APPLICATION FOR MEDICAL LICENSE

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 500
MINNEAPOLIS, MINNESOTA 55414-3246
612-617-2130 or www.bmp.state.mn.us
Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

4912 20

MAY 11 2015
MN BOARD OF MEDICAL PRACTICE

APPLICATION #: 111427
CHECK/RECEIPT #:
AMT PAID:
TEMP PERMIT #:
BOARD ACTION:
BOARD DATE: 9-12-15
LICENSE #: 59828

ACCOUNT CODE	AMOUNT
635009 lic	192
635010 app	200
635012 tp	60
513122 sur	39.20

Instructions to Applicant

1. The application will be returned if the fee is not included or the questions are not answered completely, accurately, and legibly.
2. Account for all time from the beginning of high school, whether spent in school, practice, or otherwise. Dates must include Month and Year. Attach separate sheet if necessary. 1539 3-44
3. Failure to answer all questions completely and accurately, omission or falsification of material facts, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
4. Incomplete applications may be destroyed after six months of inactivity.

Medical Professional Name If your name has changed at any time during your life and you are not using FCVS, submit a copy of the legal documentation (marriage certificate, divorce decree, etc.).

Last Name Traxler
First Name Sarah
Middle Name Ann
Maiden Name
All Other Names Used

Designated Address (Public, **required by Minn. Stat. 13.41, Subd. 2,** will be placed on license and on our website)

Street 671 Vandalia Street
City Saint Paul State MN Zip Code 55114 Country USA
Phone 651-201-7926 Email (optional)

Private Address (cannot be accessed by public)

Street
City State Zip Code Country
Phone Email

Intended Address (if known) Effective Date

Street
City State Zip Code Country

Applicant Name Sarah Traxler Last 4 digits of SSN ___ Date 4/28/2015

Identification Submit a notarized copy of your US/Canadian driver's license.

Date of Birth (mm/dd/yyyy) '1975 Birth City _____ Birth State _____

Birth County _____ Birth Country USA Gender Female

Driver's license: State _____ Number _____ SSN _____ NPI _____

Height (ft/in ___ ____ Weight (lbs) ___ Hair Color _____ Eye Color _____

Minn. Stat. § 147.091 Subd. 7(d) requires all applicants to provide their social security number on their license application for the administration of the state tax code. Your social security number is private. Your social security number is also required to facilitate reporting of the DataBank and for accurate identification under the federal and state child support enforcement law. The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard and a unique number for covered health care providers.

Medical School List all medical schools you have attended including those from which you did not graduate. If you are not using FCVS, complete the "Medical Education Verification" form and send to all medical schools you have attended. Include a copy of your diploma for the medical school to attach their seal prior to forwarding to the Minnesota Board.

1. School Name Oregon Health and Science University

Address 3181 SW Sam Jackson Park Road

City Portland State OR Zip Code 97239 Country USA

Attended from 08/15/2004 (mm/dd/yyyy) to 05/20/2009 (mm/dd/yyyy) Graduation Date 05/20/2009 (mm/dd/yyyy) Degree MD

2. School Name _____

Address _____

City _____ State _____ Zip Code _____ Country _____

Attended from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) Graduation Date _____ (mm/dd/yyyy) Degree _____

ECFMG Certification If ECFMG is applicable and you are not using FCVS, log on to www.ecfmg.org/cvs/index.html for the request form or to submit the request online. Confirmations are sent directly to the Minnesota Board. .

Certificate Number _____ Issue Date _____ Valid Through Date _____

Military Service. Submit a notarized copy of military discharge papers (DD Form 214), if applicable.

Branch of Service _____ Entry Date (mm/dd/yyy) _____ Release Date (mm/dd/yyyy) _____

Rank at Discharge _____ Type of Discharge _____

Exam History. Contact the appropriate examination entity (see instructions) and arrange to have a certified transcript of your scores sent **DIRECTLY** to this Board. See Fact Sheet for exam requirements. Please check all that apply:

___ FLEX ___ LMCC ___ National Board (NBME) X USMLE ___ NBOME/COMLEX

___ State Board Exam (prior to 1973) Which State? _____ Date(s) passed? _____

Applicant Name Sarah Traxler Last 4 digits of SSN _____ Date 4/28/2015

Proposed practice plans in Minnesota (if any): Obstetrics and Gynecology

Current* specialty board certification (check one):

____American Board of Medical Specialties
____Royal College of Physicians and Surgeons of Canada
____College of Family Physicians of Canada
____American Osteopathic Association Bureau of Professional Education
x___None of the above

Specialty_____
Issue Date_____
Expiration Date_____

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

US/Canadian Licensure Complete the attached "Licensure Verification" form and forward to US/Canadian board issuing any type of medical license including training, locum tenens, and temporary permit even if license is not current. Attach an additional sheet as necessary. The verifying entity must forward all documentation **DIRECTLY** to this Board. Some boards charge a fee for this information.

State Pennsylvania	License Number MD447970	Date Issued 02/27/2013
State Minnesota	License Number RP21850	Date Issued 6/8/2009
State_____	License Number_____	Date Issued_____
State_____	License Number_____	Date Issued_____
State_____	License Number_____	Date Issued_____
State_____	License Number_____	Date Issued_____
State_____	License Number_____	Date Issued_____

Countries (other than U.S. and Canada) in which you have ever been licensed:

Country_____	License Number_____	Date Issued_____
Country_____	License Number_____	Date Issued_____
Country_____	License Number_____	Date Issued_____

High school (attach a separate sheet, if necessary)

From (mo/yr) ___ High School _____
To (mo/yr): City _____ State ___ Country USA

College education (attach a separate sheet, if necessary)

From (mo/yr): 08/93 College Tulane University
To (mo/yr): 05/97 City New Orleans State LA Country USA

Applicant Name Sarah Traxler Last 4 digits of SSN ___ Date 4/28/2015

Activities (copy and attach additional pages as needed) List below **all medical and non-medical activities** beginning with your graduation from high school to the present date including periods of unemployment and military duty and excluding post graduate training listed on page 5. For any non-working time, state on the form what your activities were (e.g. vacation, seeking employment). If you did locum tenens, list facilities where you worked.

