36557

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

le Opp

452.00

DEC 2001 RECEIVED BY MN BD OF MED. PRACTICE

DATE OF APPLICATION:

MONTH	DAY	YEAR
11	26	01

FOR BOARD USE ONLY

APPLICATION #: 75968
CHECK /RECEIPT #:
AMT PAID:
TEMP PERMIT #:
BOARD ACTION:
BOARD DATE: 9 MAR 02
LICENSE #: 36557

SOURCE CODE	AMOUNT
5220	192.00
5221	200.00
5223	60.00

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. 173-4 173-9 173-13
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
HANSON	MARILEE	ANN

STREET ADDRESS:

CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:
			U.S.A.

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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4. ADDRESS OF NEAREST RELATIVE

NAME OF RELATIVE: J

STREET ADDRESS:

CITY: | STATE OR PROVINCE:

ZIP CODE: | COUNTRY: | RELATIONSHIP:

5. 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:
1961	Minneapolis	Hennepin	Minnesota

FULL NAME OF FATHER: | MOTHER'S MAIDEN NAME: | COUNTRY OF BIRTH: United States

DESCRIPTIVE CHARACTERISTICS

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

IDENTIFYING MARKS:

PRELIMINARY EDUCATION

NAME OF HIGH SCHOOL: Edina West	CITY: Edina	STATE OR PROVINCE: Minnesota		FROM DATE: Month/Day/Year	TO DATE: Month/Day/Year
NAME OF COLLEGE: University of California, Irvine	CITY: Irvine	STATE OR PROVINCE: California	DEGREE B.S.	FROM DATE: Month/Day/Year	TO DATE: Month/Day/Year 6/14/86
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	DEGREE:	FROM DATE: Month/Day/Year	TO DATE: Month/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
Stanford University School of Medicine	Stanford	CA	94305	9/86	6/91

ACCOUNTING OF TIME NOT NOTED ELSEWHERE ON THIS APPLICATION

ACTIVITY (ATTACH SEPARATE SHEET, IF NECESSARY)	FROM DATE (Mo/Day/Year)	TO DATE (Mo/DayYear)
Severe illness in family, specialty Board Exam	10/99	2/00
After completing residency	7/95	11/95
(A) Postgraduate Course/Fellowship: sexually transmitted d2, Seattle		
(B) Travel: mexico, China, Costa Rica		
(C) Move from San Francisco to Boston		

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MEDICAL DIPLOMAS

BACHELOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE Mo/Day/Year
☒ MEDICINE ☐ OSTEOPATHY	Stanford University School of Medicine	Stanford	CA	94305	United States	6/16/91
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:	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
University of California, San Francisco	6/91	7/01/95

STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
505 Parnassus Ave	San Francisco	CA	United States	94143

TYPE OF TRAINING: (BE SPECIFIC)
OB/Gyn Internship and 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 (*)
Minnesota	36557	1995	NBME
Massachusetts	82114	1995	NBME
California	G 76967	1993	NBME
Hawaii	8555	1993	NBME

(*) 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)
Partners in Women's Health	11/95	9/99

NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:
Susan Foley	100 Hospital Road	Malden	MA	02148
Darwish Yusah, MD	9 Scott Road	Lexington	MA	02421

NAME OF FACILITY:	FROM DATE: (Mo/Day/Year)	TO DATE: (Mo/Day/Year)
Private practice	3/00	9/01

NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:
Melissa Eagan	55 Pond Avenue	Brookline	MA	02445
Alan Altman, MD	55 Pond Avenue	Brookline	MA	02445

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 FACILITY:	FROM DATE: (Mo/Day/Year	TO DATE: (Mo/Day/Year)

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:

PROPOSED PRACTICE PLANS IN MINNESOTA (IF ANY)

Multispecialty group: Aspen Medical Group

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):

- [x] 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: Obstetrics and Gynecology

Issue Date: Nov 12, 1999

Expiration Date: 12/31/2009

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

CERTIFICATE OF ETHICAL AND MORAL CHARACTER

THIS CERTIFICATE MUST BE SIGNED BY TWO LICENSED PHYSICIANS WHO ARE PERSONALLY ACQUAINTED WITH THE APPLICANT.

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
	12/14/01	171564	New York

Shahin Rafii
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification by Notary Public is required.

State: New York County: New York

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 14th day of December, 2001.

