

APPLICATION TO PRACTICE MEDICINE



MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA

2829 UNIVERSITY AVENUE SE, SUITE 400
MINNEAPOLIS, MINNESOTA 55414-3246

(612) 617-2130

Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353

Outside Metro Area 1-800-627-3529

FOR BOARD USE

APPLICATION #: 73129

CHECK /RECEIPT #:

AMT PAID:

TEMP PERMIT #:

BOARD ACTION:

BOARD DATE: 11-11-2000

LICENSE #: 43137

DATE OF APPLICATION:

DAY	MONTH	YEAR
21	08	00

RECEIVED
AUG 25 2000

MINNESOTA BOARD OF
MEDICAL PRACTICE

INSTRUCTIONS TO APPLICANT

1. Answer all questions completely and accurately or the application will be returned.
2. The name you enter must exactly match the name on your medical diploma, or documentation of formal name change must be submitted.
3. All addresses must include zip code, if requested on the application.
4. Account for all time from the beginning of high school, whether spent in school, practice, or otherwise. Dates must include Day, Month, and Year. Attach a separate sheet if necessary.
5. Enter all dates as DAY-MONTH-YEAR. For example, January 1, 1989 should be entered as 01-JAN-89.
6. The application fee is not refundable.
7. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
8. Incomplete applications will be destroyed after six months of inactivity.

067-4
067-9
067-13

SOURCE CODE	AMOUNT
5200	192.00
5201	200.00
5203	60.00

TO: The Minnesota Board of Medical Practice:

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

YOUR CURRENT NAME AND ADDRESS			
FULL LEGAL NAME:	LAST	FIRST	MIDDLE
	Eggleston	Kathryn	Louise
STREET ADDRESS:			
1			
CITY:	STATE OR PROVINCE:		COUNTRY:
			USA
HOME PHONE:	OTHER PHONE:	GENDER	MAIDEN NAME:
		<input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE	
SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER:			

BASIS FOR APPLICATION (CHECK ONE)
<input type="checkbox"/> FEDERATION LICENSING EXAMINATION (FLEX)
<input type="checkbox"/> NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINATION (NBME)
<input type="checkbox"/> NATIONAL BOARD OF OSTEOPATHIC EXAMINERS EXAMINATION (NBOE)
<input type="checkbox"/> LICENTIATE OF MEDICAL COUNCIL OF CANADA EXAMINATION (LMCC)
<input type="checkbox"/> STATE BOARD EXAMINATION (STATE)
<input checked="" type="checkbox"/> UNITED STATES MEDICAL LICENSING EXAM (USMLE)
<input type="checkbox"/> COMBINATION FLEX, NBME, USMLE

ECFMG CERTIFICATION (FOREIGN ONLY)
NUMBER:
DATE ISSUED:

DRIVERS LICENSE
STATE:
NUMBER:

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

YOUR INTENDED ADDRESS		
STREET ADDRESS:		
CITY:	STATE OR PROVINCE:	
ZIP CODE:	COUNTRY:	EFFECTIVE DATE:
	USA	11/1/00
PHONE:		

RECORD OF BIRTH			
BIRTHDATE (DD-MMM-YY)	CITY OF BIRTH:	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH:
69	St. Louis Park	Hennepin	MN
FULL NAME OF FATHER:		MOTHER'S MAIDEN NAME:	COUNTRY OF BIRTH:
			USA

IDENTIFYING CHARACTERISTICS			
HEIGHT (inches):	WEIGHT (lbs):	COLOR HAIR:	COLOR EYES:
IDENTIFYING MARKS:			

PRELIMINARY EDUCATION					
NAME OF HIGH SCHOOL:	CITY:	STATE OR PROVINCE:		FROM DATE:	TO DATE:
Bloomington Jefferson	Bloomington	MN		8/1984	6/1987
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	DEGREE	FROM DATE:	TO DATE:
Colorado State University	Fort Collins	CO	BS	01 August 87	20 December 91
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	DEGREE:	FROM DATE:	TO DATE:
				(DD-MMM-YY)	(DD-MMM-YY)

MEDICAL EDUCATION (MEDICAL COLLEGES MUST BE RECOGNIZED BY THE BOARD)					
INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE (DD-MMM-YY)	TO DATE (DD-MMM-YY)
Medical College of Wisconsin	Milwaukee	WI	53226	01 July 92	01 July 96

