Met | |
| Affidavit of applicant, signed and notarized | 05/26/2009 | Met | |
| National Board Scores, original certification | 05/26/2009 | Met | USMLE |
| Authorization and Waiver, signed and notarized | 05/26/2009 | Met | |
| Copy of Medical diploma | 05/26/2009 | Met | |
| Physicians Profile Data Report from AOA or AMA | 06/04/2009 | Met | Report date 5/28/09 |
| Disciplinary Inquiry Report from Federation (Form #1445) | 05/26/2009 | Met | Report date 5/14/09 |
| Work History (Form #1934) | 05/26/2009 | Met | |
| Certificate of Post-Graduate Training (Form #2165) | 05/26/2009 | Met | |
| Medical Education Verification Form (Form #2164) | 05/26/2009 | Met | Graduated 5/03 |
| Certification of Legal Status Completed. | 05/26/2009 | Met | |
| Hospital Verification-Privileges, Employment or Appointment (Form #2167) | 05/26/2009 | Met | |
| Verification of state license(s) directly from State Board office(s) | 05/26/2009 | Met | Rec'd: MN |
| Completed National Practitioner Data Bank Report/Self-query (both parts of report NPDB and HIPDB) | 06/01/2009 | Met | Report date 5/14/09 |
| Social Security Number Collection Form (#2380) | 05/26/2009 | Met | |
| Oral Exam to be determined after application is completed | | Not Met | |

# Department of Regulation & Licensing

STATE OF WISCONSIN
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**MEDICINE AND SURGERY**
**CHECK FORM**

[redacted]

| DESCRIPTION | COMPLETION DATE | REQUIREMENT | COMMENTS |
|---|---|---|---|
| WI Statute & Rules Examination | | Not Met | [redacted] |
| Application Fee | 05/26/2009 | Met | PD 5/19/09 |
| Pages One and Two - Applicable blanks completed | 05/26/2009 | Met | |
| Pre-Professional and Professional Education | 05/26/2009 | Met | |
| All activities and practice accounted for | 05/26/2009 | Met | |
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| Authorization and Waiver, signed and notarized | 05/26/2009 | Met | |
| Copy of Medical diploma | 05/26/2009 | Met | |
| Physicians Profile Data Report from AOA or AMA | | Not Met | |
| Disciplinary Inquiry Report from Federation (Form #1445) | 05/26/2009 | Met | Report date 5/14/09 |
| Work History (Form #1934) | 05/26/2009 | Met | |
| Certificate of Post-Graduate Training (Form #2165) | 05/26/2009 | Met | |
| Medical Education Verification Form (Form #2164) | 05/26/2009 | Met | Graduated 5/03 |
| Certification of Legal Status Completed. | 05/26/2009 | Met | |
| Hospital Verification-Privileges, Employment or Appointment (Form #2167) | 05/26/2009 | Met | |
| Verification of state license(s) directly from State Board office(s) | 05/26/2009 | Met | Rec'd: MN |
| Completed National Practitioner Data Bank Report/Self-query (both parts of report NPDB and HIPDB) | 06/01/2009 | Met | Report date 5/14/09 |
| Social Security Number Collection Form (#2380) | 05/26/2009 | Met | |
| Oral Exam to be determined after application is completed | | Not Met | |

# Department of Regulation & Licensing

STATE OF WISCONSIN
Phone: (608) 266-2112
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HOPE E FRISCH DO
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**MEDICINE AND SURGERY**
**CHECK FORM**

[redacted]

| | | | |
|---|---|---|---|
| WI Statute & Rules Examination | | Not Met | [redacted] |
| Application Fee | 05/26/2009 | Met | PD 5/19/09 |
| Pages One and Two - Applicable blanks completed | 05/26/2009 | Met | |
| Pre-Professional and Professional Education | 05/26/2009 | Met | |
| All activities and practice accounted for | 05/26/2009 | Met | |
| Pages Three, Four and Five - Applicable blanks completed | 05/26/2009 | Met | |
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| Authorization and Waiver, signed and notarized | 05/26/2009 | Met | |
| Copy of Medical diploma | 05/26/2009 | Met | |
| Physicians Profile Data Report from AOA or AMA | | Not Met | |
| Disciplinary Inquiry Report from Federation (Form #1445) | 05/26/2009 | Met | Report date 5/14/09 |
| Work History (Form #1934) | 05/26/2009 | Met | |
| Certificate of Post-Graduate Training (Form #2165) | 05/26/2009 | Met | |
| Medical Education Verification Form (Form #2164) | 05/26/2009 | Met | Graduated 5/03 |
| Certification of Legal Status Completed. | 05/26/2009 | Met | |
| Hospital Verification-Privileges, Employment or Appointment (Form #2167) | 05/26/2009 | Met | |
| Verification of state license(s) directly from State Board office(s) | 05/26/2009 | Met | Rec'd: MN |
| Completed National Practitioner Data Bank Report/Self-query (both parts of report NPDB and HIPDB) | | Not Met | Obtain from www.npdb-hipdb.com/ |
| Social Security Number Collection Form (#2380) | 05/26/2009 | Met | |
| Oral Exam to be determined after application is completed | | Not Met | |

