ORTH DAKOTA
oard of Medicine

DEC 3 1 2015

Application for License to Practice Medicine

If you will be away from your computer for any period of time after starting your online application, it is strongly advised that you click on the "Save for Later" button located at the bottom of each page to minimize the risk of losing the application data that you have already input into the system. You can then log back into the application at a later time by clicking on "Continue Saved Application" located in the New Applicants section.

Note: For healthcare staffing firms or others facilitating this application for the applicant, please provide your contact information:

Name of Contact: **Company:**

Telephone: **Email:** Example: account@domain.com

Example: (000) 000-0000

PT 14130

FCVS is a service of the Federation of State Medical Boards that, for a fee, provides primary source verification of core credentials for physicians applying for a medical license. It is accepted, but not required, by the North Dakota Board of Medicine. For further information about FCVS, click here.

Please choose one of the following:

- ○ I will be using the Federation's Credentialing Verification Service (FCVS).
- ◉ I will NOT be using the Federation's Credentialing Verification Service (FCVS).

Biographical Information

First Name: Sarah **Middle Name:** Ann **Last Name:** Traxler **Title:** MD

Other Names Used:

First Name: Middle Name: Last Name:

Click here to add fields for additional names used.

Cell Phone: [redacted] **Gender:** Female

Example: (000) 000-0000

Place of Birth: [redacted] Please list city, state or province and country.

Date of Birth: [redacted]

Height: [redacted] feet [redacted] inches **Weight:** [redacted] pounds

Eye Color: [redacted]

Hair Color: Brown **Social Security #:** [redacted]

Example: 000-00-0000

DEA Registration #: [redacted] **Identifying Marks:**

Business Address:

Address Line 1: [redacted] **Address Line 2:** **City:** [redacted] **State/Province:** [redacted]

Zip/Postal Code: [redacted] **Phone:** [redacted]

Example: (000) 000-0000

Email: [redacted]

Example: account@domain.com

Home Address:

Address Line 1: [redacted] **Address Line 2:** **City:** [redacted]

State/Province: [redacted] **Zip/Postal Code:** [redacted] **Country:** USA

Phone: [redacted]

Example: (000) 000-0000

Email: [redacted]

Example: account@domain.com

Mail Preference:

- ◉ I prefer to receive mail (letters) at my business address.
- ○ I prefer to receive mail (letters) at my home address.

Email Preference:

- ◉ I prefer to receive email at my business address.
- ○ I prefer to receive email at my home address.

NORTH DAKOTA
Board of Medicine

Application for License to Practice Medicine

Intended Place of Practice

Name and address of hospital, clinic, or office where you intend to practice:

Planned Parenthood Minnesota, North Dakota . St Paul, MN

Anticipated Start Date: 01/01/2016

Example: mm/dd/yyyy

Specialty Information

Please list any specialties:

Specialty	ABMS/AOA Certified
Obstetrics and Gynecology	(•) Yes ( ) No

You may upload copies of American Board certificate(s) and/or Canadian Board certificate(s) by clicking here.
Click here to view the recently uploaded file.
Click here to view the recently uploaded file.
Click here for recommendations on uploading files.

ECFMG

Complete the Request for Status Report of ECFMG certification forms and submit to the ECFMG office with the required fee OR make your request online at www.ecfmg.org.

Are you a graduate of a medical school located in the United States, Canada, Australia, New Zealand or the United Kingdom or have you completed a 5th pathway program? (•) Yes ( ) No

Licensing Examination

Choose only one option and request the appropriate organization to send your examination scores to the North Dakota Board of Medicine. *Note: An applicant is permitted a maximum of three attempts to pass each step, part or component of a licensing examination and all steps, parts, or components must be passed within a 7-year time period.* To view exceptions to this rule, click here.

I am applying for licensure in North Dakota based on:

(•) **A. USMLE** Step 1 2 3

Contact the Federation of State Medical Boards at their website http://www.fsmb.org for instructions on how to electronically request transcripts or to download an EBAHR report request form. The EBAHR must be sent directly to the North Dakota Board of Medicine by the FSMB office.

( ) **B. COMLEX or NBOME**

Contact the National Board of Osteopathic Medicine at their website http://www.nbome.org; 8765 W Higgins Rd, Suite 200, Chicago, IL 60631-4101; Phone 773-714-0622; E-mail admin@nbome.org; Fax 773-714-0631; to request that a certified transcript of your scores be sent directly to the North Dakota Board of Medicine.

( ) **C. LMCC**

Contact the Medical Council of Canada at their website http://www.mcc.ca; PO Box 8234, Station T, Ottawa, Ontario, Canada K1G 3H6, Phone 613-738-0372, Fax 613-521-9417; to request an Endorsement of Licentiate Status. The Endorsement of Licentiate Status must be sent directly to the North Dakota Board of Medicine by the Medical Council of Canada office.

( ) **D. FLEX**

Contact the Federation of State Medical Boards at their website http://www.fsmb.org; 400 Fuller Wiser Rd, Suite 300; Euless, TX 76039; Phone 817-868-4041 for instructions on how to electronically request transcripts or to download an EBAHR report request form. The EBAHR must be sent directly to the North Dakota Board of Medicine by the FSMB office.