ACCOUNTING OF TIME NOT NOTED ELSEWHERE ON THIS APPLICATION		
ACTIVITY (ATTACH SEPARATE SHEET, IF NECESSARY)	FROM DATE (DD-MMM-YY)	TO DATE (DD-MMM-YY)
Worked as a nurse's aide in Fort Collins, CO.	20 December 91	01 July 92
Worked at local mall / summer vacation.	01 June 87	01 August 87

43137

MEDICAL DIPLOMAS						
BACHELOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE:	ZIP:	COUNTRY:	DATE DD-MMM-YY
<input checked="" type="checkbox"/> MEDICINE <input type="checkbox"/> OSTEOPATHY	Medical College of Wisconsin	Milwaukee	WI	53226	USA	01 July 96
DOCTOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE:	ZIP:	COUNTRY:	DATE DD-MMM-YY
<input type="checkbox"/> MEDICINE <input type="checkbox"/> OSTEOPATHY						

ACCREDITED GRADUATE CLINICAL MEDICAL TRAINING				
NAME OF HOSPITAL:	FROM DATE (DD-MMM-YY)		TO DATE (DD-MMM-YY)	
Eau Claire Family Medicine	01 July 1996		01 July 1999	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
807 S. Farwell	Eau Claire	WI	USA	54701
TYPE OF TRAINING: (BE SPECIFIC)				
Community based family medicine				
NAME OF HOSPITAL:	FROM DATE (DD-MMM-YY)		TO DATE (DD-MMM-YY)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:	FROM DATE (DD-MMM-YY)		TO DATE (DD-MMM-YY)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				

POST GRADUATE NON-CLINICAL MEDICAL EDUCATION/TRAINING				
FACILITY NAME:	FROM DATE (DD-MMM-YY)		TO DATE (DD-MMM-YY)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
FACILITY NAME:	FROM DATE (DD-MMM-YY)		TO DATE (DD-MMM-YY)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:

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

STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE BEEN LICENSED			
STATE/PROVINCE/COUNTRY	LICENSE NUMBER	DATE ISSUED (DD-MMM-YY)	HOW OBTAINED (*)
Wisconsin	39038	25 July 1997	USMLE

(*) NATIONAL BOARD OF MEDICAL EXAMINERS (NBME)
 STATE BOARD EXAM (STATE)
 NATIONAL BOARD OF OSTEOPATHIC EXAMINERS (NBOE)
 LICENTATE OF MEDICAL COUNCIL OF CANADA (LMCC)

FLEX EXAMINATION (FLEX)
 UNITED STATES MEDICAL LICENSING EXAM (USMLE)
 COMBINATION FLEX, NBME, USMLE

PRACTICE REFERENCES

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

NAME OF FACILITY: Marshfield Clinic		FROM DATE: (DD-MMM-YY) 01-July 99	TO DATE: (DD-MMM-YY) Current
NAME OF REFERENCE: Jeff Shepich	STREET ADDRESS: 3501 Golf Rd	CITY: Eau Claire	STATE/CNTR WI
NAME OF REFERENCE: Greg Melby	STREET ADDRESS: 3501 Golf Rd	CITY: Eau Claire	STATE/CNTRY WI
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTR
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTR
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY
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NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTR
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY

PROPOSED PRACTICE PLANS IN MINNESOTA (IF ANY)

Robbinsdale Clinic, P.A. - family practice, full time

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE
American Academy of Family Physicians	1996	current
American Medical Women's Association	1998	current

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

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

Specialty: **Family Medicine**
Expiration Date: **2006**

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

43137

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. Eggleston

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

W E Cayley, Jr

SIGNATURE

8/22/2000

DATE

39025

LICENSE NUMBER

WI

STATE OF ISSUE

William Edward Cayley, Jr MD

PRINT OR TYPE FULL NAME

Needed to
move picture to
reach stamp.