From (mo/yr): 05/93
To (mo/yr): 08/93
Activity
Address
City State Country USA
Position % Clinical %Administrative

From (mo/yr): 08/93
To (mo/yr): 05/97
Activity Tulane University - College
Address 6823 St. Charles Avenue
City New Orleans State LA Country USA
Position college student % Clinical %Administrative

From (mo/yr): 05/97
To (mo/yr): 08/97
Activity Vera Cruz Mexican Restaurant
Address 7537 Maple Street
City New Orleans State LA Country USA
Position waitress % Clinical %Administrative

From (mo/yr): 08/97
To (mo/yr): 10/98
Activity AmeriCorps VISTA - Texas Homeless Network
Address 1713 Fortview Road
City Austin State TX Country USA
Position VISTA volunteer % Clinical %Administrative 100

From (mo/yr): 10/98
To (mo/yr): 03/99
Activity Austin Independent School District
Address 1111 West 6th Street
City Austin State TX Country USA
Position substitute teacher % Clinical %Administrative

From (mo/yr): 03/99
To (mo/yr): 06/99
Activity Casa Xelaju
Address Callejon 15, D13-02 Zona 1
City Quetzaltenango State Country Guatemala
Position volunteer % Clinical %Administrative

From (mo/yr): 06/99
To (mo/yr): 08/99
Activity Travel
Address Mexico, Guatemala, Nicaragua, Honduras, Costa Rica, Panama
City State Country
Position % Clinical %Administrative

Applicant Name Sarah Traxler Last 4 digits of SSN Date 4/28/2015

Activities (copy and attach additional pages as needed) List below **all medical and non-medical activities** beginning with your graduation from high school to the present date including periods of unemployment and military duty and excluding post graduate training listed on page 5. For any non-working time, state on the form what your activities were (e.g. vacation, seeking employment). If you did locum tenens, list facilities where you worked.

From (mo/yr): 08/99
To (mo/yr): 03/00
Activity: People's Community Clinic - AmeriCorps
Address: 2909 N Interstate 35, Frontage Road
City: Austin State: TX Country: USA
Position: health educator % Clinical: 100 %Administrative:

From (mo/yr): 03/00
To (mo/yr): 07/00
Activity: LifeWorks Street Outreach - AmeriCorps
Address: 408 W. 23rd Street
City: Austin State: TX Country: USA
Position: AmeriCorps % Clinical: %Administrative:

From (mo/yr): 07/00
To (mo/yr): 07/02
Activity: LifeWorks Street Outreach
Address: 408 W. 23rd Street
City: Austin State: TX Country: USA
Position: HIV Specialist % Clinical: %Administrative:

From (mo/yr): 08/02
To (mo/yr): 06/04
Activity: Texas Homeless Network
Address: 1713 Fortview Road
City: Austin State: TX Country: USA
Position: Technical Assistance Coordinator % Clinical: %Administrative: 100

From (mo/yr): 08/04
To (mo/yr): 05/09
Activity: Oregon Health and Science University - Medical School
Address: 3181 SW Sam Jackson Park Road
City: Portland State: OR Country: USA
Position: Medical Student % Clinical: %Administrative:

From (mo/yr): 06/09
To (mo/yr): 06/13
Activity: University of Minnesota - Residency
Address: Mayo Mail Code 395, 420 Delaware Street SE
City: Minneapolis State: MN Country: USA
Position: OB/GYN Resident % Clinical: 100 %Administrative:

From (mo/yr): 07/13
To (mo/yr): present
Activity: University of Pennsylvania - Fellowship
Address: Dulles 5, 3400 Spruce Street
City: Philadelphia State: PA Country: USA
Position: Family Planning Fellow % Clinical: 50 %Administrative: 50

Applicant Name: Sarah Traxler Last 4 digits of SSN: Date: 4/28/2015

Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. If you are not using FCVS, you must complete the attached "Post graduate Training Verification" form and send to **all** postgraduate training programs you have attended. Submit a copy of your certificate of program completion. The post graduate program must forward the documentation **DIRECTLY** to this Board. Copy and attach additional pages if necessary

1. Hospital Name University of Minnesota Medical Center
Hospital Address 2450 Riverside Avenue
City Minneapolis State MN Zip Code 55454 Country USA
PGY: (e.g., 1, 2, 3, etc.) 1 Internship 2-4 Residency ___Fellowship ___Research ___Other
Department/Specialty Obstetrics and Gynecology
From 06 / 2009 To 06 / 2013 Successfully Completed? ___Yes ___No ___In Progress
Month Year Month Year

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2. Hospital Name Hospital of the University of Pennsylvania
Hospital Address 3400 Spruce Street
City Philadelphia State PA Zip Code 19104 Country USA
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___Residency 5-6 Fellowship ___Research ___Other
Department/Specialty Obstetrics and Gynecology/Family Planning
From 07 / 2013 To 06 / 2015 Successfully Completed? ___Yes ___No ___In Progress
Month Year Month Year

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3. Hospital Name _____
Hospital Address _____
City _____ State _____ Zip Code _____ Country _____
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___Residency ___Fellowship ___Research ___Other
Department/Specialty _____
From _____ / _____ To _____ / _____ Successfully Completed? ___Yes ___No ___In Progress
Month Year Month Year

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4. Hospital Name _____
Hospital Address _____
City _____ State _____ Zip Code _____ Country _____
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___Residency ___Fellowship ___Research ___Other
Department/Specialty _____
From _____ / _____ To _____ / _____ Successfully Completed? ___Yes ___No ___In Progress
Month Year Month Year

Applicant Name Sarah Traxler Last 4 digits of SSN ___ Date 4/28/2015

Certificate of Ethical and Moral Character

This certificate must be signed by **two** licensed physicians who are personally acquainted with the applicant.

