MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

March 21, 2018

VIA E-MAIL ONLY

RE: Request for data regarding Mary Kathleen Mahoney, M.D.

To Whom It May Concern:

This is in follow up to your request, received on March 20, 2018, for data relating to the Minnesota medical license of Mary Kathleen Mahoney, M.D. Pursuant to the Minnesota Government Data Practices Act, Minn. Stat. §§ 13.02, Subd. 15, 13.03, Subd. 1 and 4, and 13.41, Subd. 5, enclosed are copies of Dr. Mahoney's Minnesota medical license application, renewals and professional profile. Non-public information has been redacted pursuant to Minn. Stat. §§ 13.02, Subd. 12, and 13.41, Subd. 2. Dr. Mahoney has not been subject to disciplinary or corrective action. This is the extent of the public information the Board of Medical Practice has on Dr. Mahoney. If there is any other data in the Board's possession, it is not public and is classified as private or confidential, pursuant to Minn. Stat. §§ 13.41, Subds. 2(a) and 4.

I hope this information is helpful to you. If you have any questions, please feel free to contact me at the number or e-mail listed below.

Sincerely,

K. L. Van Etta-Olson

Kate Van Etta-Olson
Legal Analyst
(612) 548-2154
kathryn.van.etta-olson@state.mn.us

Enclosures

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

392

RECEIVED
OCT 27 2000
MN BOARD OF MEDICAL PRACTICE

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

DATE OF APPLICATION:

MONTH	DAY	YEAR
10	22	00

FOR BOARD USE ONLY

APPLICATION #:	73350
CHECK /RECEIPT #:	
AMT PAID:	
TEMP PERMIT #:	
BOARD ACTION:	
BOARD DATE:	1-13-01
LICENSE #:	43,382

SOURCE CODE	AMOUNT
5200	192.00
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. 138-2
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. 138-7
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
MAHONEY	MARY	KATHLEEN

STREET ADDRESS:

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

HOME PHONE:	OTHER PHONE:	GENDER	MAIDEN NAME:
		☐ MALE ☒ FEMALE	N/A

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:

ADDRESS OF NEAREST RELATIVE

NAME OF RELATIVE:		
STREET ADDRESS:		
CITY:		STATE OR PROVINCE:
ZIP CODE:	COUNTRY:	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) 1/60	CITY OF BIRTH: GOLDEN VALLEY	COUNTY OF BIRTH: ~~25~~ HENNEPIN	STATE/PROVINCE OF BIRTH: MINNESOTA
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: TOTINO-GRACE	CITY: FRIDLEY	STATE OR PROVINCE: MN		FROM DATE: Month/Day/Year 09/80	TO DATE: Month/Day/Year 06/84
NAME OF COLLEGE: UNIVERSITY OF MINNESOTA	CITY: MPLS	STATE OR PROVINCE: MN	DEGREE B.S.	FROM DATE: Month/Day/Year 09/84	TO DATE: Month/Day/Year 12/89
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
UNIVERSITY OF MINNESOTA	MINNEAPOLIS	MN	55455	9/93	6/97

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)
MINNESOTA VALLEY EDUCATION DISTRICT	3/90	8/93

43322

MEDICAL DIPLOMAS

BACHELOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE Mo/Day/Year
☐ MEDICINE ☐ OSTEOPATHY						
DOCTOR OF:	**NAME OF SCHOOL:**	**CITY:**	**STATE OR PROVINCE**	**ZIP:**	**COUNTRY:**	**DATE: Mo/Day/Year**
☒ MEDICINE ☐ OSTEOPATHY	UNIVERSITY OF MINNESOTA	MINNEAPOLIS	MN	55455	USA	6/14/93

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

NAME OF HOSPITAL:	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
TWIN CITIES INTEGRATED RESIDENCY IN OB/GYN	6/97	PRESENT

STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
420 DELAWARE STREET BOX 395	MPLS	MN	USA	55455

TYPE OF TRAINING: (BE SPECIFIC) OB/GYN - 4 year 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 N/A

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 N/A

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

RESIDENCY PERMIT # 12914

(*) 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

PRACTICE REFERENCES N/A

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)

PRIVATE PRACTICE GENERAL OB/GYN

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE
ACOG	1997	PRESENT

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.

43322

CERTIFICATE OF ETHICAL AND MORAL CHARACTER

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

MN

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Mark L. Tanz MD	10/23/00	022265	Mn

MARK L. TANZ MD
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification by Notary Public is required.

State: Minnesota County: Hennepin

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 23rd day of October, 2000.