PASTE RECENT PHOTO HERE

NOTE: PHOTO MUST BE NOTARIZED

THAT IT IS A TRUE I



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

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

Jean Hamblin

SIGNATURE

8/22/00

DATE

39351

LICENSE NUMBER

WI

STATE OF ISSUE

Jean Hamblin MD

PRINT OR TYPE FULL NAME

AFFIDAVIT OF APPLICANT:

STATE OF: Wisconsin

COUNTY OF: Sau Claire

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

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

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

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

Sworn to before me this 22 day of August, 19-2000

Susan K Jackson

Signature of Notary Public

Kathryn L Eggleston

Signature Of Applicant

My Commission Expires: 7/28/02

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: Kathryn Eggleston Start Date: 6/16/2011 8:22:08 PM
Service Name: License Renewal - PY Complete Date: 6/16/2011 8:27:30 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	6/16/2011 8:22:20 PM	
2	Verify Information	6/16/2011 8:22:51 PM	
3	Privileges & Continuing Medical Education	6/16/2011 8:23:07 PM	
4	Practice Questions	6/16/2011 8:23:58 PM	
5	Profiling - Practice Addresses	6/16/2011 8:24:10 PM	
5	Profiling - Post Graduate Training	6/16/2011 8:24:16 PM	
5	Profiling - Post Graduate Training	6/16/2011 8:24:16 PM	
5	Profiling - ABMS/AOA	6/16/2011 8:24:30 PM	
5	Profiling - ABMS/AOA	6/16/2011 8:24:30 PM	
5	Profiling - Criminal Convictions	6/16/2011 8:24:38 PM	
6	Review	6/16/2011 8:25:10 PM	
7	Prescription Monitoring Program Registration	6/16/2011 8:25:19 PM	

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 43137
Name: Kathryn Louise Eggleston

Drivers License:
Is license current?

Designated Address: Midwest Health Center for Women
33 South Fifth Street
4th Floor
Minneapolis, MN 55402

Phone: (612) 332-2311
Email Address:
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Abbott Northwestern Hospital	Minneapolis	MN	Courtesy

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 07/31/2013.

**User Admin** Search and maintain all registered users**Online Service History Detail**

(Use Back button to return to summary page)

User Name: Kathryn Eggleston Start Date: 6/11/2012 8:54:15 AM
Service License Renewal - Complete 6/11/2012 9:08:28 AM
Name: PY Date: AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	6/11/2012 8:54:46 AM	
2	Verify Information	6/11/2012 8:58:55 AM	
3	Privileges & Continuing Medical Education	6/11/2012 8:59:16 AM	
4	Practice Questions	6/11/2012 9:01:22 AM	
5	Profiling - Practice Addresses	6/11/2012 9:04:05 AM	
5	Profiling - Post Graduate Training	6/11/2012 9:04:17 AM	
5	Profiling - Post Graduate Training	6/11/2012 9:04:17 AM	
5	Profiling - ABMS/AOA	6/11/2012 9:04:45 AM	
5	Profiling - ABMS/AOA	6/11/2012 9:04:45 AM	
5	Profiling - Criminal Convictions	6/11/2012 9:04:52 AM	
6	Review	6/11/2012 9:06:13 AM	
7	Prescription Monitoring Program Registration	6/11/2012 9:06:24 AM	

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

Application for License Renewal

License Number: PY 43137
Name: Kathryn Louise Eggleston

Drivers Licen
Is license current?

Designated Address: PPMNS
671 Vandalia Street
St. Paul, MN 55114

Phone: (651) 698-2406
Email Address:
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Abbott Northwestern Hospital	Minneapolis	MN	Courtesy

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 07/31/2013.

**User Admin** Search and maintain all registered users**Online Service History Detail**

(Use Back button to return to summary page)

User Name: Kathryn Eggleston Start Date: 6/10/2013 5:16:34 PM
 Service Name: License Renewal - PY Complete Date: 6/10/2013 6:43:05 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	6/10/2013 5:16:39 PM	<ul style="list-style-type: none"> Specify credit card type for payment
1	Information	6/10/2013 5:16:51 PM	
2	Verify Information	6/10/2013 5:17:20 PM	
3	Privileges & Continuing Medical Education	6/10/2013 5:36:49 PM	
4	Practice Questions	6/10/2013 5:37:34 PM	
5	Profiling - Practice Addresses	6/10/2013 5:38:37 PM	
5	Profiling - Post Graduate Training	6/10/2013 5:38:44 PM	
5	Profiling - Post Graduate Training	6/10/2013 5:38:44 PM	
5	Profiling - ABMS/AOA	6/10/2013 5:39:06 PM	
5	Profiling - ABMS/AOA	6/10/2013 5:39:06 PM	
5	Profiling - Criminal Convictions	6/10/2013 5:39:15 PM	
6	Review	6/10/2013 5:39:52 PM	
7	Prescription Monitoring Program Registration	6/10/2013 5:40:08 PM	

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Verification Page

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

Application for License Renewal

License Number: PY 43137
 Name: Kathryn Louise Eggleston

Drivers License:
 Is license current?