1.

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
[signature]	4/28/15	MD451084	PA

Elizabeth Gurney
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

State: Pennsylvania County: Philadelphia

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 29th day of April 2015

Notary Public Signature Marian M Rossi

Expiration Date 06 / 19 / 2018
Month Day Year

party upon the photo

[signature]
Applicant's Signature

2.

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
[signature]	4/29/15	MD422192	PA

COURTNEY A. SCHREIBER
PRINT OR TYPE FULL NAME

Applicant Name Sarah Traxler Last 4 digits of SSN _____ Date 4/28/2015

Affidavit and Release

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

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

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

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

State of: Pennsylvania, County of: Philadelphia

Sworn to before me this 29th day of April, 2015.

Sarah Traxler — 4/29/2015

Signature of Applicant — Date of signature (must correspond to date of notarization)

Marian M Rossi

Signature of Notary Public

My Commission Expires: June 19, 2018

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
MARIAN M ROSSI
Notary Public
CITY OF PHILADELPHIA, PHILADELPHIA CNTY
My Commission Expires Jun 19, 2018

RIGHTS OF SUBJECTS OF DATA

The information on your application 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, omission or falsification of material fact, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

Applicant Name Sarah Traxler Last 4 digits of SSN _____ Date 4/28/2015

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
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MN Relay Service for Hearing Impaired (800) 627-3529

MALPRACTICE HISTORY REPORT

The Board is requires information on all malpractice suits. For each malpractice suit in which you have been named, complete the Malpractice Liability Claims Information form and submit insurance papers or other formal documentation of the outcome/status.

NAME AND ADDRESS OF PROFESSIONAL LIABILITY INSURER IN OTHER STATE:

1. Hennepin County Medical Center
2. Claire Schnurr Senior Paralegal 300 South Sixth Street
3. Hennepin County Attorney's office Minneapolis, MN 55487

NUMBER, DATE, AND DISPOSITION OF ANY MEDICAL MALPRACTICE SETTLEMENT OR AWARD RELATING TO THE QUALITY OF MEDICAL TREATMENT:*

Number	Date	Disposition
not yet assigned	9/30/2014	dismissed with no payment of damages

I hereby certify that the above is a true and accurate statement.

Print Name Sarah Traxler

Signature S. Traxler Date 5/4/2015

*If you have had no malpractice suits, write **NONE**, sign and date this form.

01/14

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4000

Date : 04/28/2015

Recipient:

Minnesota Board of Medical Practice
ATTN: Ruth A Martinez, MA, Executive Director
University Park Plaza
2829 University Ave SE, Suite 500
Minneapolis, MN 55414-3246

Examinee: Traxler, Sarah Ann
Alt Name(s):

Examinee ID#:
Date of Birth:

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
06/15/2006	Pass	226	(182)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
06/18/2007	Pass	235	(182)	

Clinical Skills (CS)*

Test Date	Pass/Fail	Total	MP	Comments
01/24/2009	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
MINNESOTA	10/18/2010	Pass	221	(187)	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

MINNESOTA BOARD OF MEDICAL PRACTICE

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CERTIFICATION OF MEDICAL EDUCATION

This form is for certification of medical education and must be completed and mailed by the facility directly to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name Sarah Traxler Birthdate /1975 Last 4 digits of SSN ____

Signature Sarah Traxler Date 4/28/2015

Date of Degree 5/2009 Degree Received MD

THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) Sarah Traxler

MATRICULATED IN:(Name of School) Oregon Health & Science University

AT:(Location of School) Portland, OR

AND RECEIVED A DIPLOMA CONFERRING:(Degree) Doctor of Medicine

ON:(Month, Day, Year) June 4, 2009

ANY DISCIPLINARY ACTION? Yes*_____ No X
(N/A is not an acceptable response)

ANY DEROGATORY INFORMATION ON FILE? Yes*_____ No X
(N/A is not an acceptable response)

School Seal**

President, Secretary, Dean, Registrar:
Print Name Bethany Kouba, Admin Coordinator (Registrar & Financial Aid office)
Signature Bethany Kouba
Date 5/12/15
Phone Number 503-494-7800
Fax Number 503-494-4629

*Please attach letter of explanation.

**If there is no school seal, attach letter of explanation on letterhead.

03/15

Oregon Health & Science University

To all whom this writing may come, Greetings:
Be it known that

Sarah Ann Traxler

having successfully completed the prescribed course of study and having complied with all other requirements established by the University, is granted the Degree of

Doctor of Medicine

by authority of the State of Oregon and is entitled to all the rights and privileges appertaining to that Degree. In Testimony Whereof the Oregon Health & Science University Board of Directors upon recommendation of the Faculty has granted this Diploma this 4th day of June, A.D., 2009.

Joe E Robertson
President, Oregon Health & Science University

Mark A Liebow MD
Dean, School of Medicine

OREGON HEALTH & SCIENCE UNIVERSITY

Keith F Thomas
Chairman of the Board

Patty M. Pollick
Provost

MINNESOTA BOARD OF MEDICAL PRACTICE

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VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

(Copy this form for multiple programs)

This form is for verification of all US/Canadian post graduate medical training (i.e. internship, residency and fellowship) and must be completed and mailed by the facility **DIRECTLY** to the **Minnesota Board of Medical Practice**. The applicant's signature authorizes release of information, favorable or otherwise, **DIRECTLY** to the Board.

