APPLICATION TO PRACTICE MEDICINE

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

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

4912O

BOARD OF MEDICAL PRACTICE

APR 27 2011

DATE OF APPLICATION:

MONTH	DAY	YEAR
4	22	2011

FOR BOARD USE ONLY

APPLICATION #: 9196
CHECK/RECEIPT #: 390-15
AMT PAID: _____
TEMP PERMIT #: _____
BOARD ACTION: _____
BOARD DATE: 9-10-11
LICENSE #: 54557

SOURCE CODE	AMOUNT
5200 lic	192 W
5201 app	200 W
5203 tp	60 W
6215	39.20

INSTRUCTIONS TO APPLICANT

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

TO: The Minnesota Board of Medical Practice:

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

YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME: LAST	FIRST	MIDDLE
Posthuma	Rebecca	Leah

STREET ADDRESS:

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

HOME PHONE:	OTHER PHONE:	OTHER NAMES:

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER:

GENDER ☐ MALE ☑ FEMALE

BASIS FOR APPLICATION (CHECK ONE)

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

ECFMG CERTIFICATION (FOREIGN ONLY)

NUMBER:

DATE ISSUED:

DRIVER'S LICENSE

STATE: MN

NUMBER:

74557

ADDRESS OF NEAREST RELATIVE		
NAME OF RELATIVE: Patricia Hayes		
STREET ADDRESS: N2905 Kelly Road		
CITY: Fond du Lac		STATE OR PROVINCE: WI
ZIP CODE: 54935	COUNTRY: USA	RELATIONSHIP: mother

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

RECORD OF BIRTH			
BIRTHDATE (MO/DAY/YEAR) 11 / 27 / 1979	CITY OF BIRTH: Fond du Lac	COUNTY OF BIRTH: Fond du Lac	STATE/PROVINCE OF BIRTH: WI
FULL NAME OF FATHER: Robert Posthuma		MOTHER'S MADEN NAME: Patricia Fisher	COUNTRY OF BIRTH: USA

IDENTIFYING CHARACTERISTICS			
HEIGHT (ft./in.): 5/8	WEIGHT (lbs): 135	COLOR HAIR: Brown	COLOR EYES: Hazel
IDENTIFYING MARKS:			

PRELIMINARY EDUCATION					
NAME OF HIGH SCHOOL: Lomira High	CITY: Lomira	STATE OR PROVINCE: WI		FROM DATE: (Mo/Day/Year) 8 / 1 / 1994	TO DATE: (Mo/Day/Year) 6 / 1 / 1998
NAME OF COLLEGE: University of Wisconsin	CITY: Madison	STATE OR PROVINCE: WI	DEGREE BS	FROM DATE: (Mo/Day/Year) 8 / 1 / 1998	TO DATE: (Mo/Day/Year) 5 / 1 / 2003
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	DEGREE	FROM DATE: (Mo/Day/Year) / /	TO DATE: (Mo/Day/Year) / /

MEDICAL EDUCATION (MEDICAL COLLEGES MUST BE RECOGNIZED BY THE BOARD)					
INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
St. Louis University	St. Louis	MO	63104	7/17/2003	5/19/2007

ACCOUNTING OF TIME NOT NOTED ELSEWHERE ON THIS APPLICATION		
ACTIVITY (ATTACH SEPARATE SHEET, IF NECESSARY)	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)

MEDICAL DIPLOMAS

BACHELOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE Mo/Day/Year
☐ MEDICINE ☐ OSTEOPATHY						
DOCTOR OF OF:	**NAME OF SCHOOL:**	**CITY:**	**STATE OR PROVINCE**	**ZIP:**	**COUNTRY:**	**DATE Mo/Day/Year**
☑ MEDICINE ☐ OSTEOPATHY	St. Louis University	St. Louis	MO	63014	USA	5/19/17

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

NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
University of Minnesota		6/11/2007	6/3/2011	
STREET ADDRESS:	**CITY:**	**STATE OR PROVINCE:**	**COUNTRY:**	**ZIP CODE:**
515 Delaware St SE, 12-190 Moos Tower	Minneapolis	MN	USA	55455
TYPE OF TRAINING: (BE SPECIFIC)				
ObGyn Residency				

NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	**CITY:**	**STATE OR PROVINCE:**	**COUNTRY:**	**ZIP CODE:**
TYPE OF TRAINING: (BE SPECIFIC)				

NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	**CITY:**	**STATE OR PROVINCE:**	**COUNTRY:**	**ZIP CODE:**
TYPE OF TRAINING: (BE SPECIFIC)				

NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	**CITY:**	**STATE OR PROVINCE:**	**COUNTRY:**	**ZIP CODE:**
TYPE OF TRAINING: (BE SPECIFIC)				

NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	**CITY:**	**STATE OR PROVINCE:**	**COUNTRY:**	**ZIP CODE:**
TYPE OF TRAINING: (BE SPECIFIC)				

MILITARY SERVICE

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

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

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

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

PRACTICE REFERENCES

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

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

PROPOSED PRACTICE PLANS IN MINNESOTA (IF ANY)

Midwest Health Center for Women

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE
American College of Obstetricians and Gynecologists	6/1/2007	present

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

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

Specialty: __________

Issue Date: __________

Expiration Date: __________

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

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 have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable questions(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). 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 us 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. If responses to questions change during the time your application is pending, you must make the board aware of the new information.

Y 1. Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.

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

Y 3. Are you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider). Please describe.

Y 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 4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? If you answer this question 'yes", please answer the following:

Y N 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?

Y N 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?

Y N 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?

4d. Please explain._____

4e. Identify your treating physician._____

Y ✗N 5. Have ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.

Y ✓	6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.
Y ✓	7. Have you ever been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If so, give particulars.
Y ✓	8. Has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by Medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If so, give particulars.
Y ✓	9. Have you ever been notified of any investigations by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board? If so, give particulars.
Y ✓	10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents).
Y ✓	11. Have your hospital privileges been restricted or revoked? If so, give particulars.
Y ✓	12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Y ✓	13. Have there ever been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed.
Y ✓	14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.
Y ✓	15. Have you ever applied for licensure in Minnesota before? If so, please give license # and issue date or withdrawal/denial date.
✓ N	16. Have you ever had a residency permit in Minnesota? If so, please give residency permit number. (Residents are required to have residency permits as of 1993 unless licensed in Minnesota). 20168

AFFIDAVIT OF APPLICANT:

5 4 5 7

STATE OF: MN

COUNTY OF: USA

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

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

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

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

Sworn to before me this 5th day of March, 2011.

Judith A Shurson

Signature of Notary Public

My Commission Expires: 1-31-2015

Signature of Applicant

Judith A. Shurson
NOTARY PUBLIC - MINNESOTA
My Commission Expires 1-31-2015

NOTICE TO SUBJECTS OF DATA

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

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. Rebecca Posthuma

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
	4/15/11	39269	MN ~~39269~~

Jeffrey S. Warshaw
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required

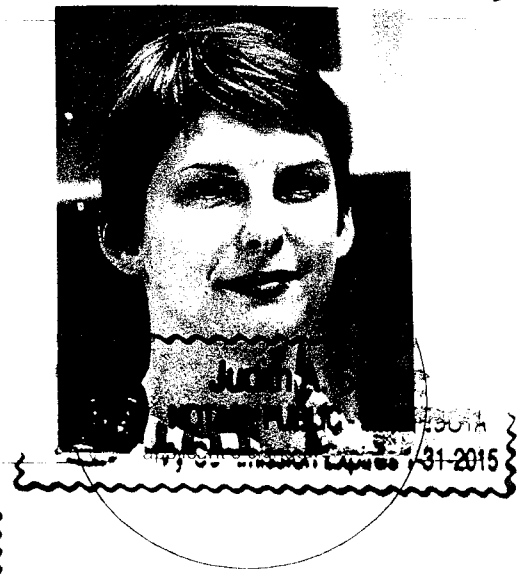
State Minnesota County Dakota

I certify that on the date set forth below the individual named above did appear before me and that I did identify the applicant by (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto and (b) comparing the applicant's signature made in my presence to the same with the signature on his/her identifying document. Sworn to before me by the applicant on the 14th day of April 2011.

Notary Public Signature

My Commission Expires: 1 31 2015
Month Day Year

Judith A. Shurson
NOTARY PUBLIC - MINNESOTA
My Commission Expires 1-31-2015



Applicant Signature

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
	4/15/11	022216	MN

March 1, 2012 MD