( ) **E. National Boards**

Contact the National Board of Medicine at their website http://www.nbme.org to request an Endorsement of Certification. You may also reach the NBME via phone (215) 590-9700 or e-mail - scores@nbme.org. The Endorsement of Certification must be sent directly to the North Dakota Board of Medicine by the NBME office.

( ) **F. State Constructed Exam**

Contact the state licensing board for which you took a state-constructed written exam (prior to the advent of Exam FLEX or USMLE) to request that they send an official transcript of your written exam scores directly to our office.

( ) **G. A combination of portions of FLEX, NBME, or USMLE, specifica**

NBME Parts I, II, III administered by the NBME - See Item E above.

NBME Parts I, II, III administered by the ECFMG - Contact the Educational Council for Foreign Medical Graduates at their website http://www.ecfmg.org; 3624 Market St., Philadelphia, PA 19104; Phone 215-386-5900; for instructions on how to request an Endorsement of NBME Certification. The Endorsement of Certification must be sent directly to the North Dakota Board of Medicine by the ECFMG office.

FLEX and USMLE - See Item A or Item D above.

SUBMIT & CONTINUE | SAVE FOR LATER | CANCEL & EXIT

NORTH DAKOTA
Board of Medicine

Application for License to Practice Medicine

Medical Licenses

List all medical licenses (i.e., permanent, temporary, locum tenens, resident, etc.) you have ever applied for in the U.S. or Canada, whether or not the license was granted. You must direct the licensing board of every state/province where you have ever applied for any type of medical license **(regardless of whether the license was granted or not granted, is active or inactive, temporary or permanent, restricted or unrestricted)** to provide us with a verification of your licensure status. License verifications may also be requested electronically. Verification requests and participating boards can be accessed at http://www.veridoc.org.

State/Province:	Year Issued or Denied:	Number: (as it appears on the license)	License Status:
MINNESOTA	2009	RP21850	Inactive
MINNESOTA	2015	59828	Active
PENNSYLVANI	2013	MD447970	Active
SOUTH DAKOT	2015	9597	Active

Click here to add fields for additional license information.

AMA
FSD
BC

Professional Training and Experience

List in chronological order all professional education and experience including college and/or university, medical school, internship, residencies, and practice locations. Include an explanation of your primary activity during **all** periods of time from the beginning of your professional education to the present, whether or not you were engaged in activities related to medicine. If your education or training was interrupted for any reason, you will be prompted at the end of this section to explain the gap in chronological order. **A curriculum vitae will not be accepted in lieu of completion of this section.** You must include **every** health care facility at which you have ever practiced, applied for privileges, or held privileges.

Undergraduate/Graduate Studies:

Start Date:	End Date:	University:	City & State:	Degree or Certificate:
08 / 1993	05 / 1997	Tulane University	New Orleans, LA	Bachelor of Arts
07 / 2013	05 / 2015	University of Pennsylvania	Philadelphia, PA	Master of Science in Health Policy

Click here to add fields for additional undergraduate information.

Medical School(s):

Start Date:	End Date:	Medical School:	City & State:	Degree:	Date Rec'd:
08 / 2004	05 / 2009	Oregon Health and Sciences University	Portland, OR	MD	06/04/2009 mm/dd/yyyy

Click here to add fields for additional medical schools.

You may upload a copy of medical school diploma, and English translation if necessary, by clicking here.
Click here for recommendations on uploading files.

Postgraduate Training:

Start Date:	End Date:	Training Program:	City & State:	Specialty:	Nature of Training:
06 / 2009	06 / 2013	University of Minnesota	Minneapolis, MN	Obstetrics and Gynecology	Residency
07 / 2013	06 / 2015	University of Pennsylvania	Philadelphia, PA	Other Other Specialty?: Family Planning	Fellowship

non accredited.

Click here to add fields for additional postgraduate training.

You may upload copies of internship, residency and/or fellowship certificates by clicking here.
Click here for recommendations on uploading files.

Locum Tenens:

Have you worked with or are you currently working with any locum tenens companies? ○ Yes ◉ No

Employment/Privileges & Other Activities:

Start Date:	End Date:	Employer:	City & State:	Nature of Experience:
08 / 1997	10 / 1998	Texas Homeless Network	Austin, TX	AmeriCorps VISTA
11 / 1998	06 / 1999	Casa Xelaju	Guatemala	Education Volunteer, Spanish Translator
07 / 1999	06 / 2002	LifeWorks Street Outreach	Austin, TX	HIV Specialist
07 / 2002	06 / 2004	Texas Homeless Network	Austin, TX	Technical Assistance Coordinator

Click here to add fields for additional employment information.

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7/15-8/15- Traveling the country w/ family ~ no employment
6/15-Pres - Planned Parenthood; MN, ND, SD; St Paul, MN

NORTH DAKOTA
Board of Medicine

Application for License to Practice Medicine

Personal Information

If any of the questions below are answered "yes", you will be required to provide full details.