Notary Public Signature Anna T. Ansari

Expiration Date 07 / 31 / 05
Month Day Year

ANNA T. ANSARI
Notary Public, State of New York
No. 01TH4736858
Qualified in New York County
Commission Expires 7/31, 20 05

Marilee A. Hanson, MD
Applicant Signature

I certify that the photograph attached is a recent one and likeness of Dr. Marilee Hanson,

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

SIGNATURE	DATE	DEA # / LICENSE NUMBER	STATE OF ISSUE
	12/14/01	BB3835545 / 198990	New York

PETER LEIF BERGMEL.
PRINT OR TYPE FULL NAME

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AFFIDAVIT OF APPLICANT:

STATE OF: Minnesota

COUNTY OF: Hennepin

I, Marilee Hanson, MD, 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 14th day of Dec., 2001

Anna T. Ansari
Signature of Notary Public

My Commission Expires: 7/31/05

ANNA T. ANSARI
Notary Public, State of New York
No. 01TH6726858
Qualified in New York County
Commission Expires 7/31 20 05

Marilee A. Hanson MD
Signature of Applicant

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

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Marilee Hanson	Start Date:	10/3/2017 2:51:53 PM
Service Name:	License Renewal - PY	Complete Date:	10/3/2017 3:35:24 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	10/3/2017 2:52:15 PM	
2	Verify Information	10/3/2017 2:52:48 PM	
2	Verify Information	10/3/2017 3:19:45 PM	
3	Privileges & Continuing Medical Education	10/3/2017 3:19:57 PM	
4	Practice Questions	10/3/2017 3:21:21 PM	
5	Profiling - Practice Addresses	10/3/2017 3:21:50 PM	PracticeAddress
5	Profiling - Post Graduate Training	10/3/2017 3:22:19 PM	Bypass Case
5	Profiling - Post Graduate Training	10/3/2017 3:22:19 PM	
5	Profiling - ABMS/AOA	10/3/2017 3:22:42 PM	
5	Profiling - ABMS/AOA	10/3/2017 3:22:42 PM	
5	Profiling - Criminal Convictions	10/3/2017 3:22:52 PM	
6	Review	10/3/2017 3:25:44 PM	
7	Prescription Monitoring Program Registration	10/3/2017 3:25:52 PM	
9	Payment	10/3/2017 3:33:39 PM	

Verification Page

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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 36557
Name: Marilee Ann Hanson

Drivers License:
Is license current? Yes

Designated Address: 710 East 24th Street
Suite 403
Minneapolis, MN 55404

Phone: (612) 870-1334
Email Address: mshfront@gmail.com
Web Site:

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Fairview Southdale Hospital	Edina	MN	Active
Fairview Riverside Hospital	Minneapolis	MN	Active
Abbott Northwestern Hospital	Minneapolis	MN	Active

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
Total Reported Hours: 0

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

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Marilee Hanson	Start Date:	9/12/2016 12:48:21 PM
Service Name:	License Renewal - PY	Complete Date:	9/12/2016 1:16:01 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	9/12/2016 12:48:28 PM	
2	Verify Information	9/12/2016 12:49:21 PM	
3	Privileges & Continuing Medical Education	9/12/2016 12:49:34 PM	
4	Practice Questions	9/12/2016 12:51:52 PM	
5	Profiling - Practice Addresses	9/12/2016 12:52:25 PM	PracticeAddress
5	Profiling - Post Graduate Training	9/12/2016 12:52:35 PM	Bypass Case
5	Profiling - Post Graduate Training	9/12/2016 12:52:35 PM	
5	Profiling - ABMS/AOA	9/12/2016 12:52:47 PM	
5	Profiling - ABMS/AOA	9/12/2016 12:52:47 PM	
5	Profiling - Criminal Convictions	9/12/2016 12:52:56 PM	
4	Practice Questions	9/12/2016 12:54:36 PM	
5	Profiling - Practice Addresses	9/12/2016 12:54:47 PM	PracticeAddress
5	Profiling - Post Graduate Training	9/12/2016 12:54:54 PM	Bypass Case
5	Profiling - Post Graduate Training	9/12/2016 12:54:54 PM	
5	Profiling - ABMS/AOA	9/12/2016 12:54:59 PM	
5	Profiling - ABMS/AOA	9/12/2016 12:54:59 PM	
5	Profiling - Criminal Convictions	9/12/2016 12:55:08 PM	
6	Review	9/12/2016 12:55:34 PM	
7	Prescription Monitoring Program Registration	9/12/2016 12:55:42 PM	
9	Payment	9/12/2016 1:13:08 PM	

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Application for License Renewal

License Number: PY 36557
Name: Marilee Ann Hanson

Drivers License:
Is license current?

Designated Address: 710 East 24th Street
Suite 403
Minneapolis, MN 55404

Phone: (612) 870-1334
Email Address: mshfront@gmail.com
Web Site:

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Fairview Southdale Hospital	Edina	MN	Active
Fairview Riverside Hospital	Minneapolis	MN	Active
Abbott Northwestern Hospital	Minneapolis	MN	Active

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 10/31/2017.

