47.029

APPLICATION TO PRACTICE MEDICINE

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 400
MINNEAPOLIS, MINNESOTA 55414-3246
612-617-2130 or www.bmp.state.mn.us

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

392 00

RECEIVED BY MN BD OF MED PRACTICE

FOR BOARD USE ONLY

APPLICATION #: 80805
CHECK/RECEIPT #:
AMT PAID:
TEMP PERMIT #:
BOARD ACTION:
BOARD DATE: 9-11-04
LICENSE #: 47029

SOURCE CODE	AMOUNT
5200 lic	192.00
5201 app	200.00
5203 tp	

DATE OF APPLICATION:

MONTH	DAY	YEAR
02	23	04

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, and/or omission or falsification of *material facts may be cause for denial of your application, or disciplinary action if you are subsequently* licensed by the Board.
8. Incomplete applications may be destroyed after six months of inactivity.

207-44
202-44

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 t he following statement concerning my age, moral character, preliminary and medical education and practice.

YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME: LAST	FIRST	MIDDLE
KUTIL	ROBIN	JEAN

STREET ADDRESS:

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

HOME PHONE:	OTHER PHONE:	GENDER	OTHER NAMES:
(		☐ MALE ☒ FEMALE	

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER:

BASIS FOR APPLICATION (CHECK ONE)*

- ☐ FEDERATION LICENSING EXAMINATION (FLEX)
- ☐ NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINATION (NBME)
- ☐ NATIONAL BOARD OF OSTEOPATHIC EXAMINERS EXAMINATION (NBOE)
- ☐ LICENTIATE OF MEDICAL COUNCIL OF CANDADA 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: or

NUMBER:

47029

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

YOUR INTENDED ADDRESS (IF KNOWN)		
STREET ADDRESS:		
CITY:	STATE OR PROVINCE:	
ZIP CODE:	COUNTRY: USA	EFFECTIVE DATE: 01/2004
PHONE:		

RECORD OF BIRTH			
BIRTHDATE (Mo/Day/Year) 1977	CITY OF BIRTH: West Allis	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH: WI
FULL NAME OF FATHER:		MOTHER'S MAIDEN NAME:	COUNTRY OF BIRTH: USA

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

PRELIMINARY EDUCATION					
NAME OF HIGH SCHOOL: Wauwatosa West H.S.	CITY: Wauwatosa	STATE OR PROVINCE: WI		FROM DATE: (Mo/Day/Year) 09/01/92	TO DATE: (Mo/Day/Year) 05/15/95
NAME OF COLLEGE: U of WI-Madison	CITY: Madison	STATE OR PROVINCE: WI	DEGREE BS	FROM DATE: (Mo/Day/Year) 09/01/95	TO DATE: (Mo/Day/Year) 05/15/99
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	DEGREE	FROM DATE: (Mo/Day/Year) / /	TO DATE: (Mo/Day/Year) / /

MEDICAL EDUCATION (MEDICAL COLLEGES MUST BE RECOGNIZED BY THE BOARD)					
INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
University of WI Medical College	MADISON	WI	53703	08/15/99	05/16/03

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)

47029

MEDICAL DIPLOMAS

	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE Mo/Day/Year
BACHELOR OF: ☐ MEDICINE ☐ OSTEOPATHY						
DOCTOR OF OF: ☒ MEDICINE ☐ OSTEOPATHY	U of WI Medical School	MADISON	WI	53703	USA	5/16/03

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

NAME OF HOSPITAL:			FROM DATE (Mo/Day/Year)		TO DATE (Mo/Day/Year)
St. Joseph's Hospital			07/01/03		06/2006
STREET ADDRESS:	CITY: St. Paul		STATE OR PROVINCE: MN	COUNTRY: USA	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC) FAMILY MEDICINE					

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

47029

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 (Mo/Day/Year)	TO DATE (Mo/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 (Mo/Day/Year)	TO DATE (Mo/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 (Mo/Day/Year)	TO DATE (Mo/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 (Mo/Day/Year)	TO DATE (Mo/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 (Mo/Day/Year)	TO DATE (Mo/Day/Year)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:

PROPOSED PRACTICE PLANS IN MINNESOTA (IF ANY)

After residency I may stay in the Twin Cities and work as a Family Doc.

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE
American Academy of Family Physicians	07/01/03 →	continuing
MN Academy of Family Physicians	07/01/03 →	continuing

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
- ☐ 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.