A. Have you ever failed a licensing examination or any component of a *licensing* examination for a medical license or for any other professional license? (You must answer "yes" even if you later passed the test or component. This question applies only to *licensing* examination - USMLE, COMLEX, NBOME, LMCC, FLEX - not board certification examinations.)	○ Yes	◉ No
B. Have you ever had an application for a professional license denied?	○ Yes	◉ No
C. Have you ever been investigated by any licensing board, agency, professional association or medical facility?	○ Yes	◉ No
D. Have you ever been disciplined by any licensing board, agency, professional association or medical facility?	○ Yes	◉ No
E. Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, taken a leave of absence or been placed on probation or reprimanded at a medical school or postgraduate training program?	◉ Yes	○ No
F. Have you ever been subject to informal or formal proceedings by any licensing board, agency or professional association to revoke, suspend, restrict, deny or limit a professional license?	○ Yes	◉ No
G. Have you ever been subject to informal or formal proceedings which might have resulted in the surrender of a state and/or federal narcotic registration certificate?	○ Yes	◉ No
H. Have you ever had hospital and/or clinic privileges denied, removed or restricted, or limitations imposed on such privileges or resigned hospital and/or clinic privileges to avoid formal action?	○ Yes	◉ No
I. Are you now or have you ever been named as a defendant or respondent in any malpractice proceeding?	◉ Yes	○ No
J. Have you ever been convicted of any crime, felony or misdemeanor? (You must answer "yes", even if the imposition of sentence was deferred and the crime was later dismissed.)	○ Yes	◉ No
K. Have you ever been arrested for, or charged with, any crime?	○ Yes	◉ No
L. Within the past five years have you had or have you been admitted to any hospital or other inpatient care facility for any physical, mental or emotional condition which impaired or could be said to impair your ability to practice safely and competently?	○ Yes	◉ No
M. Do you currently have or within the past five years have you had a dependency on the use of alcohol or drugs which impaired or does impair your ability to practice medicine competently?	○ Yes	◉ No
N. Within the past five years, have you engaged in the excessive or habitual use of alcohol or drugs or received any treatment for alcoholism or excessive or illegal drug use?	○ Yes	◉ No

SUBMIT & CONTINUE | SAVE FOR LATER | CANCEL & EXIT

NORTH DAKOTA
Board of Medicine

Application for License to Practice Medicine

Personal Information

Please provide details and/or upload documentation to explain each question with a "yes" answer.

Alternatively, you may fax your documentation to 701-328-6505. Please note your intention to fax your documentation in the field below.

Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, taken a leave of absence or been placed on probation or reprimanded at a medical school or postgraduate training program?

My son was born on 7/20/2007 and thus between third and fourth year of medical school, from 6/2007 to 6/2008, I took a leave of absence for maternity leave. I returned for

You may upload a file by clicking here. Click here for recommendations on uploading files.

Are you now or have you ever been named as a defendant or respondent in any malpractice proceeding?

In October 2014, I was named as a defendant in a case from my residency training. The plaintiff claimed that negligence in her pregnancy led to infection during her

You may upload a file by clicking here. Click here to view the recently uploaded file. Click here for recommendations on uploading files.

SUBMIT & CONTINUE | SAVE FOR LATER | CANCEL & EXIT

NORTH DAKOTA
Board of Medicine

Application for License to Practice Medicine

Personal References

Please provide the names of two licensed physicians who have known you personally for **one year or more**, are willing to attest to your ethical and moral character, and are willing to furnish additional information to the North Dakota Board of Medicine. (Family members or physicians in the practice group you are joining will not be accepted.)

A.
Name: Susan Willson Title: MD
Address: 4735 Ogletown-Stanton Road, Medical Arts Pavilion, Suite 1109 City: Newark
State or Province: DELAWARE Zip: 19713
Email: susan.f.wilson@gmail.com Example: account@domain.com
Phone: Example: (000) 000-0000
Fax: Example: (000) 000-0000

B.
Name: Elizabeth Gurney Title: MD
Address: 1000 Courtyard, 3400 Spruce Street City: Philadelphia
State or Province: PENNSYLVANIA Zip: 19104
Email: gurney.liz@gmail.com Example: account@domain.com
Phone: Example: (000) 000-0000
Fax: Example: (000) 000-0000

Certification of Application

☑

By checking this box, I certify that:

I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of the State of North Dakota; that I am the person named in the copy of the diploma which accompanies this application; that I am the lawful holder of said diploma; and that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, all medical institutions or organizations, all medical schools and postgraduate training programs, 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 required by the Board for its evaluation of my professional, ethical and physical qualifications for licensure in the State of North Dakota.

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 denial, suspension or revocation of my license to practice medicine in the State of North Dakota.

I agree that:

If any of the information supplied on this application form changes, or becomes inaccurate or incomplete before I am granted a license to practice medicine in North Dakota, I will immediately provide the corrected information to the North Dakota Board of Medicine.

Failure to provide such corrected information to the Board will constitute the use of a fraudulent, deceitful, dishonest, or immoral practice in connection with the North Dakota licensing requirements and will, therefore, be a violation of Sec. 43-17-31, NDCC, which will subject me to disciplinary action or denial of licensure.

Photograph

You may **upload a scanned or digital photograph** by clicking here. If you choose to submit a photograph via U.S. mail, please follow these instructions.

The photos **must** be:

a. Original passport quality photographs. No computer scanned or polaroid photographs with thick backing.

b. Close-up front view of head and shoulders (not a profile).

c. No larger than 2" X 3" and no smaller than 2" X 2" and

d. taken within **90-120 days** prior to filing this application.

Name Changes

If your name differs from that on any of your documents, please provide documentation of this change.

You may upload notarized copies of marriage certificate or legal name change document by clicking here.
Click here for recommendations on uploading files.

