43540

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

392

DATE OF APPLICATION:

MONTH	DAY	YEAR
02	13	01

FOR BOARD USE ONLY

FOR BOARD USE ONLY

APPLICATION #:	23826
CHECK /RECEIPT #:	
AMT PAID:	
TEMP PERMIT #:	
BOARD ACTION:	
BOARD DATE:	5-12-01
LICENSE #:	43,540

	SOURCE CODE	AMOUNT
251-5	5200	192.00
251-12	5201	200.00

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 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.

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
Mark	Kimberly	Ann

STREET ADDRESS:			
CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY: USA
HOME PHONE:	OTHER PHONE:	GENDER: ☐ MALE ☒ FEMALE	MAIDEN NAME: —
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 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:

DRIVERS LICENSE

STATE:

NUMBER:

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ADDRESS OF NEAREST RELATIVE

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

YOUR INTENDED ADDRESS (IF KNOWN)

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

RECORD OF BIRTH

BIRTHDATE (Mo/Day/Year)	CITY OF BIRTH:	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH:
72	Witchita	Sedgwick	Kansas

FULL NAME OF FATHER:	MOTHER'S MAIDEN NAME:	COUNTRY OF BIRTH:
		USA

IDENTIFYING CHARACTERISTICS

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

IDENTIFYING MARKS:

PRELIMINARY EDUCATION

NAME OF HIGH SCHOOL:	CITY:	STATE OR PROVINCE:		FROM DATE: Month/Day/Year	TO DATE: Month/Day/Year
Viborg Public	Viborg	South Dakota		9-810-86	5-20-90
NAME OF COLLEGE:	**CITY:**	**STATE OR PROVINCE:**	**DEGREE**	**FROM DATE: Month/Day/Year**	**TO DATE: Month/Day/Year**
University of Northern Colorado	Greely	CO	None	8-20-90	5-15-91
NAME OF COLLEGE:	**CITY:**	**STATE OR PROVINCE:**	**DEGREE:**	**FROM DATE: Month/Day/Year**	**TO DATE: Month/Day/Year**
University of South Dakota	Vermillion	SD	BS Biology	9-15-91	12-22-93

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 South Dakota	Vermillion/Sioux Falls	SD	57069	9-8-95	5-8-99

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)
University of South Dakota Masters of Natural Science	1-10-94	5-13-95

APP-PY-02 8/89

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MEDICAL DIPLOMAS

BACHELOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE Mo/Day/Year
☒ MEDICINE ☐ OSTEOPATHY	University of South Dakota	Vermillion	SD	57069	USA	5-8-99

DOCTOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE : Mo/Day/Year
☐ MEDICINE ☐ OSTEOPATHY						

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

NAME OF HOSPITAL: Regions Hospital
FROM DATE (Mo/Day/Year): 6-24-99
TO DATE (Mo/Day/Year): 6-30-00
STREET ADDRESS: 640 Jackson St
CITY: St. Paul
STATE OR PROVINCE: MN
COUNTRY: USA
ZIP CODE: 55101
TYPE OF TRAINING: (BE SPECIFIC) OB/Gyn

NAME OF HOSPITAL: Regions Hospital
FROM DATE (Mo/DayYear): 7-1-00
TO DATE (Mo/Day/Year): Current/present
STREET ADDRESS: 640 Jackson St
CITY: St. Paul
STATE OR PROVINCE: MN
COUNTRY: USA
ZIP CODE: 55101
TYPE OF TRAINING: (BE SPECIFIC) OB/Gyn

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

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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)

Finishing Residency, Moonlighting opportunities

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE

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: __________

Issue Date: __________

Expiration Date: __________

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

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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. Kimberly A. Mark

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

Kathryn Strom	2-13-01	26474	MN
SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE

Kathryn Strom
PRINT OR TYPE FULL NAME

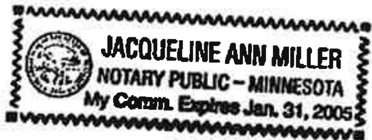
CERTIFICATION OF IDENTIFICATION
Certification by Notary Public is required.

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 applicant's 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 13 day of February 2001.

