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JAN 16 2018
Board of Registration in Medicine

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/massmedboard

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Type of License ☒ Initial Full License ☐ Administrative License ☐ Volunteer License

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

REDACTED COPY

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)
Treder	Kelly	Marie	

☒ M.D. ☐ D.O. ☐ PhD ☒ Other degree M P.H ☐ Male ☒ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here. ☒

Entire Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

Social Security Number: _____ Date of Birth: _____ (Month Day Year)

NPI (National Provider Identifier) Number: 1235558727

Place of Birth: _____ (City) _____ (State/Province/Territory) _____ (Country if not USA)

*Mailing Address: _____ (Number and Street) Telephone: _____

_____ (City) _____ (State/Province/Territory) _____ (Zip (or postal) Code)

Home Address: _____ (Number and Street) Telephone: _____

_____ (City) _____ (State/Province/Territory) _____ (Zip (or postal) Code)

Business Address: 250 E Superior St Ste 5-2177 (Number and Street) Telephone: 312-472-4673

Chicago (City) IL (State/Province/Territory) 60611 (Zip (or postal) Code)

E-mail Address: _____ Fax number: 312-472-4687

Are you applying for licensure through FCVS? ☐ Yes ☒ No

*** The Board will use your Mailing Address for all correspondence**

Pre-medical School | **From** | **To**

Name: Columbia University Degree: B.A. Year: 2004 Year: 2008
Street: 116th St and Broadway City: New York State: NY

Name: _____ Degree: _____ Year: _____ Year: _____
Street: _____ City: _____ State: _____

Medical School

Name: University of Washington School of Medicine Degree: M.D.
Street: 1959 NE Pacific St City: Seattle State: WA

Name: University of Washington School of Public Health Degree: M.P.H
Street: 1959 NE Pacific St City: Seattle State: WA

Medical School Graduation Date: 06 / 2014
Month Year

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. You must account for all periods of training or postgraduate work from the time you graduated from medical school. Enter month and year only.

From | **To**

Facility: Northwestern Memorial Hospital PGY Year: 1-4 07 / 2014 06 / 2018
Specialty: Obstetrics and gynecology City: Chicago State: IL

Facility: _____ PGY Year: _____ ___/___ ___/___
Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ ___/___ ___/___
Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ ___/___ ___/___
Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: _____ ___/___ ___/___
Specialty: _____ City: _____ State: _____

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination.

Examination	Number of attempts	Passed (P) or Failed (F)
USMLE Step I	1	☒ P ☐ F
USMLE Step II	1	☒ P ☐ F
USMLE Step III	1	☒ P ☐ F
NBME Part I		☐ P ☐ F
NBME Part II		☐ P ☐ F
NBME Part III		☐ P ☐ F
FLEX Component 1		☐ P ☐ F
FLEX Component 2		☐ P ☐ F
FLEX Pre-1985		☐ P ☐ F
NBOME Part I		☐ P ☐ F
NBOME Part II		☐ P ☐ F
NBOME Part III		☐ P ☐ F
COMLEX Level 1		☐ P ☐ F
COMLEX Level 2		☐ P ☐ F
COMLEX Level 3		☐ P ☐ F
COMVEX		☐ P ☐ F
LMCC – Single		☐ P ☐ F
LMCC – Part I		☐ P ☐ F
LMCC – Part II		☐ P ☐ F
State Board Exam	(State of examination and year)	☐ P ☐ F

Hospital Affiliations and Employment

List hospital appointments, in chronological order by month and year where you ever had medical staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility: Northwestern Memorial Hospital	Position: Resident	07 / 2014	06 / 2018
Street: 250 E Superior St.	City: Chicago	State: IL	
Facility:	Position:	/	/
Street:	City:	State:	
Facility:	Position:	/	/
Street:	City:	State:	

1. List other states (abbreviations) where you are currently or have ever had a full license: not applicable

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s): none

4. List your practice specialt(ies): obstetrics and gynecology, family planning

5. Have you completed the Opioid and Pain Management training? (See Instructions) ☒ Yes ☐ No

6. Have you completed training to recognize and report suspected child abuse or neglect? ☒ Yes ☐ No
   (Your license will not be processed until you complete the required training – see instructions.)

7. Reason for requesting a Massachusetts medical license: I was placed into the fellowship in Family Planning at Boston University / Boston Medical Center

8. Name of Facility: Boston Medical Center
   Address: YACC-5, 850 Harrison Ave City: Boston

9. Anticipated starting date in Massachusetts: 07 / 01 / 2018

10. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete.