AGREEMENT TO UPDATE APPLICATION INFORMATION:

By signing this section of the North Dakota Board of Medical Examiners license application form, I agree that:

If any of the information supplied on this application form changes, or becomes inaccurate or incomplete before I am granted a license to practice medicine in North Dakota, I will immediately provide the corrected information to the North Dakota Board of Medical Examiners.

Failure to provide such corrected information to the Board will constitute the use of a fraudulent, deceitful, dishonest, or immoral practice in connection with the North Dakota licensing requirements and will, therefore, be a violation of Sec. 43-17-31, NDCC, which will subject me to disciplinary action or denial of licensure.

Sarah Traxler

SIGNATURE OF APPLICANT

AFFIDAVIT:

I, Sarah Traxler, swear that

(Name of Applicant)

I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of the State of North Dakota; that I am the person named in the copy of the diploma which accompanies this application; that I am the lawful holder of said diploma; and that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, all medical institutions or organizations, all medical schools and postgraduate training programs, 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 required by the Board for its evaluation of my professional, ethical and physical qualifications for licensure in the State of North Dakota.

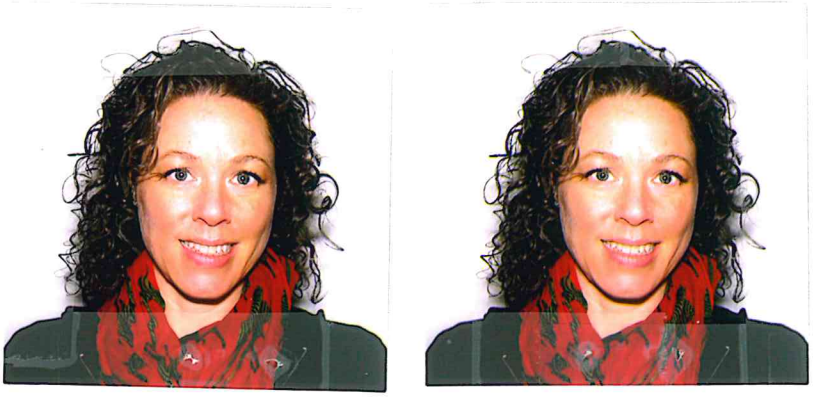
I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine in the State of North Dakota.

Sarah Traxler

SIGNATURE OF APPLICANT

12/30/2015

DATE



explainE_file1451475113.txt

My son was born on 7/20/2007 and thus between third and fourth year of medical school, from 6/2007 to 6/2008, I took a leave of absence for maternity leave. I returned for my fourth year in 6/2008 in good academic standing.

In October 2014, I was named as a defendant in a case from my residency training. The plaintiff claimed that negligence in her pregnancy led to infection during her delivery and hypoxic injury to her newborn with subsequent cognitive sequelae. I was dismissed with prejudice from the case in December 2014 and the case was dismissed for all defendants in May 2015. Please see the attached documentation that was sent to the Minnesota Medical Board for further details.

OFFICE OF THE HENNEPIN COUNTY ATTORNEY
MICHAEL O. FREEMAN COUNTY ATTORNEY

May 28, 2015

Paul Luecke
Licensure Specialist
Minnesota Board of Medical Practice
University Park Plaza
2829 University Avenue SE, Suite 500
Minneapolis, MN 55414

Re: Sarah A. Traxler, M.D.

Dear Mr. Luecke:

Enclosed please find a letter that you sent to Dr. Traxler requesting additional information on the lawsuit that is entitled Aguilar vs. Hennepin Healthcare System, Inc. et al.

Pursuant to Dr. Traxler's request, I am forwarding to you a signed copy of a Stipulation of Dismissal with Prejudice which releases her from the lawsuit without the payment of costs, fees and disbursements by any party. This document is the only documentation which is available and it is not part of a court record. As you know, it is possible in the State of Minnesota to start and finish a lawsuit and never file it with the Court. Plaintiff's counsel in this case has not filed this matter with the Court.

If you have any further questions, please feel free to call me at (612) 348-5230.

Sincerely,

CLAIRE J. SCHNURR
Sr. Paralegal
Telephone: (612) 348-5230
Fax: (612) 348-8299

Enclosures
cc: Sarah Traxler, M.D.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

Case Type: Medical Malpractice
DISTRICT COURT

FOURTH JUDICIAL DISTRICT

Court File No. Case Not Yet Filed
Judge: Case Not Yet Filed

Merlin Aguilar, on behalf of herself, individually, as well as on behalf of her child, N.A.,

Plaintiff,

vs.

Hennepin Healthcare System, Inc., d/b/a Hennepin County Medical Center, Dr. Elizabeth E. Doty, Dr. Virginia Lupo, Dr. David Wigren, John Doe and Jane Roe,

Defendants.

STIPULATION OF DISMISSAL WITH PREJUDICE OF DR. ABBEY LYNN MELLO, DR. SARAH A. TRAXLER, DR. JENNIFER ANN WILLETTE, F/K/A JENNIFER ANN LUETH & DR. MEGAN M. ZAANDER

IT IS HEREBY AGREED, by and between counsel for the parties hereto, that Dr. Abbey Lynn Mello, Dr. Sarah A. Traxler, Dr. Jennifer Ann Willette, f/k/a Jennifer Ann Lueth, Dr. Megan M. Zaander, are dismissed with prejudice from the above-captioned action without costs and disbursements to any party.