Notary Public Signature Jacqueline Ann Miller

Expiration Date 1 / 31 / 05
Month Day Year



I certify that the photograph attached is a recent one and likeness of Dr. Kimberly A. Mark

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

Carol E. Ball, MD	2/13/01	24235	MN
SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE

Carol E. Ball, MD
PRINT OR TYPE FULL NAME

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AFFIDAVIT OF APPLICANT:

STATE OF: Minnesota

COUNTY OF: Ramsey

I, Kimberly A. Mark, 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.

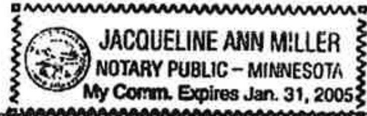
I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, 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 13 day of Feb, '01

Jacqueline Ann Miller
Signature of Notary Public

Kimberly A. Mark
Signature of Applicant

My Commission Expires: 1-31-05



RIGHTS OF SUBJECTS OF DATA

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

Minnesota Health Licensing Boards
Minnesota Board of Medical Practice

Minnesota.gov
Monday, March 19, 2018

Home Online Services User Admin Search Welcome Paul Luecke! | Logoff

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Kimberly Fischer	Start Date:	2/21/2013 12:30:16 PM
Service Name:	License Renewal - PY	Complete Date:	2/21/2013 12:33:16 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	2/21/2013 12:30:22 PM	
2	Verify Information	2/21/2013 12:30:44 PM	
3	Privileges & Continuing Medical Education	2/21/2013 12:30:50 PM	
4	Practice Questions	2/21/2013 12:31:21 PM	
5	Profiling - Practice Addresses	2/21/2013 12:31:33 PM	
5	Profiling - Post Graduate Training	2/21/2013 12:31:39 PM	
5	Profiling - Post Graduate Training	2/21/2013 12:31:39 PM	
5	Profiling - ABMS/AOA	2/21/2013 12:31:46 PM	
5	Profiling - ABMS/AOA	2/21/2013 12:31:46 PM	
5	Profiling - Criminal Convictions	2/21/2013 12:31:54 PM	
6	Review	2/21/2013 12:32:07 PM	
7	Prescription Monitoring Program Registration	2/21/2013 12:32:12 PM	

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Verification Page

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

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

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

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

Application for License Renewal

License Number: PY 43540
Name: Kimberly Ann Fischer

Drivers License:
Is license current?

Designated Address:
Kimberly Fischer MD
Parkview Ob/Gyn
347 North Smith Avenue
St. Paul, MN 83501

Phone: (651) 249-3385
Email Address:
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
United Hospital	St Paul	MN	Admitting/Full

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 02/28/2014.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Kimberly Fischer	Start Date:	2/10/2014 10:36:19 AM
Service Name:	License Renewal - PY	Complete Date:	2/10/2014 10:42:46 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	2/10/2014 10:37:28 AM	
2	Verify Information	2/10/2014 10:38:07 AM	
3	Privileges & Continuing Medical Education	2/10/2014 10:38:55 AM	
4	Practice Questions	2/10/2014 10:39:51 AM	
5	Profiling - Practice Addresses	2/10/2014 10:40:36 AM	
5	Profiling - Post Graduate Training	2/10/2014 10:40:40 AM	
5	Profiling - Post Graduate Training	2/10/2014 10:40:40 AM	
5	Profiling - ABMS/AOA	2/10/2014 10:40:46 AM	
5	Profiling - ABMS/AOA	2/10/2014 10:40:46 AM	
5	Profiling - Criminal Convictions	2/10/2014 10:40:51 AM	
6	Review	2/10/2014 10:41:01 AM	
7	Prescription Monitoring Program Registration	2/10/2014 10:41:06 AM	

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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 43540
Name: Kimberly Ann Fischer

Drivers License:
Is license current?

Designated Address: Kimberly Fischer MD
Parkview Ob/Gyn
347 North Smith Avenue
St. Paul, MN 83501

Phone: (651) 249-3385
Email Address:
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
United Hospital	St Paul	MN	Admitting/Full

Continuing Education

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

Years	Description
0	Residency Program
0	Fellowship Program

Required Hours: 75
Category 1 Course Hours: 80
Category 1 Equivalent Course Hours: 0
Total Reported Hours: 80

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?