47.029

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. Robin Kutil

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
B. Kumar	3/10/04	45769	MN

Beena Kumar
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

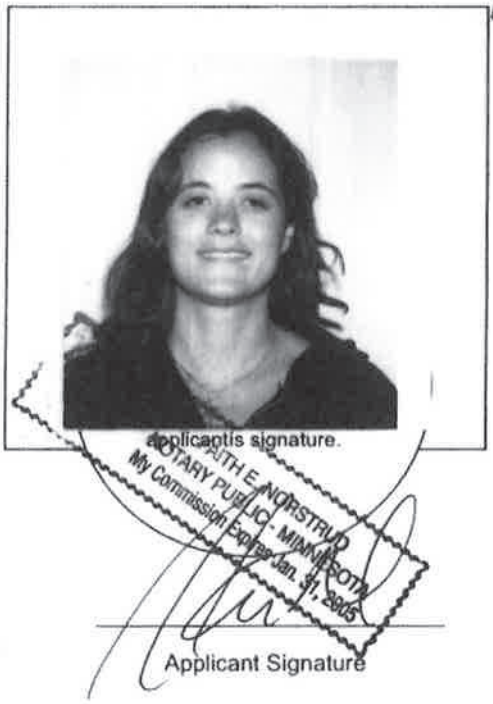
State: MINNESOTA County: RAMSEY

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicantIs signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant on this 10 day of MARCH 2004.

Notary Public Signature Faith E Norstrud

Expiration Date 1/31/05
Month Day Year

FAITH E. NORSTRUD
NOTARY PUBLIC - MINNESOTA
My Commission Expires Jan. 31, 2005



applicantis signature.

FAITH E. NORSTRUD
NOTARY PUBLIC - MINNESOTA
My Commission Expires Jan. 31, 2005

Applicant Signature

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
[signature]	3/10/04	38855	MN

Casey Martin MD
PRINT OR TYPE FULL NAME

47029

AFFIDAVIT OF APPLICANT: Robin JEAN KUTIL

STATE OF: Minnesota

COUNTY OF: RAMSEY

I, Robin Kutil, 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 11th day of March, 2004.

Faith E Norstrud
Signature of Notary Public

My Commission Expires: 1/31/05

Signature of Applicant

FAITH E. NORSTRUD
NOTARY PUBLIC - MINNESOTA
My Commission Expires Jan. 31, 2005

RIGHTS OF SUBJECTS OF DATA

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

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Robin Bresette	Start Date:	6/27/2011 3:13:53 PM
Service Name:	License Renewal - PY	Complete Date:	6/27/2011 3:36:42 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	6/27/2011 3:14:14 PM	
2	Verify Information	6/27/2011 3:15:00 PM	
3	Privileges & Continuing Medical Education	6/27/2011 3:30:03 PM	
4	Practice Questions	6/27/2011 3:31:22 PM	
5	Profiling - Practice Addresses	6/27/2011 3:31:39 PM	
5	Profiling - Post Graduate Training	6/27/2011 3:32:07 PM	
5	Profiling - Post Graduate Training	6/27/2011 3:32:07 PM	
5	Profiling - ABMS/AOA	6/27/2011 3:32:26 PM	
5	Profiling - ABMS/AOA	6/27/2011 3:32:26 PM	
5	Profiling - Criminal Convictions	6/27/2011 3:32:39 PM	
6	Review	6/27/2011 3:33:38 PM	
7	Prescription Monitoring Program Registration	6/27/2011 3:33:50 PM	

1

Verification Page

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

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

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

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

Application for License Renewal

License Number: PY 47029
Name: Robin Jean Kutil Bresette
Alternate Name: Kutil

Drivers License:
Is license current?

Designated Address: 2316 26th Ave S
Minneapolis, MN 55406

Phone: (612) 362-4111 Ext. 490
Email Address: robinbresette@gmail.com
Web Site:

Private Address:

Hospital Staff Privileges

You have no hospital staff privileges

Continuing Education

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

Years	Description
0	Residency Program
0	Fellowship Program

Required Hours: 75
Category 1 Course Hours: 119
Category 1 Equivalent Course Hours: 0
Total Reported Hours: 119