# Wisconsin Department of Regulation & Licensing


**Mail To:** P.O. Box 8935
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
**Phone #:** (608) 266-2112

E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov/


## MEDICAL EXAMINING BOARD

339562

## APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY

**Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).**

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

| Last Name | First Name | MI | Former / Maiden Name(s) |
|---|---|---|---|
| Frisch | Hope | E | |

Your Street: [redacted]

Mail To Address (if different)

Date of Birth: [redacted]

Daytime Telephone Number: [redacted]

Ethnic/gender status information is optional.

**Sex:** ☐ M ☑ F

**Ethnic:** [redacted]

**Medical School:** Kansas City University of Medicine & Biosciences - College of Osteopathic Medicine

**School Address:** Kansas City (City) MO USA (State/Country)

**Degree:** D.O

**Date Degree Granted:** 5/19/2003 (month/day/year)

**Select only one code.**
**(For a list of specialty codes see Form #546)**

**Specialty:** OB Gyn

**Specialty Code:** 12

**APPLICATION FEES** Please check only one blank: (Make check payable to Department of Regulation and Licensing and attach to application.)

___ **To Write PART III USMLE**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
$ 15.00 Contract Exam Fee
**$ 125.00 Total Fee Attached***

___ **Endorsement of National Boards (MD or DO)**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 110.00 Total Fee Attached***

___ **Endorsement of FLEX**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 110.00 Total Fee Attached***

___ **Reciprocity of State Board Exam (Taken Prior to 1972)***
$ 106.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 163.00 Total Fee Attached***

___ **Endorsement of LMCC (Taken after 1/1/78)**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 110.00 Total Fee Attached***

✓ **Endorsement of Steps 1, 2, & 3 of USMLE**
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 110.00 Total Fee Attached***

___ **LOCUM TENENS***
$ 106.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 163.00 Total Fee Attached***

___ **VISITING PROFESSOR***
$ 53.00 Initial Credential Fee
$ 57.00 State Law Exam
**$ 110.00 Total Fee Attached***

***ORAL EXAMINATION INTERVIEW FEE: $266.00**
If you should be selected for an oral examination, the additional oral examination fee will be required prior to being scheduled for the exam.

**For Receipting Use Only**

LIC #53320
7/2/09

Trn# 128174 05/19/09 02.06
CHECK

021-ICF 53.00

021-EXAM 57.00

TOTAL 110.00

#570 (Rev. 10/08)
Ch. 448, Stats.

# Wisconsin Department of Regulation & Licensing

**APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:**

Application (Form #570)

Copy of ECFMG certificate if a Foreign Graduate (FCVS)

Copy of Professional Diploma and translation if necessary (FCVS)

Medical Education Verification Form (Form #2164 (FCVS)

Certificate of Post-graduate Training (Form #2165 (FCVS)

National Board, FLEX, State Board, USMLE or LMCC score (FCVS)

Work History (Form 1934)

National Practitioner Data Bank Report (not applicable for visiting professor)

Hospital, Facility and Employer Verification-(Form #2167) **(not applicable for visiting professor)**

Copies of malpractice suit. Court documents with allegations and settlement. (If apply, complete Form #2829 Malpractice Suits or Claims Form)

Signed Authorization and Waiver Form (Form #571)

Physician Profile Data Report from the American Medical Association or American Osteopathic Association

Disciplinary Inquiry Report from the Federation of State Medical Boards (Form #1445) (FCVS)

Fee attached to application (Form #570)

Wisconsin Statutes and Rules Examination

Convictions & Pending Charges Form (Form #2252), **if applicable**

Letter from the appointing authority of a medical school in Wisconsin indicating that the applicant has been invited to serve on the academic staff of such medical school as a visiting professor. **(Only required for visiting professor)**

Letter from a physician licensed to practice medicine and surgery requesting the applicant's services **(only required for locum tenens)**.

Copy of a license to practice medicine and surgery in another state or Canada and a letter of good standing **(only required for locum tenens or visiting professor)**.

**IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.**

**PRE-PROFESSIONAL EDUCATION: (schools, locations, dates of graduation and degrees) (list all schools attended)**

| | SCHOOL | DEGREE | DATES OF GRADUATION |
|---|---|---|---|
| 1. | Brandeis University | B.A - Biology | 5/1996 |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**PROFESSIONAL EDUCATION: (schools, locations, dates of graduation and degrees) (list all schools attended)**

| | SCHOOL | DEGREE | DATES OF GRADUATION |
|---|---|---|---|
| 1. | Kansas City University of Medical & Biosciences - COM | D.O. | 5/2003 |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**POST-GRADUATE TRAINING AND FELLOWSHIPS: Outline in chronological order. (Attach additional sheets if necessary)**

| | NAME OF HOSPITAL OR CLINIC | LOCATION | DATES (from - to) mo/yr |
|---|---|---|---|
| 1. | University of Minnesota Medical School | Minneapolis MN | 6/03 - 6/07 |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**PRACTICE AND OTHER ACTIVITIES: Outline in chronological order from the date of completion of your training/fellowship to the present time. Must include professional and nonprofessional activities. All activities must be accounted for. (Attach additional sheets if necessary.)**

| | NAME OF HOSPITAL OR CLINIC | LOCATION | DATES (from - to) mo/yr |
|---|---|---|---|
| 1. | John Haugen + Associates, P.A. | Minneapolis, MN | 9/07 - present |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

(attach additional sheets if necessary)

| ECFMG EXAM TAKEN | CERTIFICATE ISSUED | CERTIFICATE NO. | DATE ISSUED |
|---|---|---|---|
| ____ Yes ____ No | ____ Yes ____ No | | mo / day / yr |

SPECIALTY BOARD CERTIFICATIONS ____ Yes ____ No DATE CERTIFIED ____ mo / day yr

# Wisconsin Department of Regulation & Licensing

**LIST ALL HOSPITALS THAT YOU HAVE HAD STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENTS DURING THE LAST 5 YEARS:**

| | NAME OF HOSPITAL | LOCATION (City/State/Country) | DATES (from-to) mo/yr/ |
|---|---|---|---|
| 1. | Abbott Northwestern Hospital | Minneapolis/MN/USA | 9/07-present |
| 2. | Fairview Southdale Hospital | Edina/MN/USA | 9/07-present |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

I AM CURRENTLY OR HAVE BEEN CREDENTIALED IN THE FOLLOWING U.S. STATES OR TERRITORIES AND CANADIAN PROVIENCES OR TERRITORIES **UNLIMITED (INCLUDE ACTIVE AND INACTIVE CREDENTIALS).**

By Written Exam:

By Endorsement/Reciprocity: Minnesota # 49517

**YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN LICENSED SUBMIT LETTERS OF VERIFICATION TO THE WISCONSIN MEDICAL EXAMINING BOARD. THE LETTERS MUST INDICATE YOUR DATE OF BIRTH, LICENSE NUMBER, DATE OF ISSUANCE, AND A STATEMENT REGARDING DISCIPLINARY ACTIONS. THESE LETTERS WILL BE REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE.** ✓

**ANSWER THE FOLLOWING QUESTIONS:** (Attach additional sheets if necessary.

| | | YES | NO |
|---|---|---|---|
| 1. | Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases? | ☒ | ☐ |
| 2. | Have you ever surrendered, resigned, cancelled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency. | ☒ | ☒ NO |
| 3. | Have you ever failed to pass any state board examination, national board examination, or USMLE, or FLEX examination? If yes, give details on an attached sheet. | ☒ | ☒ NO |
| 4. | Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action. | ☐ | ☒ |
| 5. | Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action. | ☐ | ☒ |
| 6. | Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.) | ☐ | ☒ |
| 7. | Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.) | ☐ | ☒ |
| 8. | Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer. | ☐ | ☒ |

# Wisconsin Department of Regulation & Licensing

| | | YES | NO |
|---|---|---|---|
| 9. | Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition. (If yes, complete Form 2829.) | ☐ | ☒ |
| 10. | Have your hospital privileges ever been limited or removed? If yes, give details on an attached sheet. (If yes, complete Form 2829.) | ☐ | ☒ |
| 11. | Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s). | ☐ | ☒ |
| 12. | Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under. | ☐ | ☒ |
| 13. | Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet. | ☐ | ☒ |

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

| | | YES | NO |
|---|---|---|---|
| 14. | Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain. | ☐ | ☒ |
| 15. | Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain. | ☐ | ☒ |
| 16. | Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain. | ☐ | ☒ |
| 17. | Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain. | ☐ | ☒ |
| 18. | Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain. | ☐ | ☒ |
| 19. | Are you currently engaged in the illegal use of controlled dangerous substances? | ☐ | ☒ |
| 20. | If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain. | ☐ | ☐ |

# Wisconsin Department of Regulation & Licensing

**CERTIFICATION OF LEGAL STATUS.**

I declare under penalty of law that I am (check one):

X a citizen or national of the United States, or

___ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

**ALL APPLICANTS MUST COMPLETE THIS SECTION**

**AFFIDAVIT OF APPLICANT**
**(Sign and date in the presence of a notary)**

**I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.**

Hope Frasch
Signature of Applicant

5/4/09
Date

State of MN County of Hennepin

Subscribed and sworn to before this 4th day of May, 2009, by Hope Frasch
(Applicant name)