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Minnesota.gov

Monday, March 19, 2018

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Kimberly Fischer	Start Date:	2/6/2015 12:11:29 PM
Service Name:	License Renewal - PY	Complete Date:	2/6/2015 12:19:22 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	2/6/2015 12:11:43 PM	
2	Verify Information	2/6/2015 12:12:06 PM	
3	Privileges & Continuing Medical Education	2/6/2015 12:12:11 PM	
4	Practice Questions	2/6/2015 12:13:00 PM	
5	Profiling - Practice Addresses	2/6/2015 12:13:14 PM	
5	Profiling - Post Graduate Training	2/6/2015 12:13:29 PM	
5	Profiling - Post Graduate Training	2/6/2015 12:13:29 PM	
5	Profiling - ABMS/AOA	2/6/2015 12:13:38 PM	
5	Profiling - ABMS/AOA	2/6/2015 12:13:38 PM	
5	Profiling - Criminal Convictions	2/6/2015 12:13:43 PM	
6	Review	2/6/2015 12:15:58 PM	
8	Questionnaire	2/6/2015 12:18:32 PM	

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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 43540
Name: Kimberly Ann Fischer

Drivers License:
Is license current?

Designated Address: Kimberly Fischer MD
Parkview Ob/Gyn
347 North Smith Avenue
St. Paul, MN 83501

Phone: (651) 249-3385
Email Address:
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
United Hospital	St Paul	MN	Admitting/Full

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 02/28/2017.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Kimberly Fischer	Start Date:	2/23/2016 8:04:52 AM
Service Name:	License Renewal - PY	Complete Date:	2/23/2016 8:13:26 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	2/23/2016 8:05:05 AM	
2	Verify Information	2/23/2016 8:05:42 AM	
3	Privileges & Continuing Medical Education	2/23/2016 8:05:46 AM	
4	Practice Questions	2/23/2016 8:06:48 AM	
5	Profiling - Practice Addresses	2/23/2016 8:07:25 AM	
5	Profiling - Post Graduate Training	2/23/2016 8:07:31 AM	
5	Profiling - Post Graduate Training	2/23/2016 8:07:31 AM	
5	Profiling - ABMS/AOA	2/23/2016 8:07:43 AM	
5	Profiling - ABMS/AOA	2/23/2016 8:07:43 AM	
5	Profiling - Criminal Convictions	2/23/2016 8:07:51 AM	
6	Review	2/23/2016 8:08:02 AM	
8	Questionnaire	2/23/2016 8:12:32 AM	

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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 43540
Name: Kimberly Ann Fischer

Drivers License:
Is license current?

Designated Address: Kimberly Fischer MD
East Metro Allina Women's Health
347 North Smith Avenue
St. Paul, MN 83501

Phone: (651) 249-3385
Email Address: kimberly.fischer@allina.com
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
United Hosptal	St Paul	MN	Admitting/Full

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 02/28/2017.

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Minnesota.gov

Monday, March 19, 2018

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Kimberly Fischer	Start Date:	1/5/2017 3:02:07 PM
Service Name:	License Renewal - PY	Complete Date:	1/5/2017 3:12:06 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	1/5/2017 3:02:13 PM	
2	Verify Information	1/5/2017 3:02:33 PM	
3	Privileges & Continuing Medical Education	1/5/2017 3:03:16 PM	
4	Practice Questions	1/5/2017 3:03:53 PM	
5	Profiling - Practice Addresses	1/5/2017 3:04:10 PM	PracticeAddress
5	Profiling - Post Graduate Training	1/5/2017 3:04:15 PM	Bypass Case
5	Profiling - Post Graduate Training	1/5/2017 3:04:15 PM	
5	Profiling - ABMS/AOA	1/5/2017 3:05:15 PM	
5	Profiling - ABMS/AOA	1/5/2017 3:05:15 PM	
5	Profiling - Criminal Convictions	1/5/2017 3:05:19 PM	
6	Review	1/5/2017 3:05:33 PM	
7	Prescription Monitoring Program Registration	1/5/2017 3:07:27 PM	• Please select a Health Profession Type
7	Prescription Monitoring Program Registration	1/5/2017 3:08:06 PM	• Please select a Health Profession Type
7	Prescription Monitoring Program Registration	1/5/2017 3:08:24 PM	
7	Prescription Monitoring Program Registration	1/5/2017 3:08:25 PM	PMP Submitted Successfully: 1/5/2017 3:08:25 PM
7	Prescription Monitoring Program Registration	1/5/2017 3:08:35 PM	
9	Payment	1/5/2017 3:11:09 PM	

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Verification Page

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

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

Application for License Renewal

License Number: PY 43540
Name: Kimberly Ann Fischer

Drivers License:
Is license current?