By: _____

Paul A. Sortland, Esq.
Louis Bass, Esq.
431 South Seventh Street
Suite 2415
Minneapolis, MN 55415
Attorneys for the Plaintiffs

Date: 5 Dec, 2014

By: _____

Rodger Hagen, Esq.
Meagher & Geer
4400 Multifoods Tower
33 South Sixth Street
Minneapolis MN 55402
Attorneys for Elizabeth Doty, M.D.,
Virginia Lupo, M.D. & David Wigren, M.D.

Date: 17 Dec., 2014

MICHAEL O. FREEMAN
Hennepin County Attorney

By: _____

Henry A. Parkhurst, Esq. (0388706)
Assistant County Attorney
2000A Government Center
Minneapolis, MN 55487
Telephone: (612) 348-4145
Attorney for Abbey Lynn Mello, M.D.,
Sarah A. Traxler, M.D., Jennifer Ann Willette,
f/k/a Jennifer Ann Lueth, M.D., Megan M.
Zaander, M.D. & Hennepin Healthcare
System, Inc.

Date: December 5, 2014

JAN 19 2016

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

January 19, 2016

North Dakota Board of Medicine
418 E. Broadway Ave. #12
Bismarck, ND 58501

This is to certify that a standard search of the available records of the Minnesota Board of Medical Practice indicates the following:

Physician:	Sarah Ann Traxler
Date of birth:	[redacted]
Was issued license number:	59828
On:	September 12, 2015
Expiration date is:	May 31, 2016
Status:	Active
Issued on the basis of:	USMLE - United States Med Lic Exam
Corrective action:	None
Disciplinary action:	None

Licensure History:

TP108331 -Temporary Permit Issued:June 22, 2015 Expired: September 12, 2015

RP21850 -Residency Permit Issued:June 08, 2009 Expired: June 07, 2013

This license information was last updated on: 1/18/2016 9:23:36PM

The above format is the standard format prepared for all physicians regulated by this board.

Please be advised that the Board does not release information as to whether there has been a complaint filed or an investigation conducted on individual verifications. All physicians are considered in good standing unless noted otherwise.

Further public records including disciplinary and corrective actions may be available from the Board's website at www.bmp.state.mn.us under professional profile. If other information is needed, please contact the Minnesota Board of Medical Practice at 612-617-2130.

Ruth M. Martinez
Executive 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

01/19/2016

VERIFICATION/CERTIFICATION OF LICENSE

This is to certify that the individual or business 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, Commissioner
Bureau of Professional and Occupational Affairs

Lynn Schreiner

From: st-medicine@pa.gov
Sent: Tuesday, January 19, 2016 1:30 PM
To: Lynn Schreiner; RA-STBPOA-LOGS@pa.gov
Subject: PENNSYLVANIA VERIFICATION/CERTIFICATION OF LICENSE - MD447970
Attachments: 3083487_LIC_12_ND - ND State Board of Medical ExaminersJan_19_2016_12_50_10_233PM.PDF

Attached is a VERIFICATION/CERTIFICATION OF LICENSE for:

Licensee Information	
Licensee #	MD447970
Licensee Type	Medical Physician and Surgeon
Last Name	Traxler
First Name	Sarah

Open the attachment to view and print the document. To verify the authenticity of the letter and/or to download any disciplinary action documents if exist for the requested licensee, please click this link https://www.mylicense.state.pa.us/L2KSupportSite/ReceiverVerification.

Verification Code:A704EF41-1C9E-4D0B-9043-A2B86C97B2DB.
Please note that this link cannot be forwarded and will only be available for 60 days from the date of this email.

Please contact the Pennsylvania board/commission at 7177831400 or email st-medicine@pa.gov for any questions.

Thanks,
BPOA

South Dakota Board of Medical and Osteopathic Examiners

Primary Source Verification

101 N Main Ave Suite 301
Sioux Falls, SD 57104

Phone: 605-367-7781
Email: sdbmoe@state.sd.us

Name: **Sarah Ann Traxler, MD**

Last Reported Address(es):

No Work Address Listed

Licenses, Permits, Registrations, Certificates: As of 01/22/2016

Type	Number	Issue Date	Expiration Date	Status
Medical License (MD/DO)	9597	July 09, 2015	March 01, 2016	Active

Board Actions:

Date	
	No Board Actions on File

To expedite the verification of licensure process, the above is the standard format for all professionals regulated by the Board.

Board Action
If Board Action is indicated please review the board action documents available at http://www.sdbmoe.gov. If the document is not listed, please email the Board at sdbmoe@state.sd.us.

License verification data is updated daily, and may not reflect changes to licensure occurring within the past 24 hours.

Document Generation Date: 1/22/2016 11:25:51AM

form version 20120223a

Lynn Schreiner

From: SDBMOE <SDBMOE@state.sd.us>
Sent: Friday, January 22, 2016 11:27 AM
To: Lynn Schreiner; Lynette McDonald
Subject: State Board to State Board Primary Source Verification of Medical License for Sarah Ann Traxler, MD - CL 90129
Attachments: Dr. Sarah Ann Traxler.pdf

Importance: High

SOUTH DAKOTA Medical & Osteopathic Examiners Primary Source Licensure Verification Confirmation: a SD Licensure Verification is attached.

