Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

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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: Jesaika Ann Ralph ↗ New Search

License: Physician and Surgeon - #65910 Print

Licensee Public Information

Licensure Designated Address: Womens Health Specialists
Riverside Professional Building
Minneapolis, MN 55454

Web Site:
E-mail:
Birth Year: 1987
Gender: Female

License Information

License Number:	65910	**License Type:**	Physician and Surgeon
Expiration Date:	02/28/2021	**Grant Date:**	07/03/2019
License Status:	Active		
Disciplinary Action:	No		
Corrective Action:	No		

Disciplinary Actions by Other States (Reported to the Board since July 1, 2013): No

Public - Other: No

Education

Medical School:	NORTHWESTERN UNIVERSITY MEDICAL SCHOOL, CHICAGO, IL USA	**Degree:**	M.D.
Location:	Chicago, IL USA	**Date:**	05/23/2013

Practice Locations (Self-Reported Information)

Primary Location: Womens Health Specialists
Riverside Professional Building
606 24th Ave S, Suite 300
Minneapolis, MN 55454
Phone: Unknown

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
Medical College of Wisconsin	Obstetrics and Gynecology	07/00/2013	06/00/2017	Yes
Northwestern University McGaw Medical Center	Family Planning	07/00/2017	06/00/2019	Yes

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

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 6/19/2020 8:27:07 AM

Disclaimer

The Minnesota Board of Medical Practice provides this information as a service to the public. The Board relies upon information provided by licensees to be true and accurate. Information that is self-reported by the provider has not been verified by the Board. The Board makes no warranty or guarantee concerning the accuracy or completeness of the self-reported information contained on this web page. Neither the Minnesota Board of Medical Practice, nor any source of information on this web page, shall be responsible for any errors or omissions, or for the use of this information.

Primary Source Verification

The license information in this web page has been designed and implemented to meet primary source verification requirements of the Joint Commission accredited hospitals and the National Committee for Quality Assurance (NCQA) certified managed care organizations, and it can be used as the primary source verification.

Note on 'Area of Specialty'

Specialty board certification information was obtained directly from American Board of Medical Specialties (ABMS), www.abms.org, or American Board of Osteopathic Medical Specialties (AOA), www.aoa-net.org, as a written direct verification, quarterly update, or from the official ABMS or AOA primary source verification website. Minnesota's Physician Profile contains specialty certifications only from ABMS and AOA, because they are universally recognized and easily verifiable. Other organizations certify and endorse specialization with their own standards and procedures. You may wish to ask your physician about such certifications if he or she does not list one of the specialties from the ABMS or AOA.

Maintenance of Certification (MOC)

MOC is an ABMS program of lifelong learning and requires physicians to self-assess their competency. Further information can be found at www.abms.org. The American Osteopathic Association also has a continuous lifelong process "Osteopathic Continuous Certification" or OCC. Further information is available at www.osteopathic.org.

Criminal Conviction

Minnesota Statute 214.072 (a)(1) requires the Board to post licensee's "conviction of a felony or gross misdemeanor occurring on or after July 1, 2013, in any state or jurisdiction."

IMLC (Interstate Medical Licensure Compact)

License Types with the designation (IMLC) denote that this Minnesota Physician & Surgeon License was issued though the IMLC process. Please refer to https://imlcc.org for more information about the Interstate Medical Licensure Compact.

425.25

MINNESOTA BOARD OF MEDICAL PRACTICE

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

Addendum to Application Cover Sheet

Basis for Application (Check One):

- ☐ Federation Licensing Examination (FLEX)
- ☐ National Board of Medical Examiners Examination (NBME)
- ☐ National Board of Osteopathic Medical Examiners Examination (NBOME)
- ☐ Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)
- ☐ Licentiate of Medical Council of Canada Examination (LMCC)
- ☐ State Board Examination (State Board)
- ☒ United States Medical Licensing Exam (USMLE)
- ☐ Combination of FLEX, NBME, USMLE (must be completed by year 2000)

For Board Use Only

Application #: 124749
Check/Receipt #: 325-35
Amount Paid:
License #: 65910 7/3/19

Account Code	Amount
635009 lic	192.5
635010 app	200
635064 cbc	33.25

Instructions

Complete each section of the Addendum as instructed. Please type or print your responses and your identifying info at the bottom of the addendum pages.

If additional space is necessary, attach a separate sheet referencing the question number to which you are responding.

If the answer to any question is "yes", please explain in detail on the addendum, using a separate sheet if necessary. Additional documents may be required.

Return the completed addendum along with this cover page, application fee of $425.25, forms, and other required documents to the Minnesota Board. Use the checklists to ensure you send all required items.

IMPORTANT NOTICE: Minnesota Statute, section 214.074 requires that all new applicants for licensure must complete a fingerprint – based criminal background check. Applications received on and after January 1st, 2019 must include the $33.25 criminal background check fee or they will be returned. For more information please visit: https://mn.gov/boards/medical-practice/.

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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: Women's Health Specialists, Riverside Professional Building

Street Address: 606 24th Ave. S, Suite 300

City / State or Province / Zip: Minneapolis, MN 55454

☑ 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? ☑ No ☐ Yes - me. ☐ Yes - spouse. If discharged, provide discharge date: _____

☑ I certify that I have not served any military duty.