Notary Public Signature Sandra R. Nanti

Expiration Date 01 / 31 / 2005
Month Day Year

Paste a recent photo, front-view passport-type photo in this square

Mary Mahoney
Applicant Signature

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Philip E. Olson	10/23/00	17174	MN

HARDIN ELLING OLSON
PRINT OR TYPE FULL NAME

AFFIDAVIT OF APPLICANT:

STATE OF: MN

COUNTY OF: Hennepin

I, Mary Mahoney, 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 23rd day of October, 2000

Sandra R. Nanti

Signature of Notary Public

My Commission Expires: 01/31/2005

SANDRA R. NANTI
Notary Public
Minnesota
My Commission Expires Jan. 31, 2005

Mary Mahoney

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.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Mary Mahoney	Start Date:	3/13/2018 9:04:03 AM
Service Name:	License Renewal - PY	Complete Date:	3/13/2018 9:14:09 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	3/13/2018 9:04:08 AM	
2	Verify Information	3/13/2018 9:04:16 AM	
3	Privileges & Continuing Medical Education	3/13/2018 9:04:20 AM	
4	Practice Questions	3/13/2018 9:05:13 AM	
5	Profiling - Practice Addresses	3/13/2018 9:05:24 AM	PracticeAddress
5	Profiling - Post Graduate Training	3/13/2018 9:05:27 AM	Bypass Case
5	Profiling - Post Graduate Training	3/13/2018 9:05:27 AM	
5	Profiling - ABMS/AOA	3/13/2018 9:05:31 AM	
5	Profiling - ABMS/AOA	3/13/2018 9:05:31 AM	
5	Profiling - Criminal Convictions	3/13/2018 9:05:36 AM	
6	Review	3/13/2018 9:06:16 AM	
7	Prescription Monitoring Program Registration	3/13/2018 9:06:21 AM	
9	Payment	3/13/2018 9:09:02 AM	

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 43322
Name: Mary Kathleen Mahoney

Drivers License:
Is license current?

Designated Address: Riverside Prof Bldg
606 24th Ave S #300
Minneapolis, MN 55454

Phone: (612) 273-7111
Email Address: mahon014@umn.edu
Web Site: www.umn.edu/obgyn/

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
fairview university medical center	mpls	MN	admitting

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 03/31/2019.

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:	Mary Mahoney	Start Date:	2/15/2017 11:54:48 AM
Service Name:	License Renewal - PY	Complete Date:	2/15/2017 12:07:49 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	2/15/2017 11:54:55 AM	
2	Verify Information	2/15/2017 11:55:59 AM	
3	Privileges & Continuing Medical Education	2/15/2017 11:56:22 AM	
4	Practice Questions	2/15/2017 11:59:05 AM	
5	Profiling - Practice Addresses	2/15/2017 11:59:28 AM	PracticeAddress
5	Profiling - Post Graduate Training	2/15/2017 11:59:55 AM	Bypass Case
5	Profiling - Post Graduate Training	2/15/2017 11:59:55 AM	
5	Profiling - ABMS/AOA	2/15/2017 12:00:00 PM	
5	Profiling - ABMS/AOA	2/15/2017 12:00:00 PM	
5	Profiling - Criminal Convictions	2/15/2017 12:00:09 PM	
6	Review	2/15/2017 12:00:32 PM	
7	Prescription Monitoring Program Registration	2/15/2017 12:00:37 PM	
9	Payment	2/15/2017 12:04:43 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 43322
Name: Mary Kathleen Mahoney

Drivers License:
Is license current?

Designated Address: Riverside Prof Bldg
606 24th Ave S #300
Minneapolis, MN 55454

Phone: (612) 273-7111
Email Address: mahon014@umn.edu
Web Site: www.umn.edu/obgyn/

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
fairview university medical center	mpls	MN	admitting

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 03/31/2019.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Mary Mahoney	Start Date:	2/9/2016 11:20:05 AM
Service Name:	License Renewal - PY	Complete Date:	2/9/2016 12:12:12 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	2/9/2016 11:20:43 AM	
2	Verify Information	2/9/2016 11:20:58 AM	
3	Privileges & Continuing Medical Education	2/9/2016 11:21:52 AM	
4	Practice Questions	2/9/2016 11:23:07 AM	
5	Profiling - Practice Addresses	2/9/2016 11:23:19 AM	
5	Profiling - Post Graduate Training	2/9/2016 11:23:24 AM	
5	Profiling - Post Graduate Training	2/9/2016 11:23:25 AM	
5	Profiling - ABMS/AOA	2/9/2016 11:23:30 AM	
5	Profiling - ABMS/AOA	2/9/2016 11:23:30 AM	
5	Profiling - Criminal Convictions	2/9/2016 11:23:44 AM	
6	Review	2/9/2016 11:24:35 AM	
1	Information	2/9/2016 11:48:48 AM	
2	Verify Information	2/9/2016 11:48:53 AM	
3	Privileges & Continuing Medical Education	2/9/2016 11:49:01 AM	
4	Practice Questions	2/9/2016 11:49:05 AM	
5	Profiling - Practice Addresses	2/9/2016 11:49:10 AM	
5	Profiling - Post Graduate Training	2/9/2016 11:49:13 AM	
5	Profiling - Post Graduate Training	2/9/2016 11:49:13 AM	
5	Profiling - ABMS/AOA	2/9/2016 11:49:15 AM	
5	Profiling - ABMS/AOA	2/9/2016 11:49:15 AM	

1 2

Verification Page

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Application for License Renewal

License Number: PY 43322
Name: Mary Kathleen Mahoney

Drivers License:
Is license current?