The South Dakota Board of Medical and Osteopathic Examiners (SDBMOE) has been asked to officially verify information to your Board regarding previously or currently held licensure which would include a credential, registration, a permit, certificate or license. Attached is a primary source PDF verification which displays proof of licensure as it appears in the database of the SDBMOE as of the time date stamped on the bottom of the verification. It is consistent with a Board to Board Primary Source Verification which also would include JCAHO and NCQA standards for primary source verification.

Contact us directly by either replying to this email or using the email in the signature block if you have any questions about the Board to Board online verification process or the authenticity of the information provided to you.

Thank you,
Board Staff/jtp
SD Board of Medical & Osteopathic Examiners
101 N. Main Ave., Suite 301
Sioux Falls, SD 57104
www.sdbmoe.gov

STATE OF NORTH DAKOTA
OFFICE OF ATTORNEY GENERAL
STATE CAPITOL
600 E BOULEVARD AVE DEPT 125
BISMARCK, ND 58505-0040
(701) 328-2210 FAX (701) 328-2226
www.ag.nd.gov

Wayne Stenehjem
ATTORNEY GENERAL

BUREAU OF CRIMINAL INVESTIGATION
4205 STATE STREET, PO BOX 1054
BISMARCK, ND 58502-1054
(701) 328-5500 FAX (701) 328-5510
1-800-472-2185 (Toll Free)

February 25, 2016

ND BOARD OF MEDICINE
418 E BROADWAY AVE STE 12
BISMARCK ND 58501

Re: CRIMINAL RECORD CHECK RESULTS

In response to your inquiry on the following individual(s), a review of North Dakota criminal history records on file at this agency reveals that no information is available.

NAME	DOB
TRAXLER, SARAH ANN	05/10/1975

/s/ DALLAS CARLSON
DIRECTOR

by: Joni Bieber
JONI BIEBER
IDENTIFICATION TECHNICIAN

JAN 2 5 2016

CERTIFICATE OF MEDICAL EDUCATION

(Applicant must forward this application form to medical school granting degree for certification of his/her medical education)

It is hereby certified that Sarah Traxler (1)

received a Doctor of Medicine (2) diploma from Oregon Health and Science University (3)

3181 SW Sam Jackson Park Rd, Portland, OR 97239 (4) Location on June 4, 2009 (5) MM/DD/YY and to the best of our knowledge is of good moral character.

Signed Bethany Voul

(SEAL OF COLLEGE)

Admin Coordinator

(TITLE) Registrar's office

Date this Certificate 1/19/16

INSTRUCTIONS TO MEDICAL SCHOOL

The person whose name appears on this certificate has applied for a license to practice medicine in the State of North Dakota.

Please review this certificate to determine if the statement is correct.

If you find that it is entirely correct, please:

A. Complete the portion of the form calling for your name, your title, and the date.

B. Affix the official seal of your institution.

C. Return this certificate to the North Dakota State Board of Medical Examiners, 418 E. Broadway Ave., Suite 12; Bismarck, ND U.S.A. 58501 or FAX to 701-328-6505 Original must follow faxed copy via US mail or another courier.

-Thank You-

3-07

INSTRUCTIONS TO APPLICANT

1. Type your name on Line (1).
2. Indicate what medical school diploma you received on Line (2).
3. Type the name of your medical school on Line (3).
4. Type the address of your medical school on Line (4).
5. Type the date (month/day/year) you received your medical school diploma on Line (5).
6. Send this form to the President, Dean, or Registrar of your medical school.

University of Minnesota Medical School (UMMS)
Graduate Medical Education Administration
Standard Verification of Training Form

This form was created as a summary statement by the **University of Minnesota Residency Program in Obstetrics and Gynecology** Program Director's Office. The information below represents the composite of various attending performance evaluations submitted during the **residents** training at the University of Minnesota. Due to the increasing complexity and variability of credentialing requests and ever increasing numbers of alumni, this form was created in order to improve our own documentation and to provide more timely and accurate reporting of credentialing information for all current and former **University of Minnesota Residency Program in Obstetrics and Gynecology residents.**

To Whom it May Concern:

Name of Resident:	Sarah Traxler, MD
Program Name:	University of Minnesota Residency Program in Obstetrics and Gynecology (ACGME Accredited)
Length of Full Program:	4 Years
Dates of Attendance:	**From:** June 08, 2009 **To:** June 07, 2013
Last Level of Training:	**PGY** 4

Reason for Leaving:

_____ **Completed Internship Only:**
Since this physician only completed his/her internship in our program, I can provide an assessment of his/her performance during his/her internship but cannot verify qualifications for staff membership or clinical procedures. Please verify this information with the subsequent Residency Program Director.

__X__ **Completed Residency Program:**
During this physician's training, his/her performance, level of competence, and personal and moral conduct have been satisfactory. He/She is competent to perform all general **University of Minnesota Residency Program in Obstetrics and Gynecology** procedures with any noted exceptions listed below. I cannot verify qualifications for subspecialty privileges specific to a fellowship program. Please verify this information with the Fellowship Program Director.

_____ **Completed Fellowship Program:**
During this physician's training, his/her performance, level of competence, and personal and moral conduct have been satisfactory. He/She is competent to perform all general **[Subspecialty Name]** procedures with any noted exceptions listed below.