☐ I certify that I have served military duty in the following branch of service: _____

Rank at Discharge: _____ Type of Discharge: _____

Entry Date (mm/dd/yyyy): _____ Release Date (mm/dd/yyyy): _____

3. Criminal Conviction(s)

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 been convicted 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 two items to report, attach additional sheets as needed.

☑ I certify that I have had no felony or gross misdemeanor on or after July 1, 2013.

☐ I certify that I have had the following felony or gross misdemeanor on or after July 1, 2013:

1. Conviction Date (mm/dd/yyyy): _____ Conviction Type: ☐ Felony ☐ Gross misdemeanor

Crime Description: _____

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

Sentence: _____

2. Conviction Date (mm/dd/yyyy): _____ Conviction Type: ☐ Felony ☐ Gross misdemeanor

Crime Description: _____

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

Sentence: _____

_____

4. Malpractice Liability Claims Information

The Board requires all applicants to complete the Malpractice Liability Claims Information page within the online Uniform Application unless there have been no claims. Report all claims that are pending or have been dismissed. If you have had no claims, check the box below certifying that you have not had any claims against you and leave the online UA page blank.

☑ I certify that I have never had a malpractice claim, award, judgment, or settlement against me.

☐ I certify that I have listed all malpractice claims information within the online Uniform Application.

5. Additional Physician Information

Alien Registration Number (if applicable): Number _____

Driver's License*: State WI Number R410-4218-7558-06

Identifying Characteristics (if you are using FCVS, you do not need to complete this question):

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

Identifying marks _____

Your intended street address (if known): _____

City / State or Province / Zip / Country: _____

Effective Date: _____

Proposed practice plans in Minnesota (if any): _____

**Submit a copy of your driver's license notarized as a true likeness to the Board. The copy must be legible with a clear photo.*

6. 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: _____

Country: _____ License Number: _____ Date Issued: _____

7. Membership in Professional Societies and Organizations

Organization: Society of Family Planning From (mm/yy): 01/2016 To (mm/yy): Present

Organization: National Abortion Federation From (mm/yy): 01/2018 To (mm/yy): Present

Organization: American College of OB/GYNs From (mm/yy): 06/2013 To (mm/yy): Present

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

8. Attestation Questions

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons.

If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable question(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s).

For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders/conditions, or chemical dependency or chemical abuse.

The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your license is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling.

If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is necessary, use the end of page 7. Attach a separate sheet if needed.

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.

	YES
1. Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.	☐ no
1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe.	☐
1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.	☐
2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety? Please describe.	☐ no

YES NO

3. Are you engaged in any illegal use of controlled substances including the use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe. ☐ no

3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe. ☐

3b. If yes, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe. ☐

4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? If you answer this question "yes", please answer the following: ☐ no

4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided? ☐

4b. With regard to any condition referenced above, are you in compliance with the recommended treatment? ☐

4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety? ☐

4d. Please explain.

4e. Identify your treating physician.

5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.

6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.

[redacted]

YES NO

7. Have you even been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If so, give particulars.

8. Has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by Medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If so, give particulars.

9. Have you ever been notified of any investigation by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board? If so, give particulars.

10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, complete section 4 of this Addendum and give a detailed clinical explanation of each case in the specifics area of the Malpractice Liability Claims Information page within the Uniform Application as well as documentation of outcome (insurance papers or court documents).

11. Have your hospital privileges been restricted or revoked? If so, give particulars.

12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, complete section 3 in this Addendum and submit a personal statement below regarding the date of conduct, state and local jurisdiction in which the charges were filed, date of closure, what role you played, and the outcome.

	YES	NO
13. Have there ever been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemical filed against you? If so, submit a detailed personal statement below regarding the date of conduct, state and local jurisdiction in which the charges were filed, explaining in detail the incident and consequences including whether or not a CD evaluation was done (if so, submit results), and description of current drinking habits.		[redacted]
14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.		

Use this space for additional information. Be sure to list the question number you are answering.

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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. Jessika Ralph and that he/she is a person of good ethical and moral character.

Signature

Cassing Hammond
Print or type name

4-12-19
Date

036090424
License Number

Illinois
State of Issue

Confederation of Switzerland
Canton and City of Geneva
Consular Service of the United States of America } SS

State _____ County _____

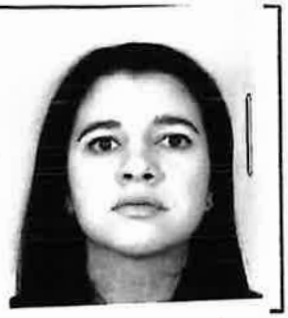
I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and b) comparing the applicant's signature made in my presence with the signature on his/her identifying document.

Sworn to before me by the applicant on this 17th day of April 2019

Notary Public Signature

Cheryl Overcash
Consular Agent

Expiration Date Does not expire



SEAL
The impression of the seal must be partly upon the photo
Geneva, Switzerland

Applicant's Signature

2. I certify that the photograph attached is a recent one and likeness of Dr. Jessika Ralph and that he/she is a person of good ethical and moral character.