Print Name Sarah Traxler Birthdate /1975 Last 4 digits of SSN ___

Signature Sarah Traxler Date 4/28/2015

Training Dates (Month,Day,Year) 07/01/2013 - 06/30/2015

This section is to be completed by the Program Director or Graduate Medical Education Representative

It is hereby certified that:(Name of Applicant) Sarah Traxler, MD

Received credit for post graduate training:(# Months) 24 from date: 7/1/13 to date: 6/30/15

The program was accredited to provide graduate, clinical, medical training during the dates above by: (Check One)
ACGME___ AOA___ RCPSC___ CFPC___ None of the above ✓ (explain) Unaccredited Fellowship

at:(Name of Hospital or Institution) Hosp. of the University of Pennsylvania

located at 3400 Spruce Street Philadelphia, PA 19104, USA
(Street Address, City, State, Zip, Country)

Affiliated Medical School Name University of Pennsylvania Specialty Family Planning PGY 5+6

Training Program (Check One): Internship___ Resident___ Chief Resident___ Fellowship ✓ Research___

Did the applicant complete all required years of the post graduate training program?
___Program was completed ✓ Anticipated date of completion 6/30/15
___Program was not completed because (will be)

Was this individual issued a certificate as proof completion of training? ..... Yes ✓ (in June) No ___
Did the individual take a leave of absence or break during training? ..... Yes* ___ No ✓
Was this individual ever placed on probation or remediation? ..... Yes* ___ No ✓
Was this individual ever disciplined or placed under investigation? ..... Yes* ___ No ✓
Were any limitations or special requirements placed upon this individual due to academic incompetence, disciplinary problems or any other reason? ..... Yes* ___ No ✓

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by Program Director or Graduate Medical Education Representative:

Print Name Courtney Schreiber, MD, MPH

Signature

Date April 29, 2015 Phone 215-615-6531

Fax 215-615-5319 Email cschreiber@obgyn.upenn.edu

*Attach letter of explanation

1/2011

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VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

(Copy this form for multiple programs)

This form is for verification of all US/Canadian post graduate medical training (i.e. internship, residency and fellowship) and must be completed and mailed by the facility **DIRECTLY** to the **Minnesota Board of Medical Practice**. The applicant's signature authorizes release of information, favorable or otherwise, **DIRECTLY** to the Board.

Print Name Sarah Traxler Birthdate '1975 Last 4 digits of SSN ____

Signature Sarah Traxler Date 4/28/2015

Training Dates (Month,Day,Year) 06/06/2009 - 06/06/2013

This section is to be completed by the Program Director or Graduate Medical Education Representative

It is hereby certified that:(Name of Applicant) Sarah Traxler

Received credit for post graduate training:(# Months)____ from date: 6/8/09 to date: 6/7/13

The program was accredited to provide graduate, clinical, medical training during the dates above by: (Check One)
ACGME ✓ AOA___ RCPSC___ CFPC___ None of the above___ (explain)____

at:(Name of Hospital or Institution) University of Minnesota

located at 420 Delaware St SE, MMC 395, Minneapolis, MN 55455
(Street Address, City, State, Zip, Country)

Affiliated Medical School Name U of MN Medical School Specialty ObGyn PGY 1-4

Training Program (Check One): Internship___ Resident X Chief Resident___ Fellowship___ Research___

Did the applicant complete all required years of the post graduate training program?
X Program was completed ___ Anticipated date of completion___/___/____

___Program was not completed because____

Was this individual issued a certificate as proof completion of training? ..... Yes ✓ No ____

Did the individual take a leave of absence or break during training? ..... Yes*____ No ✓

Was this individual ever placed on probation or remediation?..... Yes*____ No ✓

Was this individual ever disciplined or placed under investigation? ..... Yes*____ No ✓

Were any limitations or special requirements placed upon this individual due to academic incompetence, disciplinary problems or any other reason? ..... Yes*____ No ✓

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by Program Director or Graduate Medical Education Representative:

Print Name Phillip N. Rauk, MD

Signature ____

Date 5/13/15 Phone (612) 301-3417

Fax (612) 626-0665 Email raukx004@umn.edu

*Attach letter of explanation

1/2011

University of Minnesota

Department of Obstetrics, Gynecology and Women's Health

This certifies that

Sarah Traxler, M.D.

Has successfully completed and met all the requirements of the

Obstetrics and Gynecology Residency Program

At the University of Minnesota from

June 8, 2009 to June 7, 2013

In witness whereof, we have hereunto subscribed our names and affixed the seal of the University of Minnesota on this 7th day of June 2013

Linda F. Carson, M.D.
Department Chair

Phillip N. Rauk, M.D.
Program Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
POST OFFICE BOX 2649
HARRISBURG, PA 17105-2649
www.dos.pa.gov

05/04/2015

VERIFICATION/CERTIFICATION OF LICENSE

This is to certify that the individual named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	Traxler, Sarah
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE #:	MD447970
LICENSE STATUS:	Active
LICENSE ISSUE DATE:	02/27/2013
LICENSE EXPIRATION DATE:	12/31/2016
DISCIPLINARY HISTORY:	NO Disciplinary Action Exists

Ian J. Harlow, Acting Commissioner
Bureau of Professional and Occupational Affairs

MINNESOTA BOARD OF MEDICAL PRACTICE

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HOSPITAL PRIVILEGES VERIFICATION

As part of the medical license application process, the Minnesota Board of Medical Practice requires that this form be completed by each hospital where the applicant has held formal privileges within the last ten years. This form must be completed by each hospital listed on the Facilities List and mailed directly by each facility to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name Sarah Traxler Birthdate 1975 Last 4 digits of SSN _____

Signature Sarah Traxler Date 4/28/2015

THE HOSPITAL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) Sarah Traxler, MD

HAD HOSPITAL PRIVILEGES AT: (Name of Hospital) The Hospital of Univ. of Pennsylvania

LOCATED AT: (Address) 3400 Spruce, Phila, PA 19104

FROM: (Month, Day, Year) 7/1/13 **TO:** (Month, Day, Year) 6/30/15

TYPE OF PRIVILEGE: Fellow 1st yr; Attending Secondyear

ANY DISCIPLINARY ACTION? Yes* _____ No ✓

ANY DEROGATORY INFORMATION ON FILE? Yes* _____ No ✓

SEAL**

Print Name M. Allison Simpson
Signature MA Simpson
Title Admin Service Coord, OBG
Date 4/29/15
Phone 215-662-4144
Fax 215-349-5893

*Please attach letter of explanation.
**If there is no seal, attach letter of explanation on letterhead.