_____ **Served as Chief Resident:**
This physician served as Chief Resident in our program. During this time, her performance, level of competence, and personal and moral conduct were satisfactory.

____ **Completed Some Residency Training Elsewhere:**
During this physician's training, her performance, level of competence, and personal and moral conduct were satisfactory. I can only verify performance between the dates listed above. Please contact the additional Residency Program Director for further information.

_____ **Terminated - Reason for Termination:**

_____ **Withdrew from Program - Reason for Withdrawal:**

Name: Sarah Traxler, MD

Residency Program Evaluation:

	Final training period		Overall Performance	
	Satisfactory	**Unsatisfactory**	**Satisfactory**	**Unsatisfactory**
Clinical Judgment	X		X	
Medical Knowledge	X		X	
Clinical Skills – Medical Interviewing	X		X	
Clinical Skills – Physical Examination	X		X	
Clinical Skills – Procedural Skills (list attached)	X		X	
Communication-Interpersonal Skills	X		X	
Professionalism	X		X	
Practice-based learning and improvement	X		X	
Systems-based practice	X		X	
Overall Clinical Competence	X		X	

Dr. Traxler demonstrates sufficient competence to enter practice without direct supervision.

X Yes *_____No*

To the best of my knowledge, during their residency this individual:

DID**	**DID NOT**	
	X	Demonstrate alcohol/drug dependence
	X	Demonstrate mental or physical health problems connected to performance
WAS**	**WAS NOT**	
	X	A defendant in a medical malpractice action
	X	A defendant in a criminal/felony action
	X	The subject of disciplinary action, including reprimand, probation, suspension or termination . Negative evaluations are reflected under this section if they result in disciplinary action against the resident/fellow.

** Explanation: _____

_____

_____

COMMENTS:

Name: Sarah Traxler, MD

Recommendation:

__X__ Without reservation

_____ With reservation because: _____

_____ Do not recommend because: _____

This recommendation is based upon:

__X__ Personal knowledge

__X__ A review of Internship/Residency/Fellowship records

Phillip N. Rauk, MD
Residency Program Director
Obstetrics, Gynecology and Women's Health

1/13/2016
Date

Penn Medicine
Hospital *of the* University *of* Pennsylvania

Penn Family Planning & Pregnancy Loss Center

January 29, 2016

North Dakota Board of Medicine
418 E. Broadway Avenue, Suite 12
Bismarck, ND 58501-4086

Re: Sarah Traxler, MD, MSHP

Dear Colleagues:

I am writing on behalf of Dr. Sarah Traxler, who completed a Fellowship in Family Planning at the University of Pennsylvania. This two-year unaccredited Fellowship is focused on subspecialty training in research, teaching and clinical practice in family planning. Dr. Traxler commenced training on July 1, 2013 and graduated the program in good standing on June 30, 2015; she was not subject to any disciplinary actions, restrictions, suspensions, or termination of privileges.

During the course of her fellowship, Dr. Traxler demonstrated competence and expertise in the clinical aspects of family planning. She was also involved in teaching and mentoring OB/GYN residents during family planning rotations. Drs. Traxler demonstrated professional conduct, clinical competence, and ethical standards in her practice of medicine. To our knowledge, she had no history of any substance abuse, or physical or mental impairment that would impact her medical practice.

Additionally, in the second year of her fellowship, she was an instructor in Gynecology at the Hospital of the University of Pennsylvania, teaching residents and covering as the attending physician for resident gynecology cases in the operating room, in the clinic, and during gynecologic emergencies at the hospital. I am confident that she has the skill set necessary to provide gynecologic care and family planning services. It is with pleasure that I recommend Dr. Sarah Traxler for medical licensure in North Dakota.

Sincerely,

Courtney A. Schreiber, MD, MPH
Associate Professor of Obstetrics and Gynecology
Director, Division of Family Planning
Hospital of the University of Pennsylvania

3400 Spruce Street | 1000 Courtyard | Philadelphia, PA 19104 | 215.615.5234 | Fax: 215.615.5319

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Planned Parenthood Minnesota, North Dakota, South Dakota

671 Vandalia Street
St. Paul, MN 55114
www.ppmns.org

April 13, 2016

Lynn Schreiner

ND Board of Medicine
418 E Broadway Ave, Ste 12
Bismarck, ND 58501

Dear Ms. Schreiner:

This letter is in support of Sarah Traxler M.D. who is applying for a North Dakota medical license. Dr. Traxler is a staff physician and Associate Medical Director for Planned Parenthood Minnesota, North Dakota, South Dakota (PPMNS). Her employment began June 17, 2015 and she is still actively employed.

I knew Dr. Traxler as a resident in Obstetrics, Gynecology, and Women's Health at the University of Minnesota prior to her employment with PPMNS. Since her graduation from residency in 2013, she has completed a Fellowship in Family Planning, and is now Board Certified in Obstetrics and Gynecology. She has outstanding clinical knowledge and technical skills, excellent communication skills, and exemplary ethical standards. I highly recommend that she be granted a license to practice medicine in your state.