Signature

Jessica Kiley
Print or type name

4/4/19
Date

036-112700
License Number

Illinois
State of Issue

Applicant's Name Jessika Ralph
Minnesota Board of Medical Practice

Last 4 Digits of SS[redacted]

Date 4/5/2019
of Ethical and Moral Character

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at: http://www.fsmb.org/contact-a-state-medical-board/.

Please send this form to: Minnesota Board of Medical Practice
2829 University Avenue SE, Suite 500
Minneapolis, MN 55414-3246

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

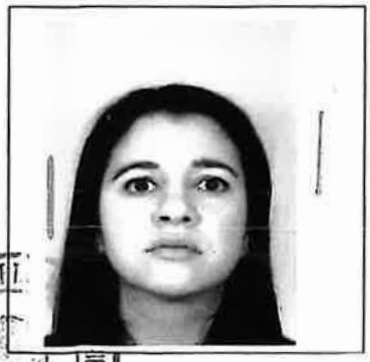
I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.



Jessika A Ralph

Applicant's signature (must be signed in the presence of a notary)

Jessika A Ralph

Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

4-17-2019

Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of _____, County of _____.

Confederation of Switzerland
Canton and City of Geneva
Consular Service of the United States of America } SS

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.

The statements on this document are subscribed and sworn to before me by the applicant on this 17th day of April, 2019.

Notary Public Signature _____ Cheryl Overcash, Consular Agent My Notary Commission Expires Does not expire

Gardner, Alex (HLB)

From: Jessika Ann Ralph <jessika.ralph@northwestern.edu>
Sent: Friday, June 7, 2019 10:46 AM
To: Gardner, Alex (HLB)
Subject: Re: Physician License Application Status
Attachments: JR_UofC Diploma.pdf

I have contacted two physicians who can submit original recommendation forms directly.

I graduated high school in May 2005. I began my undergraduate education in September 2005 at the University of Chicago. I graduated with a BA in June 2009. I attached my diploma for your reference. I began my medical education at Northwestern University in August 2009.

Thank you for your assistance,

Jessika Ralph

From: Gardner, Alex (HLB) <Alex.Gardner@state.mn.us>
Sent: Friday, June 7, 2019 10:40 AM
To: Jessika Ann Ralph
Subject: RE: Physician License Application Status

That will take care of everything except **the two physician recommendation forms**, and the **missing accounting of time from high school to start of medical school** (you can email me the accounting of time directly)

I also just received your WI license verification forms so we should be good to go on that.

PY recommendation forms attached above.

Alex Gardner

Licensure Specialist

Minnesota Board of Medical Practice
2829 University Avenue SE, Suite 500
Minneapolis, MN 55414
O: (612) 548-2140
BMP Main Phone# (612) 617-2130

mn.gov/boards/medical-practice

MINNESOTA
BOARD OF MEDICAL PRACTICE

Uniform Application for Licensure

Application ID: 275690
FID: 217277334

License Requested: MD
License Type: Permanent Medical License
Submitted to: Minnesota Board of Medical Practice
Submission Date: 04/01/2019

Practitioner Name

Ralph, Jessika

Alternate Name(s): Hopson, Jessika

Contact Information

Address

Public Access	Board Contact	Type	Address
No	Yes	Home	1310 N. Ritchie Ct. #18D Chicago, IL 60610 UNITED STATES
No	No	Business	676 N. St. Clair Ste 1315 Chicago, IL 60611 UNITED STATES
Yes	No	Business	Women's Health Specialists Clinic Riverside Professional Building 606 24th Ave. S Suite 300 Minneapolis, MN 55454 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
No	No	Business	[redacted]	
Yes	No	Business	(612) 273-7111	
No	Yes	Mobile	[redacted]	

Email

Public Access	Board Contact	Email
No	No	[redacted]
Yes	Yes	jessika.ralph@northwestern.edu

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
52674223	[redacted]	1987	Phoenix, AZ UNITED STATES	F	1871835025	MD	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Northwestern University Medical School	303 East Chicago Avenue Chicago, IL 606113008 UNITED STATES	08/01/2009	05/23/2013	05/23/2013	MD

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

Postgraduate Training

Hospital Name:	**Medical College of Wisconsin Affiliated Hospitals Program** Milwaukee, WI UNITED STATES	**Program Code:**	ACGME 2205631307
		Attendance Dates:	
Institution:	Medical College of Wisconsin Affiliated Hospitals, Inc	**Start Date:**	07/01/2013
Training Specialty:	Obstetrics & Gynecology	**End Date:**	06/30/2017
		Program Type:	Residency
Training Status:	Completed		
Clinical %:	100	**Administrative %:**	0

Hospital Name:	**Prentice Women's Hospital** Chicago, IL UNITED STATES	**Program Code:**	
		Attendance Dates:	
Institution:	Northwestern University	**Start Date:**	07/01/2017
Training Specialty:	Family Planning	**End Date:**	06/30/2019
		Program Type:	Fellowship
Training Status:	Active		
Clinical %:	100	**Administrative %:**	0

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
USMLE Step 1 Examination		06/14/2011	Pass	1
USMLE Step 2 CS Examination		11/08/2012	Pass	1
USMLE Step 2 CK Examination		12/13/2012	Pass	1
USMLE Step 3 Examination		08/05/2014	Pass	1