Vicki L Rue
Signature of Notary Public

Jan 31, 2010
Date Commission Expires

VICKI L. RUE
NOTARY PUBLIC - MINNESOTA
My Commission Expires Jan. 31, 2010

SEAL

# Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: (608) 266-2112

E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

## WORK HISTORY
## MEDICINE AND SURGERY
## MEDICAL EXAMINING BOARD

Please print

COMPLETE WORK HISTORY. If additional space is required this form may be copied and submitted with this form

**SECTION A:**

| NAME / LAST | FIRST | MI | DATE OF BIRTH |
|---|---|---|---|
| Frisch | Hope | E | [redacted] |

ADDRESS (Street, City, State, Zip Code) [redacted]

| MAIDEN OR GIVEN SURNAME | CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED: ☐ | DATE THIS FORM IS COMPLETED: |
|---|---|---|
| | | 5-15-09 |

**SECTION B:**

RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation from medical school. You must account for the entire time period including periods of unemployment and volunteer work, etc.

**1. NAME OF BUSINESS/INSTITUTION OR OTHER:** John A Haugen Associates P.A
**JOB TITLE:** OB Gyn Physician
**ADDRESS: (Street, City, State, Zip Code)** 801 Nicollet Mall, Ste 400 Minneapolis MN 55402
**DESCRIPTION OF DUTIES PERFORMED:**
**SUPERVISOR'S FULL NAME:** Andrew Mohn, MD
**DATE OF EMPLOYMENT/ ATTENDANCE:** From: 09/07 (Month/Year) To: present
**# OF HOURS WORKED PER WEEK:** 45
**TYPE OF EMPLOYMENT:** ☒ Full-time ☐ Part-time
**INDICATE TOTAL TIME WORKED IN YEARS/MONTH:** 20 months

**2. NAME OF BUSINESS/INSTITUTION OR OTHER:** University of MN Medical School
**JOB TITLE:** OB Gyn Resident Physician
**ADDRESS: (Street, City, State, Zip Code)** MMC#395 420 Delaware St SE Mpls MN 55455
**DESCRIPTION OF DUTIES PERFORMED:**
**SUPERVISOR'S FULL NAME:** Phillip Rauk, MD
**DATE OF EMPLOYMENT/ ATTENDANCE:** From: 06/03 (Month/Year) To: 06/07
**# OF HOURS WORKED PER WEEK:** 60
**TYPE OF EMPLOYMENT:** ☒ Full-time ☐ Part-time
**INDICATE TOTAL TIME WORKED IN YEARS/MONTH:** 4 years

# Wisconsin Department of Regulation & Licensing

**Mail To: P.O. Box 8935**
**Madison, WI 53708-8935**
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
**Phone #: (608) 266-2112**
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

**MEDICAL EXAMINING BOARD**

AUTHORIZATION AND WAIVER

(This form may be copied.)

Forward this form to all sources that verify information directly to the Wisconsin Medical Examining Board (example: verification of hospital privileges).

| Hope E Frisch | [redacted] MN USA | [redacted] |
|---|---|---|
| Applicant's Name | City/State/Country of Birth | Date of Birth |

having filed an application for a license to practice medicine and surgery in the State of Wisconsin, hereby authorize and consent to have an investigation made as to my professional reputation and fitness for the practice of medicine and surgery. I agree to give any further information which may be required in reference to my past record. I understand that I may inspect and copy any reports received by the Board relating to my professional reputation and fitness for the practice of medicine and surgery and that I may submit evidence including documents which tend to mitigate or explain any adverse information received from other parties. I also understand that the contents of my report will be privileged as to all other persons unless determined otherwise by court order.

I also authorize and request every person, hospital, clinic, community, governmental agency, court, association or institution having control of any documents, records and other information pertaining to me, to furnish to the Wisconsin Medical Examining Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any of its pertinent data and to permit the Wisconsin Medical Examining Board or any of its agents or representatives to inspect and make copies of such documents, records and other information.

I hereby release, discharge, exonerate the Wisconsin Medical Examining Board, its agents and representatives, and any person so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records and other information or the investigation made by the Wisconsin Medical Examining Board.

Hope Frisch
Signature of Applicant

(NOTARY SEAL)

State of MN County of Hennepin

Subscribed and sworn to before me this 7th day of May, 2009, by Hope E Frisch (Applicant name)

Vicki L Rue
Signature of Notary Public

Jan. 31, 2010
Date Commission Expires

VICKI L. RUE
NOTARY PUBLIC - MINNESOTA
My Commission Expires Jan. 31, 2010

#571 (Rev. 9/08)
Ch. 448, Stats.