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Marilee Hanson	Start Date:	10/12/2015 10:05:07 AM
Service Name:	License Renewal - PY	Complete Date:	10/12/2015 10:51:18 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	10/12/2015 10:05:41 AM	
2	Verify Information	10/12/2015 10:06:28 AM	
3	Privileges & Continuing Medical Education	10/12/2015 10:06:46 AM	
4	Practice Questions	10/12/2015 10:10:43 AM	
5	Profiling - Practice Addresses	10/12/2015 10:11:18 AM	
5	Profiling - Post Graduate Training	10/12/2015 10:11:35 AM	
5	Profiling - ABMS/AOA	10/12/2015 10:12:03 AM	
5	Profiling - ABMS/AOA	10/12/2015 10:12:03 AM	
5	Profiling - Criminal Convictions	10/12/2015 10:12:27 AM	
6	Review	10/12/2015 10:16:07 AM	
8	Questionnaire	10/12/2015 10:23:49 AM	

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Application for License Renewal

License Number: PY 36557
Name: Marilee Ann Hanson

Drivers License:
Is license current?

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Minneapolis, MN 55404

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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 10/31/2017.

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Marilee Hanson	Start Date:	9/29/2014 11:31:37 AM
Service Name:	License Renewal - PY	Complete Date:	10/7/2014 3:19:55 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	9/29/2014 11:32:05 AM	
2	Verify Information	9/29/2014 11:32:59 AM	
2	Verify Information	10/7/2014 3:03:41 PM	
3	Privileges & Continuing Medical Education	10/7/2014 3:05:39 PM	
4	Practice Questions	10/7/2014 3:08:15 PM	
5	Profiling - Practice Addresses	10/7/2014 3:08:31 PM	
5	Profiling - Post Graduate Training	10/7/2014 3:08:47 PM	
5	Profiling - Post Graduate Training	10/7/2014 3:08:47 PM	
5	Profiling - ABMS/AOA	10/7/2014 3:09:14 PM	
5	Profiling - Criminal Convictions	10/7/2014 3:09:33 PM	
6	Review	10/7/2014 3:10:33 PM	
8	Questionnaire	10/7/2014 3:17:02 PM	

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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: 95
Category 1 Equivalent Course Hours: 0
Total Reported Hours: 95

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

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Marilee Hanson	Start Date:	9/24/2013 2:36:02 PM
Service Name:	License Renewal - PY	Complete Date:	9/24/2013 2:49:11 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	9/24/2013 2:36:22 PM	
2	Verify Information	9/24/2013 2:37:07 PM	
3	Privileges & Continuing Medical Education	9/24/2013 2:38:25 PM	
4	Practice Questions	9/24/2013 2:42:24 PM	
5	Profiling - Practice Addresses	9/24/2013 2:42:50 PM	
5	Profiling - Post Graduate Training	9/24/2013 2:43:00 PM	
5	Profiling - Post Graduate Training	9/24/2013 2:43:00 PM	
5	Profiling - ABMS/AOA	9/24/2013 2:43:20 PM	
5	Profiling - ABMS/AOA	9/24/2013 2:43:20 PM	
5	Profiling - Criminal Convictions	9/24/2013 2:44:02 PM	
6	Review	9/24/2013 2:45:29 PM	
7	Prescription Monitoring Program Registration	9/24/2013 2:45:47 PM	

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Continuing Education

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Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Monday, March 19, 2018

Professional Profile

Profile Details

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Professional Profile: Marilee Ann Hanson ↗ New Search

License: Physician and Surgeon - #36557 Print

Licensee Public Information

Licensure Designated Address: 710 East 24th Street
Suite 403
Minneapolis, MN 55404

Web Site:

E-mail: mshfront@gmail.com

Birth Year: 1961

Gender: Female

License Information

License Number:	36557	**License Type:**	Physician and Surgeon
Expiration Date:	10-31-2018	**Grant Date:**	03-09-2002
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:	STANFORD UNIVERSITY SCHOOL OF MEDICINE, PALO ALTO USA	**Degree:**	M.D.
Location:	Palo Alto, CA USA	**Date:**	06/16/1991

Practice Locations (Self-Reported Information)

Primary Location: MILDRED S HANSON MD., PA.
710 E 24TH ST
STE 403
Minneapolis, MN 55404
Phone: 612-870-1334

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 California, San Francisco	Obstetrics and Gynecology	00/00/1991	00/00/1995	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
ABMS	Obstetrics and Gynecology	Obstetrics & Gynecology

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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