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Illinois Department of Financial and Professional Regulation	IL	036142418	02/15/2017	07/31/2020		Active
Wisconsin Medical Examining Board	WI	63093-20	10/09/2014	10/31/2017		Expired

Physician Reported License History

Practitioner License Type	Licensing State	License Number	Issue Date	Expiration Date	Type	License Status
None Reported						

Chronology of Activity Type

Practice/Emp/ Desc: Northwestern University Medical School
Chronology Type: Medical Education
Address: Chicago, IL US
Attendance Dates:
Position/Dept:
Start Date: 08/01/2009
End Date: 05/23/2013
Clinical %:
Admin %:
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: Vacation
Chronology Type: Vacation
Address:
Attendance Dates:
Position/Dept:
Start Date: 06/01/2013
End Date: 07/01/2013
Clinical %: 0
Admin %: 0
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: Medical College of Wisconsin Affiliated Hospitals Program
Chronology Type: Accredited Training
Address: Milwaukee, WI US
Attendance Dates:
Position/Dept:
Start Date: 07/01/2013
End Date: 06/30/2017
Clinical %: 100
Admin %: 0
Employment: **Staff Privileges:** **Affiliation:**

Practice/Emp/ Desc: Prentice Women's Hospital
Chronology Type: Other Training
Address: Chicago, IL US
Attendance Dates:
Position/Dept:
Start Date: 07/01/2017
End Date: 06/30/2019
Clinical %: 100
Admin %: 0
Employment: **Staff Privileges:** **Affiliation:**

Malpractice

None Reported

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

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 Jessika Ralph SS# [redacted]

Signature _____ Date 6/7/19

Date of Degree May 23, 2013 Degree Received MD

THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) Jessika Ralph

MATRICULATED IN: (Name of School) Northwestern Univ. Feinberg Sch. of Medicine

AT: (Location of School) 303 E. Chicago Ave., 1-003 Chicago, IL 60611-3008

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

ON: (Month, Day, Year) May 23, 2013

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 Miroslava Rachuy
Signature Miroslava Rachuy
Date June 07, 2019
Phone Number 312-503-4070
Fax Number 312-503-0715

*Please attach letter of explanation.

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

01/02

Northwestern University

On recommendation of the faculty of the

Feinberg School of Medicine

Northwestern University has conferred the degree of

Doctor of Medicine

upon

Jessika Ann Ralph

who has honorably fulfilled all the requirements
prescribed by the University for that degree
done at Chicago, Illinois this twenty-third day of May in the
year two thousand and thirteen A.D.

Chairman of the Board of Trustees

Secretary of the Board of Trustees

NORTHWESTERN UNIVERSITY · QUAECUNQUE · SUNT · VERA · 1851 ·

President of the University

Dean

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

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 Jessika Ralph SS# [redacted]

Signature _____ Date 6/12/19

Training Dates (Month,Day,Year) 7/1/2013 – 6/30/2017 Birthdate [redacted] 1987

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

It is hereby certified that (Name of Applicant) Jessika Ralph, MD

Received credit for post graduate training (# Months) 48 from date: 7/1/2013 to date: 6/30/2017

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

at (Name of Hospital or Institution) Medical College of Wisconsin Affiliated Hospitals

located at 9200 W. Wisconsin Ave. Milwaukee, WI 53226
(Street Address, City, State, Zip, Country)

Affiliated Medical School Name Medical Col. of WI Specialty OB/GYN 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 X No ____