[redacted]

**Subject:** All Partest 6/26

The following candidates took the MED exam, one failed:

| [redacted] | First | MI | Last | % | Fail? |
|---|---|---|---|---|---|
| | Hope | E | Frisch | 98 | |

[redacted]

Susan K. Bird
**Wisconsin Department of Regulation and Licensing**
Education and Examinations
1400 E Washington Ave
PO Box 8935
Madison, WI 53708-8935
T (608) 267-9362
F (608) 267-1809

# Wisconsin Department of Regulation & Licensing

**Mail To:** P.O. Box 8935
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
**Phone #:** (608) 266-2112
E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

## MEDICAL EXAMINING BOARD

DISCIPLINARY INQUIRIES REPORT

**(Not necessary if utilizing FCVS)**

**APPLICANT: PLEASE COMPLETE THIS FORM AND FORWARD DIRECTLY TO THE FEDERATION OF STATE MEDICAL BOARDS AT THE ADDRESS BELOW:**

Federation of State Medical Board, Inc.
Federation Place
P.O. Box 619850
Dallas, TX 75261-9850

---

The **State of Wisconsin** requests a Board Action/Disciplinary Search concerning the following individual:

Hope Frisch
Physician's Na[redacted]

D.O
Degree

Date of Birth (month/day/year)

[redacted]
Social Security Number

Kansas City University of Medical Biosciences
Medical School

2003
Year of Graduation

ECFMG Number

Physician's Signature

5/11/09
Date

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAY 14 2009

**ATTENTION: FEDERATION OF STATE MEDICAL BOARDS**

Barbara S. Schneidman, MD, MPH
Interim President
and Chief Executive Officer

**Please mail the response directly to the Medical Examining Board at the following address:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

#1445 (Rev. 9/08)
Ch. 448, Stats.

MAY - 6 2009

# Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

## MEDICAL EDUCATION VERIFICATION FORM

### MEDICAL EXAMINING BOARD

**(Not necessary if utilizing FCVS)**

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO YOUR MEDICAL SCHOOL*

The State of Wisconsin requests that you complete this form concerning the following individual:

APPLICANT'S NAME: Hope E Fausch Soc. Sec. #* [redacted]

MEDICAL SCHOOL: Kansas City University of Medical Biosciences - COM

MEDICAL SCHOOL ADDRESS: 1750 Independence Ave Kansas City MO 64106

| | | YES | NO |
|---|---|---|---|
| 1. | Did this physician attend the medical school noted above? | ☑ | ☐ |
| 2. | What were the applicant's dates of enrollment in this medical school? 8/1/99 - 5/18/03 | | |
| 3. | Did this physician graduate from this medical school? If no, please attach explanation on a separate sheet. Degree Granted D.O. Date Degree Granted 5/18/03 | ☑ | ☐ |
| 4. | Did this individual take a leave of absence during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 5. | Did this individual have a record of unexcused absences during his/her attendance at this medical school? | ☐ | ☑ |
| 6. | Was this individual ever disciplined or under investigation during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 7. | Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 8. | Was this individual recommended for post-graduate training? | ☑ | ☐ |

Print name of Dean Heidi Terry

Signature of Dean Heidi Terry

Date form was completed 5/6/2009

HEIDI TERRY
REGISTRAR

*For use in school locating your records

SEAL OF
MEDICAL SCHOOL

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

#2164 (Rev. 12/27/02)
Ch. 448, Stats.

**Committed to Equal Opportunity in Employment and Licensing**

# The Trustees of the

# University of Health Sciences

## College of Osteopathic Medicine

## To all whom it may concern

## Greeting:

Be it known that the Trustees having been advised by the Faculty that

## Hope Elizabeth Frisch

has completed the Course of Study required of candidates for the degree of

## Doctor of Osteopathic Medicine

and is qualified to receive the same, do by these presents confer said degree with all the honors and privileges appertaining thereto.

In testimony whereof the signatures of the proper officials and the seal of the University are affixed.

Done at the University in the City of Kansas City, State of Missouri, this eighteenth day of May, in the year of our Lord two thousand and three.

President

Dean

Jack D. Wiseman D.P.M.

Chairman of the Board of Trustees

A. W. Wright

Secretary of the Board of Trustees

# Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
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1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov

## CERTIFICATE OF POSTGRADUATE TRAINING

### MEDICAL EXAMINING BOARD

**(Not necessary if utilizing FCVS)**

*IMPORTANT: PLEASE FORWARD THIS FORM TO YOUR POSTGRADUATE TRAINING PROGRAMS (This form may be photocopied)*

The State of Wisconsin requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Hope F Kasch, DO

HOSPITAL NAME: University of Minnesota Medical School

HOSPITAL ADDRESS: _____

HOSPITAL TELEPHONE: _____

1. In what type and level(s) of training did this physician participate at your facility? Check each level in which physician participated, provide starting and ending dates of his/her training in your program and type of training and whether credit was given for the training.