Designated Address: Kimberly Fischer MD
East Metro Allina Women's Health
347 North Smith Avenue
St. Paul, MN 83501

Phone: (651) 249-3385
Email Address: kimberly.fischer@allina.com
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
United Hospital	St Paul	MN	Admitting/Full

Continuing Education

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

Years	Description
0	Residency Program
0	Fellowship Program

Required Hours: 75
Category 1 Course Hours: 0
Category 1 Equivalent Course Hours: 0

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Kimberly Fischer	Start Date:	2/3/2018 2:14:16 PM
Service Name:	License Renewal - PY	Complete Date:	2/3/2018 2:20:29 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	2/3/2018 2:14:20 PM	
2	Verify Information	2/3/2018 2:15:15 PM	
3	Privileges & Continuing Medical Education	2/3/2018 2:15:59 PM	
4	Practice Questions	2/3/2018 2:16:38 PM	
5	Profiling - Practice Addresses	2/3/2018 2:17:02 PM	PracticeAddress
5	Profiling - Post Graduate Training	2/3/2018 2:17:10 PM	Bypass Case
5	Profiling - Post Graduate Training	2/3/2018 2:17:10 PM	
5	Profiling - ABMS/AOA	2/3/2018 2:17:17 PM	
5	Profiling - ABMS/AOA	2/3/2018 2:17:17 PM	
5	Profiling - Criminal Convictions	2/3/2018 2:17:21 PM	
6	Review	2/3/2018 2:17:35 PM	
7	Prescription Monitoring Program Registration	2/3/2018 2:17:39 PM	
9	Payment	2/3/2018 2:19:39 PM	

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Verification Page

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

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

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

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

Application for License Renewal

License Number: PY 43540
Name: Kimberly Ann Fischer

Drivers License:
Is license current?

Designated Address:
Kimberly Fischer MD
East Metro Allina Women's Health
347 North Smith Avenue
St. Paul, MN 83501

Phone: (651) 249-3385
Email Address: kimberly.fischer@allina.com
Web Site:

Private Address:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
United Hospital	St Paul	MN	Admitting/Full
Cambridge Hospital	Cambridge	MN	admitting/full
Abbott Hospital	Minneapolis	MN	admitting/full

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 02/29/2020.

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Minnesota.gov

Monday, March 19, 2018

Home Online Services My Services Search Log In

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: Kimberly Ann Fischer New Search

License: Physician and Surgeon - #43540 Print

Licensee Public Information

Licensure Designated Address: Kimberly Fischer MD
East Metro Allina Women's Health
St. Paul, MN 83501

Web Site:

E-mail: kimberly.fischer@allina.com

Birth Year: 1972

Gender: Female

License Information

License Number:	43540	**License Type:**	Physician and Surgeon
Expiration Date:	02-28-2019	**Grant Date:**	05-12-2001
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 SOUTH DAKOTA, SCHOOL OF MEDICINE, SIOUX FALLS, VERMILLION USA	**Degree:**	M.D.
Location:	Vermillion, SD USA	**Date:**	05/08/1999

Practice Locations (Self-Reported Information)

Primary Location: East Metro Allina Women's Health
347 North Smith Avenue
St. Paul, MN 55102
Phone: 651-241-7733

Secondary Location: East Metro Allina Women's health
4194 North Lexington Avenue
Shoreview, MN 55126
Phone: 651-483-5461

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

Program	Specialty	Start Date	End Date	Completed
University of Minnesota	Ob/Gyn	07/00/1999	06/00/2003	Y
University of Minnesota	Gynecologic Oncology	07/00/2003	06/00/2006	I

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
ABMS	Obstetrics and Gynecology	Obstetrics & Gynecology

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

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