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

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

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

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

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 Patty Lemen, MD

Signature _____

Date 6/13/19 Phone 414-805-6600

Fax 414-805-6622 Email _____

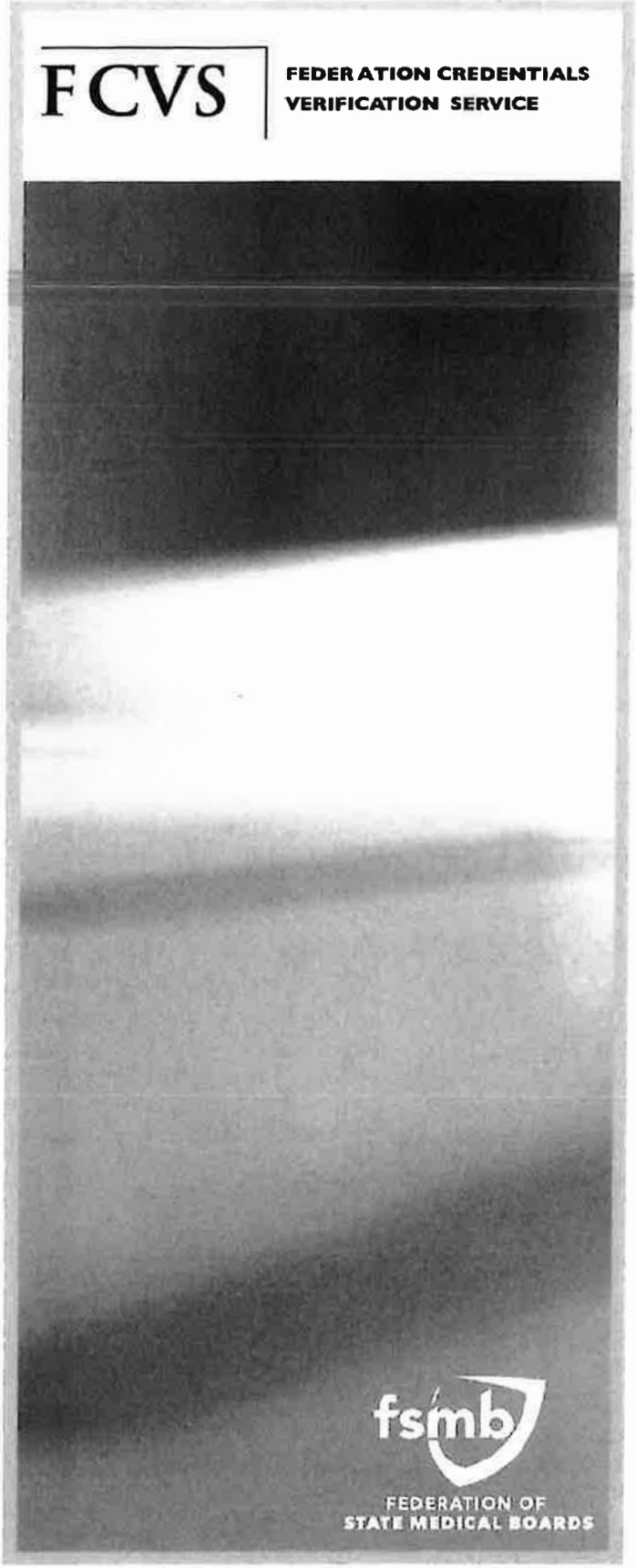
Kelly Morey - Notary 6/13/19
Expires - 1/29/2022

*Attach letter of explanation

1/2011

FCVS

FEDERATION CREDENTIALS VERIFICATION SERVICE



Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Ralph, Jessika Ann**
Social Security Number:	[redacted]
Date of Birth:	[redacted]**1987**
FID#:	**217277334**
Recipient:	**MN - Minnesota Board of Medical Practice**
Delivery Date:	**06/07/2019**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

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Affidavit and Release

Federation of STATE MEDICAL BOARDS

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Ap
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In th
curr
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of y

Jessika Ralph
signer_1@notarycam.com
Applicant's Signature (must be signed in the presence of a notary)

Ralph
Applicant's Printed Last Name

Jessika A
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

10/20/2016
Date of Signature (must correspond to date of notarization)

State of Virginia, County of Prince George

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. The statements on this document are subscribed and sworn to before me by the applicant on this 20th day of October, 20 16.

Notary Public Signature: Tara Melissa Allen

My Notary Commission Expires: 11/30/2018

Please complete and mail this original document to the Federation of State Medical Boards at:

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 |

TARA MELISSA ALLEN
ELECTRONIC NOTARY PUBLIC
REG # 7016003
EXPIRES 11/30/2018
COMMONWEALTH OF VIRGINIA

Doc ID: 20161020221212370

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Biographic Information

Medical professional Name(s): **Ralph, Jessika Ann**
Hopson, Jessika Ann
Ralph, Jessika

Date of Birth: [redacted]1987

Place of Birth: Phoenix, AZ, UNITED STATES

Contact Information

Business Address:
676 N. St. Clair Ste 1315
Chicago, IL 60611
UNITED STATES

Business Address:
Women's Health Specialists Clinic Riverside Professional Building
606 24th Ave. S
Suite 300
Minneapolis, MN 55454
UNITED STATES

Home Address:
1310 N. Ritchie Ct. #18D
Chicago, IL 60610
UNITED STATES

Business Phone: [redacted]
Mobile Phone:
Business Phone:

Email: [redacted]
Email:

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Ralph Jessika Ann
Last First Middle

FCVS ID Number: 217277334

Notary – Please complete the section below:

State of Virginia County of Prince George

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 20th, of (Month) October, (Year) 2016.