Signature of Applicant

12 / 31 / 2017
Month Day Year

Sealed Envelope

Initials: KT

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for at least one year and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts. **The form must be notarized by a U.S. Notary Public.**

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

This certifies that I have been personally acquainted with the physician named below:

Kelly Treder
(name of applicant)

for 3.5 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Signature of applicant

Signature of Certifying Physician

I certify that the photograph above is a genuine likeness of the maker of the signature above.

036097572 — License Number

IL — State

SUSAN GERBER, MD
Type or print name clearly

Address: 250 E. SUPERIOR ST
05-2184

City: CHICAGO State: IL Zip: 60611

Telephone: (312) 472-4673

Date: 1/5/18

Signature of Notary

BURTON DAVID KORMAN
Official Seal
Notary Public - State of Illinois
My Commission Expires Dec 22, 2019

My commission expires

Seal Verified
Date: 1/17/18
Initials: KT

Instructions to the certifying physician: *Please answer every question, date this form, and return it to the applicant in a sealed envelope with your signature across the seal.*

Sealed
Envelope

Initials: OTS

BoardofRegistrationinMedicine
200 HarvardMill Square, Suite330
Wakefield, MA 01880
Telephone: (781)876-8210 Fax: (781)876-8383
www.mass.gov/massmedboard

MEDICAL EDUCATION VERIFICATION – FORM A

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification. **Please note: Fourth year medical students must include the letter to the medical school registrar and Form B.**

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: [signature] Date of Birth: ___/___/___

Name(Please type or print) Treder Kelly M
(Last Name)(First Name) (Middle Initial)

Other Name(s)(Please type or print): N/A

Name of Medical School University of Washington School of Medicine

Address: 1959 NE Pacific St City Seattle State or Province WA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A. For fourth year medical graduates, please complete Form B after the student completes the degree requirements. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above-named institution when applicant attended, please enter name below:

Premedical Education: Does your school have a premedical school education requirement? ☒ Yes ☐ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Columbia University

Undergraduate School Address: 116th St & Broadway, New York, NY 10027

PRINT NAME: Kelly Treder DATE: 3/21/18

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5-11.

QUESTIONS		YES	NO
1.	While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
2-A.	Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B.	Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?		
3.	If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
4.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		
5.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
7.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
8-A.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
8-B.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		

PRINT NAME: Kelly Treder DATE: 12/31/2017

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?		
9-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?		
9-C.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
10.	Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)		
11.	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		
14-A.	Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
14-B.	Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

PRINT NAME: Kelly Treder DATE: 12/31/2017

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 15 - 17. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application; it means recently enough to impact one's functioning as a physician.

		YES	NO
15.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		
16.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
17.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: Kelly Treder DATE: 12/31/2017

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985. (*Note:* Signing this certification does not imply that you will participate in the Medicare program).
- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board's regulations, 243 CMR 1.00 through 3.00.

I certify under the penalties of perjury that all information on this form, and all attached pages, is true, to the best of my knowledge.

Applicant's Signature: Kelly Treder Date: 12/31/2017

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

Sealed Envelope

Initials KT

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: Kelly Treder Date: 12/18/2017

Print or Type Name: Kelly Treder

Name and Address of Institution: Northwestern Medicine
250 E Superior St
Chicago IL 60611

TO BE COMPLETED BY PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**.

Name of Institution: MCGAW MEDICAL CENTER OF NORTHWESTERN UNIVERSITY

Name of Institution, if different when applicant attended: _____

Verification for: KELLY TREDER
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	PGY (1,2,3,4, etc.)	Department or Type of Specialty Training (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	Dates Attended (Month/Day/Year) FROM	TO	Completed (Yes/No/In Progress)	Accredited by (ACGME, AOA, RSC, or not accredited)
Internship	1	OB/GYN	6/23/14	6/29/15	Yes	ACGME
Residency	2	OB/GYN	6/30/15	6/29/16	Yes	ACGME
Residency	3	OB/GYN	6/30/16	6/29/17	Yes	ACGME
Residency	4	OB/GYN	6/30/17	6/29/18	Progress	ACGME
			/ /	/ /		

Report incomplete training levels (years) separate from those that were successfully completed. If the training level (years) is currently in progress, report the expected completion date in the "TO" field.