Designated Address: PPMNS
 671 Vandalia Street
 St. Paul, MN 55114
 Phone: (651) 698-2406
 Email Address:
 Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Abbott Northwestern Hospital	Minneapolis	MN	Courtesy

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: 178

Category 1 Equivalent Course Hours: 0

Total Reported Hours: 178

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: Kathryn Eggleston Start Date: 6/9/2014 1:38:49 PM
Service Name: License Renewal - PY Complete Date: 6/9/2014 1:53:23 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	6/9/2014 1:39:00 PM	
2	Verify Information	6/9/2014 1:39:35 PM	
3	Privileges & Continuing Medical Education	6/9/2014 1:39:50 PM	
4	Practice Questions	6/9/2014 1:41:07 PM	
5	Profiling - Practice Addresses	6/9/2014 1:41:26 PM	
5	Profiling - Post Graduate Training	6/9/2014 1:41:32 PM	
5	Profiling - Post Graduate Training	6/9/2014 1:41:32 PM	
5	Profiling - ABMS/AOA	6/9/2014 1:41:47 PM	
5	Profiling - ABMS/AOA	6/9/2014 1:41:47 PM	
5	Profiling - Criminal Convictions	6/9/2014 1:42:01 PM	
6	Review	6/9/2014 1:42:20 PM	
7	Prescription Monitoring Program Registration	6/9/2014 1:42:28 PM	

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Verification Page

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

Application for License Renewal

License Number: PY 43137
Name: Kathryn Louise Eggleston

Drivers License:
Is license current?

Designated Address: PPMNS
671 Vandalia Street
St. Paul, MN 55114

Phone: (651) 698-2406
Email Address:
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Abbott Northwestern Hospital	Minneapolis	MN	Courtesy

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 07/31/2016.

**User Admin** Search and maintain all registered users**Online Service History Detail**

(Use Back button to return to summary page)

User Name: Kathryn Eggleston Start Date: 6/15/2015 11:55:20 AM
Service License Renewal - Complete 6/15/2015 12:26:03 PM
Name: PY Date: PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	6/15/2015 11:55:33 AM	
2	Verify Information	6/15/2015 11:56:10 AM	
3	Privileges & Continuing Medical Education	6/15/2015 11:57:14 AM	
4	Practice Questions	6/15/2015 11:58:16 AM	
5	Profiling - Practice Addresses	6/15/2015 11:58:28 AM	• Military Status question
5	Profiling - Practice Addresses	6/15/2015 11:58:44 AM	
5	Profiling - Post Graduate Training	6/15/2015 11:58:53 AM	
5	Profiling - Post Graduate Training	6/15/2015 11:58:53 AM	
5	Profiling - ABMS/AOA	6/15/2015 11:59:06 AM	
5	Profiling - ABMS/AOA	6/15/2015 11:59:06 AM	
5	Profiling - Criminal Convictions	6/15/2015 11:59:18 AM	
6	Review	6/15/2015 12:00:04 PM	
8	Questionnaire	6/15/2015 12:02:41 PM	

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Application for License Renewal

License Number: PY 43137
Name: Kathryn Louise Eggleston

Drivers License:
Is license current?

Designated Address: PPMNS
671 Vandalia Street
St. Paul, MN 55114

Phone: (651) 698-2406
Email Address:
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Regions Hospital	St. Paul	MN	

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 07/31/2016.

**User Admin** Search and maintain all registered users**Online Service History Detail**

(Use Back button to return to summary page)

User Name: Kathryn Eggleston Start Date: 5/27/2016 11:08:19 AM
Service Name: License Renewal - PY Complete Date: 5/27/2016 11:26:13 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	5/27/2016 11:08:25 AM	
2	Verify Information	5/27/2016 11:08:49 AM	
3	Privileges & Continuing Medical Education	5/27/2016 11:14:38 AM	
4	Practice Questions	5/27/2016 11:15:25 AM	
5	Profiling - Practice Addresses	5/27/2016 11:15:37 AM	PracticeAddress • Military Status question
5	Profiling - Practice Addresses	5/27/2016 11:15:50 AM	PracticeAddress
5	Profiling - Post Graduate Training	5/27/2016 11:15:56 AM	Bypass Case
5	Profiling - Post Graduate Training	5/27/2016 11:15:56 AM	
5	Profiling - ABMS/AOA	5/27/2016 11:16:25 AM	
5	Profiling - ABMS/AOA	5/27/2016 11:16:25 AM	
5	Profiling - Criminal Convictions	5/27/2016 11:16:31 AM	
6	Review	5/27/2016 11:17:22 AM	
7	Prescription Monitoring Program Registration	5/27/2016 11:18:45 AM	
7	Prescription Monitoring Program Registration	5/27/2016 11:18:45 AM	PMP Submission Failed: 5/27/2016 11:18:45 AM (Exception Encountered: The remote server returned an error: (401) Unauthorized.)
7	Prescription Monitoring Program Registration	5/27/2016 11:18:50 AM	
9	Payment	5/27/2016 11:23:50 AM	