Notary Public Signature: Tara Melissa Allen

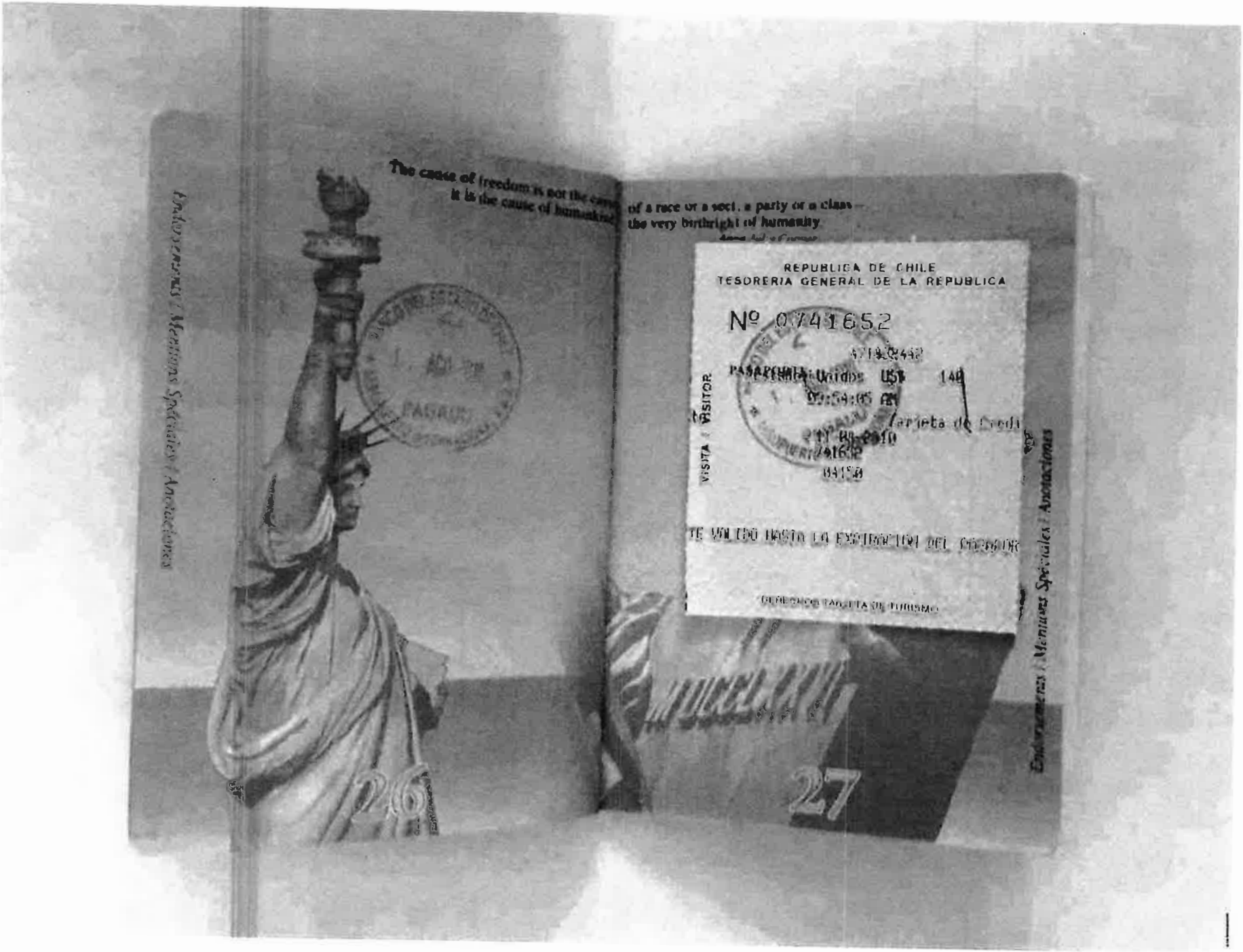
Commission Expiration Date* (Month) 11 /(Day) 30 /(Year) 2018

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Notary Stamp Here

Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856


The cause of freedom is not the cause
it is the cause of humankind
of a race or a sect, a party or a class
the very birthright of humanity
REPUBLICA DE CHILE
TESORERIA GENERAL DE LA REPUBLICA
Nº 0741652
VISITA / VISITOR
Tarjeta de Credi
DEVOLVER TARJETA DE TURISMO
Embajadores / Menores Especiales / Anotaciones
Embajadores / Menores Especiales / Anotaciones
28
27


We the People
Of the United States,
SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR
PASSPORT
PASSEPORT
PASAPORTE
USA
UNITED STATES OF AMERICA
P
USA
[redacted]
RALPH
JESSIKA ANN
UNITED STATES OF AMERICA
[redacted]1987
ARIZONA, U.S.A.
22 Jun 2010
21 Jun 2020
SEE PAGE 27
F
United States
Department of State
USA
[redacted]

CERTIFICATION OF VITAL RECORD

"VERIFICATION BOX" (HOLD BETWEEN THUMB AND FOREFINGER, OR BREATHE ON IT COLOR WILL CHANGE TO BLUE AND THEN RETURN)

STATE OF ARIZONA

STATE OF ARIZONA
DEPARTMENT OF HEALTH SERVICES - OFFICE OF VITAL RECORDS

CERTIFICATE OF LIVE BIRTH

BIRTH NO. B 102- 87-007275

NAME OF CHILD: A. First	B. Middle	C. Last	
1. Jessika	Ann	Hopson	
SEX: 2. Female	TYPE OF BIRTH (Single, twin, triplet, etc.) SPECIFY: 3A. Single	IF MULTIPLE BIRTH (Born first, second, etc.) SPECIFY: 3B	DATE OF BIRTH (Month, Day, Year): 4A. [redacted] 1987	HOUR: 4B. 0730
PLACE OF BIRTH: A. County: 5. Maricopa	B. Town or City: Phoenix	C. Hospital or Clinic (If not in hospital, give street address): St. Joseph's Family Childbirth Center		
FATHER'S NAME: A. First	B. Middle	C. Last	DATE OF BIRTH (Month, Day, Year): [redacted] 1957	PLACE OF BIRTH (State or Country): 8. Arizona
MOTHER'S USUAL RESIDENCE: A. State: 12. Arizona	B. County: Maricopa	C. Town or City: Mesa	D. Zip Code: 85204	
STREET ADDRESS OR R.F.D.: 12E. 2502 E. Carol	IN CITY LIMITS? 12F. ☒ YES ☐ NO	MOTHER'S MAILING ADDRESS (If different from Item 12): 13. Same		
14. THE INFORMATION LISTED IN ITEMS 1-13 IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE	PARENT OR INFORMANT'S SIGNATURE: 14A. Theresa J Hopson	RELATIONSHIP TO CHILD: 15. Mother	DATE SIGNED: [redacted], 1987	
17. I ATTENDED THE BIRTH OF THIS CHILD WHO WAS BORN ALIVE AT THE PLACE, TIME, AND DATE ENTERED ABOVE	ATTENDANT'S SIGNATURE (Type name below sig.): 17A. Filippo Santoro, M.D.	TITLE: ☒ M.D. ☐ D.O. ☐ OTHER (specify)	[redacted] 1987	