| DATES (MO/YR) | SPECIALTY | CREDIT | NO CREDIT | PARTIAL CREDIT |
|---|---|---|---|---|
| ✓ PGY 1 6/03-6/04 | OB Gyn | | | |
| ✓ PGY 2 6/04-6/05 | OB Gyn | | | |
| ✓ PGY 3 6/05-6/06 | OB Gyn | | | |
| ✓ PGY 4 6/06-6/07 | OB Gyn | | | |
| ____ FELLOWSHIP ____ | | | | |
| ____ OTHER ____ | | | | |

| | YES | NO |
|---|---|---|
| 2. Was the internship/residency/fellowship in the United States accredited by Accreditation Council for Graduate Medical Education (ACGME) or in Canada accredited by the Royal College of Physicians & Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC)? | ☒ | ☐ |
| 3. Did the physician complete the full training program in good standing? If no, please attach explanation on a separate sheet. | ☒ | ☐ |
| 4. Was the physician asked to or required to repeat any portion of the training at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |

#2165 (Rev. 10/08)
Ch.448, Stats.

**-OVER-**

# Wisconsin Department of Regulation & Licensing

| | | YES | NO |
|---|---|---|---|
| 5. | Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 6. | Was this physician recommended for the Board Certification examination in this specialty? | ☒ | ☐ |
| 7. | Was this physician granted a leave of absence while training at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 8. | Did this individual have a record of unexcused absences during his/her attendance at this training program? | ☐ | ☒ |
| 9. | Were any restrictions and/or special requirements placed on this physician's activities that were not placed on all other residents/fellows at his/her level of training? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 10. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 11. | Were any incident reports filed involving the professional behavior or conduct of this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 12. | Was this physician ever subject to non-routine monitoring while at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 13. | Were any malpractice actions filed naming this physician as a defendant that involved his/her period of training at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 14. | Is there any additional information in this physician's file that would assist the Board in determining this applicant's eligibility for licensure. If yes, please attach explanation on a separate sheet. | ☐ | ☒ |

Print name of Program Director Phillip N. Rauk, MD

Signature of Program Director Phillip N. Rauk

Date form was completed 5/11/09

**SEAL OF HOSPITAL**

(If hospital does not have a seal, a letter attesting to this fact, on hospital stationary, must accompany this certificate)

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

# United States Medical Licensing Examination™ (USMLE™)
## Certified Transcript of Scores

USMLE United States Medical Licensing Examination™

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 – Telephone (817) 868-4041

Date: 05/15/2009

Recipient:
Wisconsin Medical Examining Board
ATTN: Tamie Buckingham
1400 E Washington Avenue
Room 178
Madison, WI 53703

Examinee ID: [redacted]
Examinee: Frisch, Hope Date of Birth: [redacted]
Alt Name(s): Frisch, Hope Elizabeth

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

### USMLE STEP 1

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments |
| | 06/01/2001 | Pass | 215 | 182 | 87 | 75 | |

### USMLE STEP 2

Clinical Knowledge (CK)

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments |
| | 02/25/2003 | Pass | 223 | 174 | 88 | 75 | |

### USMLE STEP 3

| | | | Three-Digit Score | | Two-Digit Score | | |
|---|---|---|---|---|---|---|---|
| | Test Date | Pass/Fail | Total | MP | Total | MP | Comments |
| MINNESOTA | 08/11/2004 | Pass | 213 | 184 | 88 | 75 | |

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

[redacted] [redacted] [redacted]



TouchSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

# Wisconsin Department of Regulation & Licensing


**Mail To: P.O. Box 8935**
**Madison, WI 53708-8935**

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
**Phone #: (608) 266-2112**

E-Mail: web@drl.state.wi.us
Website: http://drl.wi.gov


## HOSPITAL, FACILITY AND EMPLOYER VERIFICATION

### MEDICAL EXAMINING BOARD

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO ALL HOSPITALS, FACILITIES AND EMPLOYERS WHERE YOU HAVE HAD STAFF PRIVILEGES OR EMPLOYMENT DURING THE LAST 5 YEARS.*
*(This form may be photocopied.)*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Hope E Frisch, DO

FACILITY/EMPLOYER: John A Haugen Associates

FACILITY/EMPLOYER ADDRESS: 801 Nicollet Mall, ste 400 Minneapolis MN 55402

FACILITY/EMPLOYER TELEPHONE: 612-3332503

1. What position did this physician hold at your facility or under your employment? OB/Gyn Physician
2. What were this physician's dates of employment or staff privileges at your facility? 9/4/07 - present

| | | YES | NO |
|---|---|---|---|
| 3. | Did this physician leave your employ in good standing? If no, please attach explanation on a separate sheet. n/a still works here | ☐ | ☐ |
| 4. | Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility or under your employment? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 5. | Was this physician granted a leave of absence while employed by you or at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 6. | Did this individual have a record of unexcused absences during his/her attendance at this facility or under your employment? | ☐ | ☒ |
| 7. | Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees/staff holding similar positions? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 8. | Were any restrictions placed on this physician's privileges? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 9. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 10. | Was this physician denied hospital privileges while employed by you? If yes, please attach explanation on a separate sheet. | ☐ | ☒ |

# Wisconsin Department of Regulation & Licensing

| | | YES | NO |
|---|---|---|---|
| 11. | Were any incident reports filed involving the professional conduct or behavior of this physician?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 12. | Was this physician ever subject to non-routine monitoring while at your facility?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 13. | Was this physician involuntarily removed from a call schedule for cause?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 14. | Was this physician subject to non-routine quality assessment review?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☒ |
| 15. | Was this physician the subject of a negative review by a quality assurance or departmental committee?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☒ |

Print name and title of Employer/Official Supplying Information: ANDREA From MD

Signature of Employer/Official Supplying Information: Andrea From M.D.