APPLICANT'S NAME: Kelly Treder

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. **If you answer "yes" to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

COMMENTS: _____

_____

_____

Certification: I hereby certify that the above information is an accurate account of this individual's record and is true and correct.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: _____

Print Name: SUSAN GERBER

Academic Title: ASSOCIATE PROFESSOR

Telephone: (312) 472-4673 Today's Date: 12/29/17

E-mail address: _____

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified
Date 1/17/18
Initials

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
www.mass.gov/massmedboard

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I. Kelly Marie Treder
(type/print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations and their representatives to release information, records, transcripts and other documents concerning my professional qualifications and competency, ethics, character and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents, and records be sent directly to:

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

Kelly Treder
Applicant's Signature

12/31/2017
Date of Signature

Treder, Kelly, M
Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

Applicant's Date of Birth (month/day/year)

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

____ Participation in a Meaningful Use program as an eligible professional;
__X__ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
____ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
____ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

____ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4);
____ for an Administrative License;
____ for a Volunteer License;
____ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
____ for an Emergency Restricted License.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME: [signature] DATE: 12/31/2017

Enrollment and Participation:

Our records indicate that Treder, Kelly, Marie
(Print the applicant's name) (Last name)(First name)(Middle Initial)

attended our medical school for a total of 187 weeks (must be included) of continuous medical education on the following dates from 09 / 01 / 2009 to 06 / 13 / 2014.
month/day/year month/day/year

This applicant:

Check one: ☒ **was awarded the degree of** Doctor of Medicine on 06 / 13 / 2014
month/day/year

☐ **will be awarded** the degree of _____ on ____/____/____
(Form B must also be completed and returned directly to the Board.) month/day/year

☐ **was not awarded** a degree because _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	NO
1. Was the medical school training more than four (4) years for U.S. graduates or 6 years for international medical graduates, or did the applicant take any leaves of absence (i.e. for research, public service, participation in an M.D./Ph.D. program) or for any "personal reasons"?		
2. Was the applicant ever placed on probation or remediation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

Please provide a detailed explanation for any of the above questions _____

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized.)

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: _____

Print Name: Gloria Rayo

Title: Registration Specialist

Date: 12 / 28 / 2017 Telephone: (206) 221-4726

E-mail address: _____

Seal Verified
Date 1/17/18
Initials

This form must be stamped with the institutional seal or notarized. Please return to the applicant with the medical school transcripts in a sealed envelope with the signature of the Dean or the seal of the medical school affixed on the back of the envelope. Thank you.

Kelly Treder

Education and Training

Residency in Gynecology and Obstetrics
Northwestern University and John H. Stroger Hospital of Cook County, Chicago, IL
Date of Matriculation: June 23, 2014
Expected Date of Graduation: June 15, 2018

M.D **University of Washington School of Medicine, Seattle WA**
Date of Matriculation: September 1, 2009
Date of Graduation: June 13, 2014

M.P.H **University of Washington School of Public Health, Seattle WA, Department of Health Services**
Date of Graduation: June 2014

B.A. **Columbia University, New York, New York, Department of Psychology**
Date of Graduation: May 2008

Community Service/Leadership Activities

UW TEST, University of Washington, Seattle, WA — November 2012-June 2014
Volunteer Outreach HIV Tester

- Provided free HIV counseling, education and testing

QMEDICINE, University of Washington School of Medicine, Seattle, WA — September 2009-June 2014
Student Officer

- Planned educational, service and social events with the goal of improving LGBTQ (lesbian, gay, bisexual, transgender, queer) health competency in medicine

STUDENT NATIONAL MEDICAL ASSOCATION, University of Washington School of Medicine, Seattle, WA — September 2009-June 2014
Community Service Chair 2009-2010, 2010-2011

- Organized and publicized the chapter's community service events including a bone marrow donor registration drive, pipeline programming to expose minority youth to health care careers, and annual Black History Month events

SEXPERTISE, University of Washington School of Medicine, Seattle, WA — September 2010-June 2014
Student Organizer

- Planned and publicized sexual health events to improve sexual health competency among medical students

AMERICORPS/YOUTHCARE ORION CENTER, Seattle, WA — September 2008-August 2009
Volunteer Activities Coordinator

- Full-time, 40 hours/week volunteer at day center for homeless youth and young adults aged 13-23
- Planned, organized, and supervised daily therapeutic, educational, and recreational activities, including a weeklong program of events focused on safer sex
- Weekly street outreach to initiate contact with youth living on the streets

CHILD FAMILY HEALTH INTERNATIONAL, Cape Town, South Africa — June 2008
Volunteer
- Rotated through the antiretroviral clinic, eye clinic and Kangaroo Mother Care (KMC) unit and developed activities to bond mothers and their underweight neonates in the KMC unit

PROJECT HEALTH FAMILY HELP DESK, New York, NY — January 2008-May 2008
Volunteer
- Connected families with children visiting Harlem Hospital's pediatric outpatient clinic to services including housing, immigration, public benefits, employment, education, and emergency services

RESIDENTIAL PROGRAMS, Columbia University, New York NY — August 2007-May 2008
Resident Advisor
- Developed community in the residence halls through programming and addressed conflicts through counseling and mediation