SUPPLEMENTARY ENTRIES: 20.

DATE REGISTERED	REG. FILE NO.	REGISTRAR'S SIGNATURE	REG. DISTRICT	DATE RECVD. BY STATE OFFICE
21. MAR 03 1987	22. 6330	23. Bonnie L. Bozzuto, Deputy	24. 07	25. APR 02 1987

7/1/2010

Patricia Adams
PATRICIA ADAMS
ASSISTANT STATE REGISTRAR

This is a true certification of the facts on file with the OFFICE OF VITAL RECORDS, ARIZONA DEPARTMENT OF HEALTH SERVICES, PHOENIX, ARIZONA issued under the authority of A.R.S. 36-341, and to direction of:

This copy not valid unless prepared on a form displaying the State seal and impressed with the raised seal of the issuing agency.

[redacted]

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Chronology of Activities

fsmb

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
08/01/2009	05/23/2013	Medical Education	Northwestern University Medical School Chicago Illinois UNITED STATES
06/01/2013	07/01/2013	Vacation	Vacation
07/01/2013	06/30/2017	Postgraduate Training	Medical College of Wisconsin Affiliated Hospitals Program Milwaukee Wisconsin UNITED STATES
07/01/2017	06/30/2019	Postgraduate Training	Prentice Women's Hospital Chicago Illinois UNITED STATES

End of Chronology of Activities report for: Ralph, Jessika Ann

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **Northwestern University Medical School**

Location: Chicago, IL
UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? — **No** ____

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the Interruption/extension was approved or unapproved:

	From Date:	To Date:
Personal/Family		
Academic remediation		
Health		
Financial		
Participation in joint degree Program (e.g., MD/PhD)		
Participation in non-research special study (e.g., fellowship, international experience)		
Participation in non-degree research		
Other:		
Other:		

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? **No**

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

	From Date:	To Date:
Academic Probation		
Probation for unprofessional conduct/behavioral		
Other:		

Please specify a reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? **No**

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? **No**

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **No**

If YES, please provide detailed documentation/information about the nature of the limitations or special requirement:

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Road
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Northwestern University Medical School

Address Line 1: 303 East Chicago Avenue

Address Line 2:

City: Chicago **State/Province:** IL **Zip Code (Postal Code):** 606113008

Country: US

If name of institution was different when this individual attended, please note this name below:
N/A

Premedical Education:
Years of education required for admission to your medical school: 4
Credential/degree presented by the applicant for admission to your medical school: BA or BS

Enrollment and Participation: Our records indicate that Ralph, Jessika
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 154 weeks of medical education on the following dates: **From:** 08/28/2009 **To:** 05/23/2013
Month Day Year Month Day Year

This individual
Was awarded the degree of Doctor of Medicine on 05/23/2013
Month Day Year
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.

ELECTRONIC SEAL VERIFIED

Name: Mary Rachuy

Signature: *Mary Rachuy*

Title: Academic Records Assistant
Date of Signature: 10/25/2016 **Phone:** (312) 503-1225
Fax: (312) 503-0715 **Email:** m-rachuy@northwestern.edu

217277334 1150 217277334

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Ralph, Jessika

Northwestern University Medical School

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Ralph, Jessika

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

NORTHWESTERN UNIVERSITY
FEINBERG SCHOOL OF MEDICINE

Northwestern University
Feinberg School of Medicine

Augusta Webster, MD, Office of
Medical Education
Ward 1-003
303 E. Chicago Avenue
Chicago, Illinois 60611-3008

Phone 312-503-0440
Fax 312-503-0438

NORTHWESTERN
UNIVERSITY

Medical Student Performance Evaluation
for
Jessika Ann Ralph
October 1, 2012

Identifying Information

Jessika Ann Ralph is a fourth-year student at Northwestern University Feinberg School of Medicine in Chicago, Illinois.

Unique Characteristics

During her medical education, Jessika was able to explore several opportunities and gain valuable experiences that will add to her skills as a physician. She participated in the Admissions Committee and the Interview Committee in order to advocate for strong candidates whose goals are consistent with the student community at Feinberg. In her third year, Jessika selected several off-site clinical rotations in order to gain exposure to medically under-served populations, including the Stroger Cook County Hospital and the Jesse Brown VA. She has gained an appreciation for practicing medicine in resource-limited settings and for accommodating language and cultural barriers. In addition to her medical training, Jessika enjoys spending her free time with her husband and their adopted miniature schnauzer.