MINNESOTA BOARD OF MEDICAL PRACTICE

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MN Relay Service for Hearing Impaired (800) 627-3529

PHYSICIAN RECOMMENDATION FORM

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed on page 7 of the application. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name_____

Signature_____ Date_____

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Physician) Sarah Traxler

1. How long have you known the applicant? 2 years
2. What has been the nature of your relationship with the applicant? Colleague and teacher
3. How would you characterize the moral and professional conduct of the applicant? OUTstanding
4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine? Yes
5. Circle the word(s) which best describes this applicant.

A.	Marginal*	(Fully Meets Standards)	A. Clinical skills
B.	Yes*	(No)	B. Any indication of chemical dependency?
C.	Yes*	(No)	C. Any indication of malprescribing?

Completed By:
Print Name Steven Sondheimer MD Phone 2156623120
Address 3701 Market St, Philadelphia PA 19104
Signature Steven Sondheimer Date 4/29/2015

*Please attach letter of explanation.

01/02

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PHYSICIAN RECOMMENDATION FORM (1)

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed on page 9 of the application. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Applicant Print Name Sarah Traxler

Applicant Signature Sarah Traxler Date 4/28/2015

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant) Sarah Traxler

1. How long have you known the applicant? (22) ~~22~~ months
2. What has been the nature of your relationship with the applicant? fellowship director / supervisor
3. How would you characterize the moral and professional conduct of the applicant? Outstanding
4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine? Yes
5. Circle the word(s) which best describes this applicant.

A.	Marginal*	(Fully Meets Standards)	A. Clinical skills
B.	Yes*	(No)	B. Any indication of chemical dependency?
C.	Yes*	(No)	C. Any indication of malprescribing?

*Please attach letter of explanation.

Completed By:
Printed Name Courtney A. Schreiber Signed

Health Profession MD License # MD42492 State PA

Date 4/28/15 Phone# 215-615-6531 Fax 215-615-5319

Email Schreibe upenn.edu

01/14

AMA Physician Profile

Name and Mailing Address
SARAH ANN TRAXLER MD

Primary Office Address

3400 SPRUCE ST
PHILADELPHIA PA 19104-4238

Phone

Birth date 1975

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)

UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration date	Deactivation date	Reactivation date	Replacement number	Last reported date
1538301650	04/03/2009	NOT RPTD	NOT RPTD	NOT RPTD	04/25/2015

Current and/or historical medical school

OREGON HEALTH & SCIENCE UNIVERSITY SCHOOL OF MEDICINE

Degree Awarded: Yes

Degree Year: 2009

AMA AMERICAN MEDICAL ASSOCIATION

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
Sponsoring State: MINNESOTA
Program name: UNIVERSITY OF MINNESOTA PROGRAM
Specialty: OBSTETRICS & GYNECOLOGY
Dates: 06/2009 - 06/2013 (Verified)

If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or historical medical licensure

Jurisdiction	MD/ DO	Date granted	Expiration date	Status	License type	Last reported
PENNSYLVANIA	MD	02/27/2013	12/31/2016	ACTIVE	UNLIMITED	04/22/2015
MINNESOTA	MD	06/08/2009	06/07/2013	INACTIVE	RESIDENT	05/04/2015

ECFMG Certfication

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at https://cvsonline2.ecfmg.org/

AMA AMERICAN MEDICAL ASSOCIATION

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration date	Last Reported date	Address:
XXXXXX379	22N 33N 4 5	11/30/2015	05/04/2015	3400 Spruce St, Philadelphia, PA 19104-4238

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

AMA AMERICAN MEDICAL ASSOCIATION

Certifying board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate type:

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

Action notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Adminstration or the US Public Health Service.

AMA
AMERICAN
MEDICAL
ASSOCIATION

Additional Information

To date, there is no additional information for this physician on file.

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log onto our website (www.ama-assn.org/go/amaprofiles) and go to the order detail page. Select the 'D' following the physician's name and enter the data in questions. Or you can mark the issues on a copy of the profile and mail or fax to:

American Medical Association
Division of Database Products
Attn: Physician Products Portfolio
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

Fax: (312) 464-5900

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for: Minnesota Board of Medicine As of Date:5/12/2015

PRACTITIONER INFORMATION

Name:	Sarah Ann Traxler
DOB:	1975
Medical School:	Oregon Health and Science University School of Medicine Portland, Oregon, UNITED STATES
Year of Grad:	2009
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
PENNSYLVANIA	MD447970	2/27/2013	12/31/2016	4/23/2015

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	Minnesota Board of Medicine	As of Date:5/12/2015
Practitioner Name:	Sarah Ann Traxler	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

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the DataBank

P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb.hrsa.gov

5500000096553563
Process Date: 04/28/2015
Page: 1 of 1

To: TRAXLER, SARAH ANN

From: National Practitioner Data Bank
Re: Response to Your Self-Query

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended; Section 1921 of the Social Security Act; and Section 1128E of the Social Security Act.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners.

Section 1921 of the Social Security Act expanded the scope of the NPDB. Section 1921 was enacted to protect program beneficiaries from unfit health care practitioners, and to improve the anti-fraud provisions of federal and state health care programs. Section 1921 authorizes the NPDB to collect certain adverse actions taken by state licensing and certification authorities, peer review organizations, and private accreditation organizations, as well as final adverse actions taken by state law or fraud enforcement agencies (including, but not limited to, state law enforcement agencies, state Medicaid Fraud Control Units, and state agencies administering or supervising the administration of a state health care program), against health care practitioners, health care entities, providers and suppliers.

Section 1128E of the Social Security Act was added by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996. The statute established a national data collection program (formerly known as the Healthcare Integrity and Protection Data Bank) to combat fraud and abuse in health care delivery and to improve the quality of patient care. Section 1128E information is now collected and disclosed by the NPDB as a result of amendments made by Section 6403 of the Affordable Care Act of 2010, Public Law 111-148. Section 1128E information includes certain final adverse actions taken by federal agencies and health plans against health care practitioners, providers, and suppliers.

Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), and HRSA, Division of Practitioner Data Banks.

Reports from the NPDB contain limited summary information and should be used in conjunction with information from other sources in granting privileges, or in making employment, affiliation, contracting or licensure decisions. NPDB responses may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an exclusion from a federal or state health care program and an adverse licensure action). The NPDB is a flagging system, and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB is considered confidential and must be used solely for the purpose for which it was disclosed. Further, ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB web site (http://www.npdb.hrsa.gov) or contact the NPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB Customer Service Center is closed on all Federal holidays.

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

the DataBank

P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb.hrsa.gov

5500000096553563
Process Date: 04/28/2015
Page: 1 of 1

TRAXLER, SARAH ANN - SELF-QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: TRAXLER, SARAH ANN
Date of Birth: /1975 **Gender:** FEMALE
Work Address:
Social Security Number: **DEA:**
NPI: 1538301650
License: PHYSICIAN (MD), MD447970, PA, OBSTETRICS & GYNECOLOGY
Professional School(s): OREGON HEALTH AND SCIENCE UNIVERSITY (2009)

B. PAYMENT INFORMATION

Credit Card Information:
NPDB Charge: $5.00* **NPDB Bill Reference Number:** N36879808
* Each charge will appear separately on your credit card statement.
Transaction Date: 04/28/2015 **Additional Paper Copies Requested:** 0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 04/28/2015

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are enclosed for restricted/limited use as prescribed by statutes listed on the preceeding cover page.

---------- **No Reports Found** ----------

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FACILITIES LIST

The Board requires a list of all facilities where you have had medical privileges during the last 10 years. List any facility where you are getting (have been) paid outside a post graduate internship, residency or fellowship training program. Submit a Hospital Privilege Form to each facility listed except those clinics which are strictly outpatient. If you have had no privileges, write **NONE** and sign and date the form.

CURRENT PRIVILEGES

Facility	City and State	Type of Privilege
Hospital of the University of Pennsylvania	Philadelphia, PA	full admitting, surgical and treatment privileges

PAST PRIVILEGES (LAST 10 YEARS)

Facility	City and State	Type of Privilege

I hereby certify that the above is a true and accurate list of inpatient and outpatient facilities at which I have (have had) medical privileges.

Print Name Sarah Traxler

Signature S. Traxler Date 4/28/2015

01/14

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ADDENDUM TO APPLICATION

1. BUSINESS ADDRESS

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide their primary business address at the time of initial application and all subsequent renewals. Your primary business address is public and you are required to submit it for application purposes. Your license will not be issued without it unless you check the box below certifying that you are not currently in the workforce related to your practice.

Facility name Hospital of the University of Pennsylvania

Street Address 5 Dulles, 3400 Spruce Street

City Philadelphia State PA Zip 19104

___I certify that I am not currently in workforce related to my practice, and I don't have a business address related to my practice.

2. MILITARY STATUS

Are you or your spouse returning from active military duty (discharged less than 6 months ago) or still in active military duty?

X No ___Yes. If discharged, please provide discharge date: _____

3. CRIMINAL CONVICTIONS

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has be conviction of a felony or gross misdemeanor occurring on or after July 1, 2013 in any state or jurisdiction. This information shall be posted for new licensees issued a license on or after July 1, 2013 and for current licensees upon license renewal occurring on or after July 1, 2013. This information is public and you are required to submit it for application purposes. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.

If you have more than one item to report please attach additional sheets.

Conviction Date (mm/dd/yyyy): _____

Conviction Type (Check one): O Felony O Gross misdemeanor

Crime Description: _____

City: _____ State: _____ County: _____ Country: _____

Sentence: _____

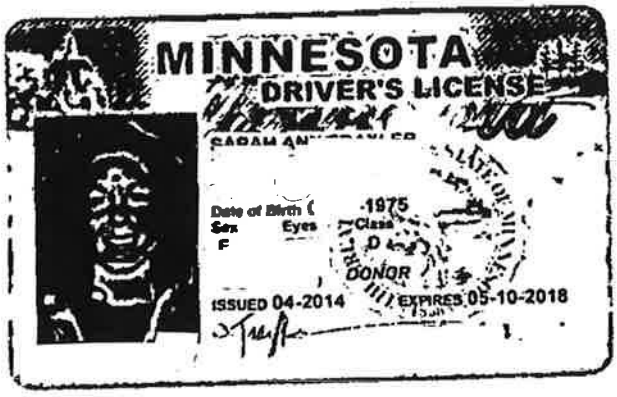
_____

X I certify that I have had no convictions on or after July, 1, 2013

Applicant Name Sarah Traxler Last 4 digits of SSN _____ Date 4/28/2015

Sarah Traxler

1/14



I have seen the original documents presented to me by Sarah Trapler on April 29th and certify that this is a true copy.

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
MARIAN M ROSSI
Notary Public
CITY OF PHILADELPHIA, PHILADELPHIA CNTY
My Commission Expires Jun 19, 2018

Marian M Rossi
Notary Public
April 29, 2015

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Treating Physician Statement

Applicant: Applicants who have a medical condition during the last five years which, if untreated, would be likely to impair their ability to practice with reasonable skill and safety must have their treating physician complete this form. A treating physician is the physician who diagnosed and provides or provided treatment for the condition and includes the current treating physician. **If not applicable, write "not applicable" on the form and submit with the application.**

Treating Physician: Complete and mail this form directly to the Minnesota Board of Medical Practice. This form is also available on our website.

Applicant's Printed Name NOT APPLICABLE

Applicant's Date of Birth (Mo/Day/Yr)_____ Health Profession_____

I hereby authorize you, my treating physician, to disclose my medical records to the Minnesota Board of Medical Practice. 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 oral information or documents, records, or other information to the Board.