Date form was completed: 4-28-09

**SEAL OF HOSPITAL, if applicable**
(If facility/employer does not have a seal, please attach a letter attesting to this fact, on facility stationery.)

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

3:02

FAIRVIEW

*These documents are being provided as confidential health review data under Minn. Stat. 145.61 to 145.67. Disclosure of all or any part of the information for any purpose other than the carrying out of the official review of this matter is prohibited. The information is not subject to discovery by subpoena or otherwise, nor may it be introduced into evidence in any administrative or judicial proceeding except as required or permitted by law. The recipient is responsible for maintaining the confidentiality of the information.*

Fairview Health Services

2450 Riverside Avenue
Minneapolis, MN 55454-1395
Tel 612-672-6300

April 28, 2009

Wisconsin Dept of Regulation & Licensing
Attn: Medical Examining Board
PO Box 8935
Madison, WI 53708-8935

Practitioner Name: **Hope Elizabeth Frisch, DO**
Primary Specialty: Obstetrics & Gynecology

To Whom It May Concern:

This letter is in response to your recent inquiry for verification and evaluation of Medical or Professional Staff membership and privileges at Fairview Health Services for the practitioner named above. The information was gathered from the practitioner's credentials file and will serve as verification of your request.

| | |
|---|---|
| **Fairview System Entity:** | Fairview Southdale Hospital |
| **Date Privileges Granted:** | 09/18/2007 |
| **Current Status:** | Provisional |
| **Resignation Date:** | |
| **Patient Activity # From Most Recent Reappointment Period:** | 92 |
| **Adverse Actions, Sanctions and/or Actions Restricting/Limiting Privileges:** | None |

This practitioner meets the qualifications relative to current competence to maintain requested membership and privileges at the entity listed above. There is no indication in the credentials file that this practitioner has any physical or mental condition which would affect the ability to exercise the clinical privileges requested or would require an accommodation to exercise those privileges safely and competently.

Unless noted, there has been no disciplinary action, such as admonition, reprimand, suspension or termination, while the practitioner held privileges, excluding administrative suspensions.

Bradley Beard — Fairview Southdale Hospital President — 952-924-8348
Name — Title — Phone

Bradley Beard — 4-30-09
Signature — Date

# Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@dri.state.wi.us
Website: http://dri.wi.gov

## HOSPITAL, FACILITY AND EMPLOYER VERIFICATION

### MEDICAL EXAMINING BOARD

*IMPORTANT: PLEASE FORWARD THIS FORM TO ALL HOSPITALS, FACILITIES AND EMPLOYERS WHERE YOU HAVE HAD STAFF PRIVILEGES OR EMPLOYMENT DURING THE LAST 5 YEARS.*
*(This form may be photocopied.)*

The State of Wisconsin requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Hope E Frisch, DO.

FACILITY/EMPLOYER: Fairview Southdale Hospital

FACILITY/EMPLOYER ADDRESS: 6401 France Ave S Edina MN 55435

FACILITY/EMPLOYER TELEPHONE: 952 924 5000

1. What position did this physician hold at your facility or under your employment? OB Gyn Physician
2. What were this physician's dates of employment or staff privileges at your facility? 9/2007 - present

| | | YES | NO |
|---|---|---|---|
| 3. | Did this physician leave your employ in good standing? If no, please attach explanation on a separate sheet. | ☐ | ☐ |
| 4. | Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility or under your employment? If yes, please attach explanation on a separate sheet. | ☐ | ☐ |
| 5. | Was this physician granted a leave of absence while employed by you or at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☐ |
| 6. | Did this individual have a record of unexcused absences during his/her attendance at this facility or under your employment? | ☐ | ☐ |
| 7. | Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees/staff holding similar positions? If yes, please attach explanation on a separate sheet. | ☐ | ☐ |
| 8. | Were any restrictions placed on this physician's privileges? If yes, please attach explanation on a separate sheet. | ☐ | ☐ |
| 9. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☐ |
| 10. | Was this physician denied hospital privileges while employed by you? If yes, please attach explanation on a separate sheet. | ☐ | ☐ |

# Wisconsin Department of Regulation & Licensing

| | | YES | NO |
|---|---|---|---|
| 11. | Were any incident reports filed involving the professional conduct or behavior of this physician?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☐ |
| 12. | Was this physician ever subject to non-routine monitoring while at your facility?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☐ |
| 13. | Was this physician involuntarily removed from a call schedule for cause?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☐ |
| 14. | Was this physician subject to non-routine quality assessment review?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☐ |
| 15. | Was this physician the subject of a negative review by a quality assurance or departmental committee?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☐ |

Print name and title of Employer/Official Supplying Information _____

Signature of Employer/Official Supplying Information _____

Date form was completed _____

**SEAL OF HOSPITAL, if applicable**
(If facility/employer does not have a seal, please attach a letter attesting to this fact, on facility stationery.)