COLUMBIA UNIVERSITY EMERGENCY MEDICAL SERVICE, New York, NY — January 2006-May 2008
Volunteer Emergency Medical Technician (EMT)
- Provided emergency care and transport for students and residents of the greater Columbia area as a member of a full-service, student-led, volunteer ambulance corps

NEW STUDENT ORIENTATION PROGRAM, Columbia University, New York, NY — September 2005, September 2006
Sexual Assault Awareness Facilitator (volunteer)
- Participated in a two-day training focused on sexual assault, consent, gender roles, stereotypes and facilitation skills
- Facilitated a discussion with first-year students about consent, and sexual assault, encouraging open discussion and clear communication between students in order to develop healthy sexual relationships

Presentations

- **McKnight Middle School Career Fair, Seattle, WA**: Exposed over 100 middle school students, many from communities underrepresented in medicine, to the possibility of a medical — February 2013

career through informal teachings and activities

- **Service Learning Summit, University of Washington School of Medicine**: Presented to an interdisciplinary group of health sciences students about pipeline programming to increase the number of underserved minorities working in health care — May 2013
- **University of Washington School of Medicine Student Orientation,** *Center for Equity Diversity and Inclusion Presentation*: Co-facilitated a challenging and intimate exercise revolving around individual bias and privilege for the rising second-year medical students — August 2012
- **UW Health Sciences Common Book Discussion**: Prepared and led a discussion on cross-culturalism and the patient experience with incoming medical students — August 2012

Research Experience

- **Perinatal Palliative Care Providers' Attitudes Toward Pregnancy Termination** — February 2017-present
  PI: Cassing Hammond
  Northwestern Department of Family Planning
  Status: Data collection
- **Implementation of Manual Vacuum Aspiration in the Obstetric Triage Unit,** a Quality/Improvement Project, Northwestern Department of Obstetrics and Gynecology — December 2016-present
- **Internalized Racism: Future Directions for Research in the Obstetric Outcomes of Black American Women** — February 2016-present
  PI: Lynn Yee
  Northwestern Department of Obstetrics and Gynecology
  Status: Review article in progress
- **The Implementation of School-Based Health Centers and Teen Birth Rates in Seattle,** University of Washington School of Public Health, Masters in Public Health Capstone — January 2013-present
- **Increasing Fresh Fruit and Vegetable Access in Seattle's Central District**, Rural/Underserved Opportunities Program, University of Washington School of Medicine — July-August 2010
- **Pain Management in Nursing Home Patients with and without Dementia**, Summer Undergraduate Research Fellowship, Columbia University — June-August 2007

Awards and Scholarships

- **Excellence in Teaching Award,** Northwestern University Department of Obstetrics and Gynecology: awarded to residents voted by the medical student class to be the best teachers — 2015, 2016, 2017
- **Catherine Marie and Naomi Libby Elvins Medical Scholarship:** awarded to Washington medical students with a sincere commitment to pursue a career in obstetrics and gynecology — 2009, 2010, 2011, 2013
- **UW School of Medicine Service Award,** University of Washington School of Medicine: awarded to the top 15% of medical students involved in providing service to underserved populations — 2012-2013, 2010-2011
- **UW School of Medicine Martin Luther King, Jr. Community Service Award,** Recipient: UW TEST, This award honors student groups for exemplifying Martin Luther King' principles through "commitment to addressing community needs, particularly communities of color and low income" and the "development and implementation of significant programs to improve the human condition" — 2013
- **University of Washington School of Medicine Martin Luther King, Jr Community Service Award,** Recipient: UW Student National Medical Association Chapter (see award description above) — 2009

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Professional Development

- **Society of Family Planning: North American Forum on Family Planning,** Denver, CO — November 2016
- **Medical Spanish Immersion School,** Antigua, Guatemala: Participated in two weeks of intensive one-on-one medical Spanish coursework — July 2016
- **Reproductive Health Externship,** Medical Students For Choice, Cedar River Clinics, Seattle WA, June 2013 — June 2013
- **University of California San Francisco LGBTQI Health Forum,** San Francisco, CA — March 2011, March 2012
- **Student National Medical Association Annual Medical Education Conference,** Chicago, IL — April 2010
- **Secondary Trauma and Trauma Stewardship,** The Trauma — November 2008

Stewardship Institute, Seattle, WA: one-day training offering practical self-care tools imperative to a successful career caring for others going through traumatic life experiences

- **Quantum Learning Training**, Seattle WA: three-day training focusing on facilitation and teaching skills, particularly working with underserved or at-risk youth populations — October 2008

Interests and Experiences

- Cooking, tennis, sewing, travel, amateur graphic design
- Study abroad in Paris, France in the summer of 2006; Travel to Australia, England, Scotland, St. Maarten, Canada, India, Thailand, South Africa, Spain, France, Guatemala