Signed_____ Date_____

Nature of medical condition including diagnosis and significant symptoms

Date first saw patient: _____ **Date last saw patient:** _____

Has the applicant been compliant with treatment? (If no, please explain)
☐ Yes ☐ No

What medications is the applicant taking for this condition?

If this medical condition was untreated, would it be likely to impair the applicant's ability to practice with reasonable skill and safety? (If yes, please explain) ☐ Yes ☐ No

Should the condition be monitored? (If yes, please explain) ☐ Yes ☐ No

Treating Physician (print name)_____

Signature_____ Date_____

Phone_____ Fax_____

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PHYSICIAN VERIFICATION OF LICENSURE

(Copy this form for multiple licenses)

This form is for verification of all medical licenses from every U.S./Canadian board issuing any type of license including training, locum tenens, and temporary permit even if license is not current. Each Board completing the form must mail directly to the **Minnesota Board of Medical Practice**. Any fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board. Verifications through VeriDoc are also accepted. Log on to www.veridoc.org and follow the onscreen instructions.

Print Name Sarah Traxler _____ Last 4 digits of SSN _____

Signature Sarah Traxler _____ Date 4/28/2015

License Number RP21850 _____ Birthdate 1975

THE STATE BOARD COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician)_____

DATE OF BIRTH: (Month, Day, Year)_____

WAS ISSUED LICENSE NUMBER:_____

BY: (state)_____ **ON:** (Month, Day, Year)_____

EXPIRATION DATE: (Month, Day, Year) _____

ISSUED ON THE BASIS OF: (Exam)_____

DISCIPLINARY ACTION EVERY INITIATED, PENDING, OR INVOKED*: (Yes/No)_____

EVER VOLUNTARILY RELINQUISHED MEDICAL LICENSE*: (Yes/No)_____

ANY DEROGATORY INFORMATION WHICH YOU CAN RELEASE*: (Yes/No)_____

Print Name_____

Signature_____

Title_____

Date_____

Phone_____

*If yes, please attach letter of explanation on letterhead.
**If there is no seal, attach letter of explanation on letterhead.
NOTE TO APPLICANT: Most states charge a fee for this service.

03/14

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June 22, 2015

Sarah A. Traxler, M.D.
671 Vandalia St
St. Paul, MN 55114

Dear Dr. Traxler:

We have received your application for Minnesota medical licensure, required supporting documentation, application fee and an additional remittance with a request for a Temporary Permit. Both fees, under Minnesota Statute, are non-refundable.

The Board will next consider candidates at the September 12, 2015 Board meeting.

Your application and supporting materials have been reviewed. You are hereby granted TEMPORARY PERMIT 108331 on June 22, 2015 to practice medicine in the State of Minnesota. Once approved, your permanent license will become effective September 12, 2015.

Temporary Permits are only issued once and are valid only until the next scheduled Board meeting date.

Sincerely,

Ruth M. Martinez
Executive Director

RMM: PEL

Temporary Permit Number: 108331

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TEMPORARY PERMIT APPLICATION

A temporary permit is available for physicians who have applied for permanent licensure and have complied with all requirements and wish to practice prior to the next regularly scheduled Board meeting. Upon request, a temporary permit will be issued after eligibility for licensure has been established and the credentialing and verification process has been completed. This process may take several weeks. The Board may, at it's discretion, issue a temporary permit under the above conditions. A temporary permit is valid only until the next Board meeting at which your application would be considered.

Applicants requesting a temporary permit must complete this form and submit a non-refundable $60 fee in U.S. currency. Please make checks payable to the **Minnesota Board of Medical Practice.**

NAME (Please print) Sarah Traxler Birthdate /1975

TEMPORARY PERMIT WILL BE USED AT THE FOLLOWING PROPOSED PRACTICE LOCATION:

Planned Parenthood Minnesota, North Dakota, South Dakota
(Hospital/Clinic)

617 Vandalia Street
(Address)

Saint Paul, MN 55114
(City, State, Zipcode)

PROFESSIONAL TELEPHONE NUMBER (including area code) 651-698-2406

ANTICIPATED DATE OF COMMENCING PRACTICE AT PROPOSED PRACTICE LOCATION: 08/17/2015

MAILING ADDRESS FOR TEMPORARY PERMIT:

3/14

Online Service History Detail

(Use Back button to return to summary page)

User Name: Sarah Traxler Start Date: 4/12/2016 8:52:55 AM
Service Name: License Renewal - PY Complete Date: 4/12/2016 9:07:29 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	4/12/2016 8:53:04 AM	• Please read notice and then answer.
1	Information	4/12/2016 8:53:12 AM	
2	Verify Information	4/12/2016 8:54:01 AM	
3	Privileges & Continuing Medical Education	4/12/2016 8:54:34 AM	• Enter hospital staff privileges or check the 'I have no hospital staff privileges' checkbox Click Add when done entering in hospital staff privilege
3	Privileges & Continuing Medical Education	4/12/2016 8:54:54 AM	
4	Practice Questions	4/12/2016 8:56:41 AM	
5	Profiling - Practice Addresses	4/12/2016 8:57:55 AM	• Primary Practice Address County
5	Profiling - Practice Addresses	4/12/2016 8:58:09 AM	
5	Profiling - Post Graduate Training	4/12/2016 8:58:53 AM	
5	Profiling - Post Graduate Training	4/12/2016 8:58:53 AM	
5	Profiling - ABMS/AOA	4/12/2016 8:59:19 AM	
5	Profiling - ABMS/AOA	4/12/2016 8:59:19 AM	
5	Profiling - Criminal Convictions	4/12/2016 8:59:26 AM	
6	Review	4/12/2016 8:59:50 AM	
7	Prescription Monitoring Program Registration	4/12/2016 8:59:54 AM	
9	Payment	4/12/2016 9:05:58 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 59828
Name: Sarah Ann Traxler

Drivers License:
Is license current? Yes

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

Phone: (651) 696-5534
Email Address: straxler@ppmns.org
Web Site:

Private Address:

Phone:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
University of Minnesota, Fairview Riverside	Minneapolis	MN	Gynecology

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 05/31/2019.