Designated Address: Riverside Prof Bldg
606 24th Ave S #300
Minneapolis, MN 55454

Phone: (612) 273-7111
Email Address: mahon014@umn.edu
Web Site: www.umn.edu/obgyn/

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
fairview university medical center	mpls	MN	admitting

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

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:	Mary Mahoney	Start Date:	3/18/2015 11:37:28 AM
Service Name:	License Renewal - PY	Complete Date:	3/18/2015 11:45:29 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	3/18/2015 11:37:33 AM	• Specify credit card type for payment
1	Information	3/18/2015 11:37:35 AM	• Specify credit card type for payment
1	Information	3/18/2015 11:37:41 AM	
2	Verify Information	3/18/2015 11:38:02 AM	
3	Privileges & Continuing Medical Education	3/18/2015 11:38:17 AM	
4	Practice Questions	3/18/2015 11:39:01 AM	
5	Profiling - Practice Addresses	3/18/2015 11:39:11 AM	
5	Profiling - Post Graduate Training	3/18/2015 11:39:27 AM	
5	Profiling - Post Graduate Training	3/18/2015 11:39:27 AM	
5	Profiling - ABMS/AOA	3/18/2015 11:39:33 AM	
5	Profiling - ABMS/AOA	3/18/2015 11:39:33 AM	
5	Profiling - Criminal Convictions	3/18/2015 11:39:44 AM	
6	Review	3/18/2015 11:40:20 AM	
8	Questionnaire	3/18/2015 11:43:35 AM	

1

Verification Page

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Application for License Renewal

License Number: PY 43322
Name: Mary Kathleen Mahoney

Drivers License:
Is license current?

Designated Address: Riverside Prof Bldg
606 24th Ave S #300
Minneapolis, MN 55454

Phone: (612) 273-7111
Email Address: mahon014@umn.edu
Web Site: www.umn.edu/obgyn/

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
fairview university medical center	mpls	MN	admitting

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 03/31/2016.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Mary Mahoney	Start Date:	3/4/2014 8:06:43 AM
Service Name:	License Renewal - PY	Complete Date:	3/4/2014 8:12:11 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	3/4/2014 8:06:52 AM	
2	Verify Information	3/4/2014 8:07:19 AM	
3	Privileges & Continuing Medical Education	3/4/2014 8:07:32 AM	
4	Practice Questions	3/4/2014 8:08:19 AM	
5	Profiling - Practice Addresses	3/4/2014 8:08:32 AM	
5	Profiling - Post Graduate Training	3/4/2014 8:08:55 AM	
5	Profiling - Post Graduate Training	3/4/2014 8:08:55 AM	
5	Profiling - ABMS/AOA	3/4/2014 8:09:21 AM	
5	Profiling - ABMS/AOA	3/4/2014 8:09:21 AM	
5	Profiling - Criminal Convictions	3/4/2014 8:09:28 AM	
6	Review	3/4/2014 8:09:43 AM	
7	Prescription Monitoring Program Registration	3/4/2014 8:09:55 AM	

1

Verification Page

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Application for License Renewal

License Number: PY 43322
Name: Mary Kathleen Mahoney

Drivers License:
Is license current?

Designated Address: Riverside Prof Bldg
606 24th Ave S #300
Minneapolis, MN 55454

Phone: (612) 273-7111
Email Address:
Web Site: www.umn.edu/obgyn/

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
fairview university medical center	mpls	MN	admitting

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 03/31/2016.

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Tuesday, March 20, 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: Mary Kathleen Mahoney New Search

License: Physician and Surgeon - #43322 Print

Licensee Public Information

Licensure Designated Address:	Riverside Prof Bldg 606 24th Ave S #300 Minneapolis, MN 55454		
Web Site:	www.umn.edu/obgyn/	**Birth Year:**	1966
E-mail:	mahon014@umn.edu	**Gender:**	Female

License Information

License Number:	43322	**License Type:**	Physician and Surgeon
Expiration Date:	03-31-2019	**Grant Date:**	01-13-2001
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 MINNESOTA MEDICAL SCHOOL MINNEAPOLIS USA	**Degree:**	M.D.
Location:	Minneapolis, MN USA	**Date:**	06/14/1997

Practice Locations (Self-Reported Information)

Primary Location: U OF MN PHYSICIANS	**Secondary Location:** Planned Parenthood MNSD
606 24TH AVE S	671 Vandalia St.
suite 300	
MINNEAPOLIS, MN 55454	St. Paul, MN 55114
Phone: 612-273-7111	**Phone:** 612-821-6172

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	06/00/1997	06/00/2001	Y
University of Minnesota	ob/gyn	06/01/1997	05/01/2001	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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