You were not certified by an ABMS, AOABPE, RCPSC, CFPC specialty board during your three-year cycle or are currently participating in MOC, OCC, or the RCPSC equivalent.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Robin Bresette	Start Date:	8/15/2012 11:47:40 AM
Service Name:	License Renewal - PY	Complete Date:	8/15/2012 11:54:27 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	8/15/2012 11:47:49 AM	
2	Verify Information	8/15/2012 11:49:41 AM	
3	Privileges & Continuing Medical Education	8/15/2012 11:49:53 AM	
4	Practice Questions	8/15/2012 11:50:47 AM	
5	Profiling - Practice Addresses	8/15/2012 11:51:03 AM	
5	Profiling - Post Graduate Training	8/15/2012 11:51:12 AM	
5	Profiling - ABMS/AOA	8/15/2012 11:51:28 AM	
5	Profiling - ABMS/AOA	8/15/2012 11:51:28 AM	
5	Profiling - Criminal Convictions	8/15/2012 11:51:40 AM	
6	Review	8/15/2012 11:52:13 AM	
7	Prescription Monitoring Program Registration	8/15/2012 11:52:41 AM	

1

Verification Page

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

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

Application for License Renewal

License Number: PY 47029
Name: Robin Jean Kutil Bresette
Alternate Name: Kutil

Drivers License:
Is license current?

Designated Address: 2316 26th Ave S
Minneapolis, MN 55406

Phone: (612) 362-4111 Ext. 490
Email Address: robinbresette@gmail.com
Web Site:

Private Address:

Hospital Staff Privileges

You have no hospital staff privileges

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 08/31/2014.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Robin Bresette	Start Date:	8/13/2013 1:03:13 PM
Service Name:	License Renewal - PY	Complete Date:	8/13/2013 1:12:36 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	8/13/2013 1:03:21 PM	
2	Verify Information	8/13/2013 1:06:00 PM	
3	Privileges & Continuing Medical Education	8/13/2013 1:06:14 PM	
4	Practice Questions	8/13/2013 1:06:53 PM	
5	Profiling - Practice Addresses	8/13/2013 1:07:10 PM	
5	Profiling - Post Graduate Training	8/13/2013 1:07:30 PM	
5	Profiling - Post Graduate Training	8/13/2013 1:07:30 PM	
5	Profiling - ABMS/AOA	8/13/2013 1:07:50 PM	
5	Profiling - ABMS/AOA	8/13/2013 1:07:50 PM	
5	Profiling - Criminal Convictions	8/13/2013 1:08:02 PM	
6	Review	8/13/2013 1:09:36 PM	
7	Prescription Monitoring Program Registration	8/13/2013 1:09:57 PM	

1

Verification Page

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

Application for License Renewal

License Number: PY 47029
Name: Robin Jean Kutil Bresette
Alternate Name: Kutil

Drivers License:
Is license current?

Designated Address: Sheridan Clinic
342 13th Ave NE
Minneapolis, MN 55413

Phone: (612) 362-4111 Ext. 490
Email Address: robinbresette@gmail.com
Web Site:

Private Address:

Hospital Staff Privileges

You have no hospital staff privileges

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 08/31/2014.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Robin Bresette	Start Date:	8/5/2014 9:01:34 AM
Service Name:	License Renewal - PY	Complete Date:	8/5/2014 9:38:59 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	8/5/2014 9:01:55 AM	
2	Verify Information	8/5/2014 9:02:41 AM	
3	Privileges & Continuing Medical Education	8/5/2014 9:10:49 AM	
4	Practice Questions	8/5/2014 9:11:28 AM	
5	Profiling - Practice Addresses	8/5/2014 9:11:40 AM	
5	Profiling - Post Graduate Training	8/5/2014 9:11:51 AM	
5	Profiling - Post Graduate Training	8/5/2014 9:11:51 AM	
5	Profiling - ABMS/AOA	8/5/2014 9:12:02 AM	
5	Profiling - ABMS/AOA	8/5/2014 9:12:02 AM	
5	Profiling - Criminal Convictions	8/5/2014 9:12:10 AM	
6	Review	8/5/2014 9:12:49 AM	
8	Questionnaire	8/5/2014 9:16:22 AM	

1

Verification Page

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

Application for License Renewal

License Number: PY 47029
Name: Robin Jean Kutil Bresette
Alternate Name: Kutil

Drivers License:
Is license current?