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name: Sarah Traxler
Service Name: License Renewal - PY
Start Date: 4/11/2017 8:36:04 AM
Complete Date: 4/11/2017 8:47:24 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	4/11/2017 8:36:12 AM	
2	Verify Information	4/11/2017 8:36:28 AM	
3	Privileges & Continuing Medical Education	4/11/2017 8:36:41 AM	
4	Practice Questions	4/11/2017 8:37:44 AM	
5	Profiling - Practice Addresses	4/11/2017 8:37:57 AM	PracticeAddress
5	Profiling - Post Graduate Training	4/11/2017 8:38:37 AM	PostGrad • Start Year must be 4 digits • End Year must be 4 digits
5	Profiling - Post Graduate Training	4/11/2017 8:39:08 AM	PostGrad
5	Profiling - Post Graduate Training	4/11/2017 8:39:18 AM	Bypass Case
5	Profiling - Post Graduate Training	4/11/2017 8:39:18 AM	
5	Profiling - ABMS/AOA	4/11/2017 8:39:32 AM	
5	Profiling - ABMS/AOA	4/11/2017 8:39:32 AM	
5	Profiling - Criminal Convictions	4/11/2017 8:39:39 AM	
6	Review	4/11/2017 8:40:10 AM	
7	Prescription Monitoring Program Registration	4/11/2017 8:40:33 AM	• Please select a Health Profession Type • Please enter a valid DEA number • The email addresses provided must match
7	Prescription Monitoring Program Registration	4/11/2017 8:40:57 AM	• Please select a Health Profession Type • Please enter a valid DEA number • The email addresses provided must match
7	Prescription Monitoring Program Registration	4/11/2017 8:41:26 AM	
7	Prescription Monitoring Program Registration	4/11/2017 8:41:26 AM	PMP Submitted Successfully: 4/11/2017 8:41:26 AM
7	Prescription Monitoring Program Registration	4/11/2017 8:41:33 AM	
9	Payment	4/11/2017 8:45:35 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 59828
Name: Sarah Ann Traxler

Drivers License:
Is license current? Yes

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

Phone: (651) 696-5534
Email Address: straxler@ppmns.org
Web Site:

Private Address:

Phone:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
University of Minnesota, Fairview Riverside	Minneapolis	MN	Gynecology

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 05/31/2019.

Online Service History Detail

(Use Back button to return to summary page)

User Name: Sarah Traxler Start Date: 3/29/2018 2:25:21 PM
Service Name: License Renewal - PY Complete Date: 4/17/2018 12:45:59 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	3/29/2018 2:25:25 PM	• Please read notice and then answer.
1	Information	3/29/2018 2:25:30 PM	
2	Verify Information	3/29/2018 2:25:41 PM	
3	Privileges & Continuing Medical Education	3/29/2018 2:26:07 PM	
4	Practice Questions	3/29/2018 2:26:54 PM	
5	Profiling - Practice Addresses	3/29/2018 2:27:02 PM	PracticeAddress
5	Profiling - Post Graduate Training	3/29/2018 2:27:08 PM	Bypass Case
5	Profiling - Post Graduate Training	3/29/2018 2:27:08 PM	
5	Profiling - ABMS/AOA	3/29/2018 2:27:13 PM	
5	Profiling - ABMS/AOA	3/29/2018 2:27:13 PM	
5	Profiling - Criminal Convictions	3/29/2018 2:27:17 PM	
6	Review	3/29/2018 2:27:31 PM	
7	Prescription Monitoring Program Registration	3/29/2018 2:28:11 PM	• Please select a Health Profession Type
7	Prescription Monitoring Program Registration	3/29/2018 2:28:46 PM	
7	Prescription Monitoring Program Registration	3/29/2018 2:28:46 PM	PMP Submitted Successfully: 3/29/2018 2:28:46 PM
7	Prescription Monitoring Program Registration	3/29/2018 2:28:51 PM	
2	Verify Information	4/17/2018 12:39:05 PM	
3	Privileges & Continuing Medical Education	4/17/2018 12:39:18 PM	
4	Practice Questions	4/17/2018 12:39:23 PM	
5	Profiling - Practice Addresses	4/17/2018 12:39:31 PM	PracticeAddress
	1 2		

Verification Page

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Application for License Renewal

License Number: PY 59828
Name: Sarah Ann Traxler

Drivers License:
Is license current? Yes

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

Phone: (651) 696-5534
Email Address: straxler@ppmns.org
Web Site:

Private Address:

Phone:

Hospital Staff Privileges

Facility	City	State	Type of Privilege
University of Minnesota, Fairview Riverside	Minneapolis	MN	Gynecology
Regions Hospital	Saint Paul	MN	Gynecology

Continuing Education

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Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Minnesota.gov

Tuesday, June 12, 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: Sarah Ann Traxler New Search

License: Physician and Surgeon - #59828 Print

Licensee Public Information

Licensure Designated Address: 671 Vandalia St
St. Paul, MN 55114

Web Site:

E-mail: straxler@ppmns.org

Birth Year: 1975

Gender: Female

License Information

License Number:	59828	**License Type:**	Physician and Surgeon
Expiration Date:	05-31-2019	**Grant Date:**	09-12-2015
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:	OREGON HEALTH SCIENCES UNIVERSITY, SCHOOL OF MEDICINE (FORMERLY UNIVERSITY OF OREGON, SCHOOL OF MEDICINE), PORTLAND USA	**Degree:**	M.D.
Location:	Portland, OR USA	**Date:**	06/04/2009

Practice Locations (Self-Reported Information)

Primary Location: Planned Parenthood of Minnesota, North Dakota, South Dakota
671 Vandalia Street
St. Paul, MN 55114
Phone: 651-696-5534

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 Pennsylvania	Family Planning	07/01/2013	06/30/2015	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

Print

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

Print

Profile Retrieved on 6/12/2018 12:32:54 PM

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