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

# Wisconsin Department of Regulation & Licensing

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## HOSPITAL, FACILITY AND EMPLOYER VERIFICATION

### MEDICAL EXAMINING BOARD

***IMPORTANT:*** *PLEASE FORWARD THIS FORM TO ALL HOSPITALS, FACILITIES AND EMPLOYERS WHERE YOU HAVE HAD STAFF PRIVILEGES OR EMPLOYMENT DURING THE LAST 5 YEARS.*
*(This form may be photocopied.)*

The **State of Wisconsin** requests that you complete this form concerning the following individual:

PHYSICIAN'S NAME: Hope Frisch, D.O.

FACILITY/EMPLOYER: Abbott Northwestern Hospital

FACILITY/EMPLOYER ADDRESS: 800 E 28th St

FACILITY/EMPLOYER TELEPHONE: 612 863 5213

1. What position did this physician hold at your facility or under your employment? 9/4/07 - present

2. What were this physician's dates of employment or staff privileges at your facility? OB6ynphysician

| | | YES | NO |
|---|---|---|---|
| 3. | Did this physician leave your employ in good standing? If no, please attach explanation on a separate sheet. | ☑ | ☐ |
| 4. | Was the physician placed on probation, suspended or in any way sanctioned/disciplined while at your facility or under your employment? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 5. | Was this physician granted a leave of absence while employed by you or at your facility? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 6. | Did this individual have a record of unexcused absences during his/her attendance at this facility or under your employment? | ☐ | ☑ |
| 7. | Were any restrictions or special requirements placed on this physician's activities that were not placed on all other employees/staff holding similar positions? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 8. | Were any restrictions placed on this physician's privileges? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 9. | Were any formal patient or staff complaints filed against this physician? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 10. | Was this physician denied hospital privileges while employed by you? If yes, please attach explanation on a separate sheet. | ☐ | ☑ |

# Wisconsin Department of Regulation & Licensing

| | | YES | NO |
|---|---|---|---|
| 11. | Were any incident reports filed involving the professional conduct or behavior of this physician?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 12. | Was this physician ever subject to non-routine monitoring while at your facility?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 13. | Was this physician involuntarily removed from a call schedule for cause?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 14. | Was this physician subject to non-routine quality assessment review?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☑ |
| 15. | Was this physician the subject of a negative review by a quality assurance or departmental committee?<br>If yes, please attach explanation on a separate sheet. | ☐ | ☑ |

Print name and title of Employer/Official Supplying Information: MARK Migliori M.D

Signature of Employer/Official Supplying Information: Mark Migliori M.D.

Date form was completed: 4-30-09

**SEAL OF HOSPITAL, if applicable**
(If facility/employer does not have a seal, please attach a letter attesting to this fact, on facility stationery.)

**Please return directly to:**

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

# MINNESOTA BOARD OF MEDICAL PRACTICE

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

May 09, 2009

Wisconsin Medical Examining Board
Dept of Regulation & Licensing
1400 E Washington Ave, Rm 178
Madison, WI 53703

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

| | |
|---|---|
| **Physician:** | Hope Elizabeth Frisch |
| **Date of birth:** | [redacted] |
| **Was issued license number:** | 49517 |
| **On:** | May 12, 2007 |
| **Expiration date is:** | May 31, 2009 |
| **Status:** | Active |
| **Issued on the basis of:** | USMLE - United States Med Lic Exam |
| **Corrective action:** | None |
| **Disciplinary action:** | None |

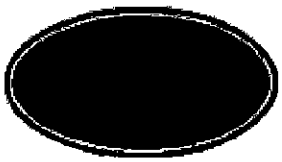
This license information was last updated on: 5/9/2009 4:56:09AM

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

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

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

Rob Leach
Executive Director





## Validation

**This confirms that the licensure verification statement for Hope Frisch, was sent to you from the VeriDoc website.**

**Thank you for using the VeriDoc system.**

[redacted]

[redacted]

**Verification of Licensure Status**

The attached verification report has been sent to you by the VeriDoc.org website. This email can be verified as coming from this site by clicking on the link below.

Validate Verifications

Physician: Frisch, Hope

[redacted]

[redacted]

1 verification should be attached to this email. If any are missing please contact support@veridoc.org