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Application for License Renewal

License Number: PY 43137
Name: Kathryn Louise Eggleston

Drivers License:
Is license current?

Designated Address: PPMNS
671 Vandalia Street
St. Paul, MN 55114

Phone: (651) 698-2406
Email Address:
Web Site:

Private Address:**Hospital Staff Privileges**

Facility	City	State	Type of Privilege
Regions Hospital	St. Paul	MN	

Continuing Education

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

Years	Description
0	Residency Program

Required Hours: 75

Category 1 Course Hours: 148

Category 1 Equivalent Course Hours: 0

Total Reported Hours: 148

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: Kathryn Eggleston Start Date: 6/10/2017 12:53:38 PM
Service Name: License Renewal - PY Complete Date: 6/10/2017 1:06:32 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	6/10/2017 12:53:44 PM	
2	Verify Information	6/10/2017 12:54:09 PM	
3	Privileges & Continuing Medical Education	6/10/2017 12:54:16 PM	
4	Practice Questions	6/10/2017 12:54:57 PM	
5	Profiling - Practice Addresses	6/10/2017 12:55:14 PM	PracticeAddress
5	Profiling - Post Graduate Training	6/10/2017 12:55:23 PM	Bypass Case
5	Profiling - Post Graduate Training	6/10/2017 12:55:23 PM	
5	Profiling - ABMS/AOA	6/10/2017 12:55:32 PM	
5	Profiling - ABMS/AOA	6/10/2017 12:55:32 PM	
5	Profiling - Criminal Convictions	6/10/2017 12:55:58 PM	
6	Review	6/10/2017 12:56:49 PM	
7	Prescription Monitoring Program Registration	6/10/2017 12:58:25 PM	
7	Prescription Monitoring Program Registration	6/10/2017 12:58:25 PM	PMP Submitted Successfully: 6/10/2017 12:58:25 PM
7	Prescription Monitoring Program Registration	6/10/2017 12:58:32 PM	
9	Payment	6/10/2017 1:02:44 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 43137
Name: Kathryn Louise Eggleston

Drivers License:
Is license current?

Designated Address: PPMNS
671 Vandalia Street
St. Paul, MN 55114

Phone: (651) 698-2406
Email Address:
Web Site:

Private Address:**Hospital Staff Privileges**

Facility	City	State	Type of Privilege
Regions Hospital	St. Paul	MN	

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 07/31/2019.



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: Kathryn Louise Eggleston

[New Search](#)

License: Physician and Surgeon - #43137

[Print](#)

Licensee Public Information				
Licensure Designated Address: PPMNS 671 Vandalia Street St. Paul, MN 55114				
Web Site:		Birth Year: 1969		
E-mail:		Gender: Female		
License Information				
License Number:	43137	License Type:	Physician and Surgeon	
Expiration Date:	07-31-2018	Grant Date:	11-11-2000	
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:	MEDICAL COLLEGE OF WISCONSIN, MILWAUKEE (FORMERLY PART OF MARQUETTE UNIVERSITY) USA		Degree:	M.D.
Location:	Milwaukee, WI USA		Date:	05/18/1996
Practice Locations (Self-Reported Information)				
Primary Location: Planned Parenthood MN, ND, SD 671 Vandalia Street St. Paul, MN 55114			Secondary Location: N/A	
Phone:	651-698-2406		Phone:	Unknown
Post-Graduate Training (Self-Reported Information, Not Verified by Board of Medical Practice)				
Program	Specialty	Start Date	End Date	Completed
Medical College of Wisconsin	Doctor of Medicine	07/00/1992	05/00/1996	Y
Eau Claire Family Medicine Residency	Family Medicine	07/01/1996	07/01/1999	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

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

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Profile Retrieved on 3/9/2018 9:56:28 AM

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Primary Source Verification