Sincerely,

Carol E. Ball, MD, FACOG

Medical Director

Planned Parenthood Minnesota, North Dakota, South Dakota
671 Vandalia Street, St. Paul, Minnesota 55114
p: 612-698-2406
f: 651-698-2405

APR 21 2016

Susan Wilson, MD MSc

Christiana Hospital

Department of Ob/Gyn

4755 Ogletown-Stanton Rd., Suite 1905P

Newark, DE 19718

April 11, 2016

North Dakota Board of Medicine

418 E Broadway Ave.

Suite 12

Bismarck, ND 58501

To Whom It May Concern at the North Dakota Board of Medicine:

I am writing this letter in support of my colleague in medicine Dr. Sarah Traxler. I worked with Sarah during our overlapping time in fellowship at the Hospital of the University of Pennsylvania. I have only known her to be a hard-working, honest, ethical medical doctor who takes excellent care of her patients using evidence-based medical practices. She is always professional and works well with her colleagues.

I support her completely in her professional endeavors, and I would be happy to answer any questions you may have.

Sincerely,

Susan Wilson

Penn Medicine
Hospital *of the* University *of* Pennsylvania

Department of Obstetrics and Gynecology
Penn Family Planning and Pregnancy Loss Center

27 January 2016

North Dakota Board of Medicine
418 E Broadway Ave, Suite 12
Bismarck, ND 58501-4086

Re: Sarah A. Traxler, MD
DOB: 5/10/1975

Dear Members of the North Dakota Board of Medicine:

I write in support of Dr. Sarah A. Traxler's application for a license to practice medicine in the State of North Dakota. I attest to her excellent ethical and moral character.

I have known Dr. Traxler since July 2014. In my observation, she is an extremely capable physician who has performed at the highest level. She is intelligent, compassionate, and provides excellent care for her patients.

Thank you.

Sincerely,

Elizabeth Gurney, MD

3400 Spruce Street Philadelphia, PA 19104-4283 / 215-615-5234 / Fax 215-615-5319

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 Heilbrun MD
Dean, School of Medicine

OREGON HEALTH & SCIENCE UNIVERSITY

Keith F Thomas
Chairman of the Board

Bailey M. Dallick
Provost

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

THE FELLOWSHIP IN FAMILY PLANNING

CERTIFIES THAT

Sarah Traxler

has successfully completed all the Fellowship requirements at the

University of Pennsylvania

Awarded this 1st day of July, 2015

Uta Landy

Uta Landy, PhD
National Director
Fellowship in Family Planning

Courtney Schreiber, MD, MPH
Fellowship in Family Planning Director
Department of Obstetrics & Gynecology
University of Pennsylvania

Larry C. Gilstrap, III, M.D.
Executive Director
American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

December 11, 2015

Sarah Ann Traxler, M.D.
1812 Pierce Street NE
Minneapolis, MN 55418

Congratulations! In recognition of your fulfillment of all requirements, you are now a Diplomate of The American Board of Obstetrics and Gynecology, Inc. Your certification is effective through December 31, 2016. Your certificate must be renewed annually by completion of all the assignments in the ABOG Maintenance of Certification (MOC) process.

Please carefully review the spelling of your name, degree and address on this letter as that name will be printed on the certificate you will receive. If there is a correction, please notify our office no later than December 25, 2015. If you have not received your certificate from the printer by May 31, 2016, please contact the Board office.

You may apply for the 2016 MOC process at www.abog.org. There is no fee for MOC for the first year. However, if you are not an ACOG fellow or junior fellow, you must pay for the category I CME credit, as that is a benefit of ACOG membership.

We hope you will maintain an active interest in the specialty, and you will continue to improve the care of women.

Best Wishes,

Larry C. Gilstrap III, MD

Larry Gilstrap, III M.D.
Executive Director

LG

ABOG ID: 9030498

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A founding member of The American Board of Medical Specialties
www.abog.org

Kenneth L. Noller, M.D.
Director of Evaluation
American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

August 30, 2013

Sarah Ann Traxler, M.D.
1812 Pierce Street NE
Minneapolis, MN 55418

Congratulations! The American Board of Obstetrics and Gynecology, Inc. is pleased to inform you that you passed the June 24, 2013 Basic Written Examination in Obstetrics and Gynecology.

Information for the 2014 Basic Oral Examination can be found in the 2014 Basic Oral Examination Bulletin which is available on the ABOG website.

Best Wishes,

Kenneth Noller, M.D.
Director of Evaluations

KLN

ABOG ID: 9030498

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www.abog.org

Lynette McDonald

From: Sarah Traxler <straxler@ppmns.org>
Sent: Wednesday, February 24, 2016 10:20 AM
To: Lynette McDonald
Subject: Re: ND Medical Applic

Not currently. Only in MN and SD where I currently have licensure. Unless general gyn services expand to ND, my main capacity in ND would be to supervise the PAs and NPs who work in our online health service. There has to be a supervising physician before we roll out that service in ND. I already have that supervisory role in MN and SD.
Thank you and let me know if you have other questions.
Sarah

On Feb 24, 2016, at 9:56 AM, Lynette McDonald <LMcDonald@ndbom.org> wrote:

> Lynn forwarded me your file for my initial review. I just have one question, do you or have you seen patients in ND in your role as the medical director of Planned Parenthood?
>
> Thank you.
>
> Lynette McDonald
> ND Board of Medicine
> 418 E Broadway Ave Suite 12
> Bismarck, ND 58501
> Ph (701) 328-6500
> Fax (701) 328-6505