Designated Address: Sheridan Clinic
342 13th Ave NE
Minneapolis, MN 55413

Phone: (612) 362-4111 Ext. 490
Email Address: robinbresette@gmail.com
Web Site:

Private Address:

Hospital Staff Privileges

You have no hospital staff privileges

Continuing Education

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

Years	Description
0	Residency Program
0	Fellowship Program

Required Hours: 75
Category 1 Course Hours: 84
Category 1 Equivalent Course Hours: 0
Total Reported Hours: 84

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

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Robin Bresette	Start Date:	8/24/2015 4:34:45 PM
Service Name:	License Renewal - PY	Complete Date:	8/24/2015 4:40:28 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	8/24/2015 4:35:12 PM	
2	Verify Information	8/24/2015 4:35:36 PM	
3	Privileges & Continuing Medical Education	8/24/2015 4:36:28 PM	
4	Practice Questions	8/24/2015 4:37:27 PM	
5	Profiling - Practice Addresses	8/24/2015 4:37:52 PM	
5	Profiling - Post Graduate Training	8/24/2015 4:38:00 PM	
5	Profiling - Post Graduate Training	8/24/2015 4:38:00 PM	
5	Profiling - ABMS/AOA	8/24/2015 4:38:19 PM	
5	Profiling - ABMS/AOA	8/24/2015 4:38:19 PM	
5	Profiling - Criminal Convictions	8/24/2015 4:38:30 PM	
6	Review	8/24/2015 4:39:01 PM	
7	Prescription Monitoring Program Registration	8/24/2015 4:39:07 PM	
8	Questionnaire	8/24/2015 4:39:14 PM	

1

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

Application for License Renewal

License Number: PY 47029
Name: Robin Jean Kutil Bresette
Alternate Name: Kutil

Drivers License:
Is license current?

Designated Address:
Sheridan Clinic
342 13th Ave NE
Minneapolis, MN 55413

Phone: (612) 362-4111 Ext. 490
Email Address: robinbresette@gmail.com
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Sanford	Fargo	ND	

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 08/31/2017.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Robin Bresette	Start Date:	8/30/2016 9:07:49 AM
Service Name:	License Renewal - PY	Complete Date:	8/30/2016 9:21:52 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	8/30/2016 9:07:56 AM	
2	Verify Information	8/30/2016 9:08:16 AM	
3	Privileges & Continuing Medical Education	8/30/2016 9:08:37 AM	
4	Practice Questions	8/30/2016 9:10:01 AM	
5	Profiling - Practice Addresses	8/30/2016 9:10:23 AM	PracticeAddress
5	Profiling - Post Graduate Training	8/30/2016 9:10:28 AM	Bypass Case
5	Profiling - Post Graduate Training	8/30/2016 9:10:28 AM	
5	Profiling - ABMS/AOA	8/30/2016 9:10:40 AM	
5	Profiling - ABMS/AOA	8/30/2016 9:10:40 AM	
5	Profiling - Criminal Convictions	8/30/2016 9:10:48 AM	
6	Review	8/30/2016 9:11:22 AM	
7	Prescription Monitoring Program Registration	8/30/2016 9:11:28 AM	
9	Payment	8/30/2016 9:20:28 AM	

1

Verification Page

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

Application for License Renewal

License Number: PY 47029
Name: Robin Jean Kutil Bresette
Alternate Name: Kutil

Drivers License:
Is license current?

Designated Address: Sheridan Clinic
342 13th Ave NE
Minneapolis, MN 55413

Phone: (612) 362-4111 Ext. 490
Email Address: robinbresette@gmail.com
Web Site:

Private Address:

Phone:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Sanford	Fargo	ND	

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 08/31/2017.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Robin Bresette	Start Date:	8/17/2017 12:31:30 PM
Service Name:	License Renewal - PY	Complete Date:	8/17/2017 12:42:02 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	8/17/2017 12:31:37 PM	
2	Verify Information	8/17/2017 12:32:20 PM	
3	Privileges & Continuing Medical Education	8/17/2017 12:34:55 PM	
4	Practice Questions	8/17/2017 12:35:55 PM	
5	Profiling - Practice Addresses	8/17/2017 12:36:14 PM	PracticeAddress
5	Profiling - Post Graduate Training	8/17/2017 12:36:23 PM	Bypass Case
5	Profiling - Post Graduate Training	8/17/2017 12:36:23 PM	
5	Profiling - ABMS/AOA	8/17/2017 12:36:42 PM	
5	Profiling - ABMS/AOA	8/17/2017 12:36:42 PM	
5	Profiling - Criminal Convictions	8/17/2017 12:36:48 PM	
6	Review	8/17/2017 12:37:59 PM	
7	Prescription Monitoring Program Registration	8/17/2017 12:38:06 PM	
9	Payment	8/17/2017 12:41:25 PM	

1

Verification Page

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

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

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

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

Application for License Renewal

License Number: PY 47029
Name: Robin Jean Kutil Bresette
Alternate Name: Kutil

Drivers License:
Is license current?

Designated Address: Sheridan Clinic
342 13th Ave NE
Minneapolis, MN 55413

Phone: (612) 362-4111 Ext. 490
Email Address: robinbresette@gmail.com
Web Site:

Private Address:

Phone:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Sanford	Fargo	ND	

Continuing Education

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

Years	Description
0	Residency Program
0	Fellowship Program

Required Hours: 75
Category 1 Course Hours: 150
Category 1 Equivalent Course Hours: 0
Total Reported Hours: 150

You were not certified by an ABMS, AOABPE, RCPSC, CFPC specialty board during your three-year cycle or are currently participating in MOC, OCC, or the RCPSC equivalent.

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Minnesota.gov

Friday, March 02, 2018

Professional Profile

Profile Details

Warning! It is a federal crime to knowingly transfer or use a means of identification of another person by using the information displayed in this web page and contents in any attached link and/or documents, with the intent to commit, or to aid or abet, any unlawful activity that constitutes a violation of Federal law (Identity Theft and Assumption Deterrence Act of 1998, 18 USC 1028 (a)(7) with Maximum Penalty 25 years' imprisonment/$250,000 fine) and any applicable state or local law, such as Minn. Stat. 609.527 Identity Theft.

Professional Profile: Robin Jean Kutil Bresette

New Search

License: Physician and Surgeon - #47029

Print

Licensee Public Information

Licensure Designated Address: Sheridan Clinic
342 13th Ave NE
Minneapolis, MN 55413

Web Site:

E-mail: robinbresette@gmail.com

Birth Year: 1977

Gender: Female

License Information

License Number:	47029	**License Type:**	Physician and Surgeon
Expiration Date:	08-31-2018	**Grant Date:**	09-11-2004
License Status:	Active		
Disciplinary Action:	No		
Corrective Action:	No		

Disciplinary Actions by Other States (Reported to the Board since July 1, 2013): No

Education

Medical School:	UNIVERSITY OF WISCONSIN, MEDICAL SCHOOL, MADISON USA	**Degree:**	M.D.
Location:	Madison, WI USA	**Date:**	05/16/2003

Practice Locations (Self-Reported Information)

Primary Location: Sheridan Clinic
342 13th Ave NE
Minneapolis, MN 55413
Phone: 612-362-4111 ext: 490

Secondary Location: N/A
Phone: Unknown

Post-Graduate Training (Self-Reported Information. Not Verified by Board of Medical Practice)

Program	Specialty	Start Date	End Date	Completed
University of Minnesota--St. Joseph's Residency Program	Family Medicine	07/01/2003	06/30/2006	Y

Area of Specialty (Certified by American Board of Medical Specialties or American Osteopathic Specialty Boards: Refer to the Note at the End of this Page)

Source	Board	Certification / Sub-Certification

Criminal Convictions (Self-Reported Information)

Type	Crime Description	Conviction Date	Court of Jurisdiction	Sentence/Comment

Print

Direct questions and comments about these results to Minnesota Board of Medical Practice.
Telephone: (612) 617-2130 e-mail: medical.board@state.mn.us

Print

Profile Retrieved on 3/2/2018 11:21:51 AM

Disclaimer

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Primary Source Verification

The license information in this web page has been designed and implemented to meet primary source verification requirements of the Joint Commission accredited hospitals and the

National Committee for Quality Assurance (NCQA) certified managed care organizations, and it can be used as the primary source verification.

Note on 'Area of Specialty'

Specialty board certification information was obtained directly from American Board of Medical Specialties (ABMS), www.abms.org, or American Board of Osteopathic Medical Specialties (AOA), www.aoa-net.org, as a written direct verification, quarterly update, or from the official ABMS or AOA primary source verification website. Minnesota's Physician Profile contains specialty certifications only from ABMS and AOA, because they are universally recognized and easily verifiable. Other organizations certify and endorse specialization with their own standards and procedures. You may wish to ask your physician about such certifications if he or she does not list one of the specialties from the ABMS or AOA.

Maintenance of Certification (MOC)

MOC is an ABMS program of lifelong learning and requires physicians to self-assess their competency. Further information can be cound at www.abms.org. The American Osteopathic Association also has a continuous lifelong process "Osteopathic Continuous Certification" or OCC. Further information is available at www.osteopathic.org.

Criminal Conviction

Minnesota Statute 214.072 (a)(1) requires the Board to post licensee's "conviction of a felony or gross misdemeanor occurring on or after July 1, 2013, in any state or jurisdiction."