Academic History

Date of Expected Graduation from Medical School:	May 2013
Date of Initial Matriculation in Medical School:	August 2009
Please explain any extensions, leave(s) of absence, gap(s), or break(s) in the student's educational program.	Not applicable
For transfer students:	
Date of Initial Matriculation in Prior Medical School:	Not applicable
Date of Transfer from Prior Medical School:	Not applicable
For dual/joint/combined degree students:	
Date of Initial Matriculation in other degree program:	Not applicable
Date of Expected graduation from other degree program:	Not applicable
Type of other degree program:	Not Applicable
Was this student required to repeat or otherwise	No

remediate any coursework during his/her medical education?

Was this student the recipient of any adverse action(s) by the medical school or its parent institution?	No

Professional Performance

We have assessed all students' capabilities to meet standards for: accountability, self-improvement and adaptability, appropriate relationship with patients, relationship with healthcare team, initiative, professional demeanor, and behavior under stress. Unless otherwise noted, all students have met the stated objectives for professionalism at Feinberg.

Academic Progress

Jessika Ann Ralph earned grades of Pass in all preclerkship courses and recorded a score of 239 on Step I of the USMLE exam.

Preclinical/Basic Science Curriculum

(Details are provided in Appendix E.)

Core Clinical Clerkships

Following are the unedited narrative evaluations of Jessika's performance on the successive clerkships and electives. Appendix B summarizes this information graphically.

INTERDISCIPLINARY MEDICINE: PASS 7/5/2011 - 6/15/2012

MEDICINE: PASS 7/5/2011 - 9/23/2011

Jessika was a very good student, who was a pleasure to work with. Her fund of knowledge assessed by her preceptors and final exam was appropriate for her level of training. She was eager to learn and clearly read about her patients. She integrated well into the patient care team and was always looking for ways to be helpful. Her oral presentations were well organized, and she synthesized information well. She showed a lot of composure on daily rounds. She appeared very comfortable in the role of physician. She had a great attitude and was very much a team player – always willing help when asked to do so by her team. Jessika's final grade is Pass.

PEDIATRICS: PASS 9/26/2011 - 11/4/2011

During her six week pediatric clerkship, Jessika rendered a very good performance. Her history taking and physical examination skills were appropriate for her level of training. Her oral case presentations were consistently thorough and she made some good presentations on pertinent topics. She followed her patients diligently and developed a very nice rapport with her patients and parents. She was well liked by her patients and had a very nice style of relating to her patients and their families. Jessika was obviously very interested and motivated and she was consistently hard working. In addition, she was professional and respectful to all members of the medical team. She was intellectually curious and read consistently about her patients. Jessika was described by the housestaff as being an important member of the medical team, asking good questions, taking initiative and sharing important information about her patients' diagnosis and medical issues. Her fund of knowledge, as assessed by her clinical evaluators, was appropriate for her level of training. On the basis of her performance, we believe that Jessika will make a very good house officer and physician. She receives a final grade of PASS for the pediatric clerkship.

OBSTETRICS & GYNECOLOGY: HIGH PASS 11/7/2011 - 12/16/2011

Jessika is a hard-working student whose overall performance during the Obstetrics and Gynecology clerkship was excellent. She spent the majority of the six week rotation at Stroger Hospital, working primarily with an under-served patient population. During her History and Physicals, she evaluated patients independently and formulated well thought-out assessments and plans. Her written notes contained pertinent positives and negatives and demonstrated a strong knowledge of the underlying disease processes. Jessika is confident in front of an audience and gave a well-received talk on health maintenance at the Cermak Jail. Her technical skills and dexterity were appropriate for her level of training. Clinical reasoning came easily to Jessika and she consistently read to improve her fund of knowledge. She was receptive to feedback and professional at all times. Her peers found her to be willing to take on more work and compassionate in her patient care. Nurse evaluators felt she was personable and respectful. Final Grade: High Pass.

PRIMARY CARE: PASS 1/3/2012 - 1/27/2012

Jessika is a motivated medical student who performed very well during the Primary Care Clerkship. She has very good history taking and solid physical examination skills for a student at her level of training. She needs to continue to broaden her differentials based on the history she obtains. Her oral case presentations in Weekly Report and the clinical setting are well organized and thorough. Her written write ups were very good. Her written examination score was just below the mean revealing a good fund of knowledge. In Weekly Report she was always well prepared. The fluency of her presentations improved during the month. She revealed excellent reading effort and had relevant teaching points related to her case. She was an active participant and revealed a good knowledge base when contributing to the discussion on other student's cases. Her Learner Centered Learning Goal presentation on "Allergic Rhinitis" was considered excellent. It was a relevant topic and her organization was superb. She gave a nice overview of the literature and kept it clinically focused. Her clinical preceptors felt her strengths to be patient and team rapport, responsiveness to feedback and motivation to learn. She is reliable and professional. She receives a grade of Pass for her work during this clerkship.

PSYCHIATRY: PASS 1/30/2012 - 2/24/2012

Jessika completed two weeks on the inpatient service and two weeks on the consultation-liaison service at Northwestern Memorial Hospital. She worked extremely hard and was a pleasure to have on both services. She was actively involved in her patients' care, and displayed strong initiative throughout the rotation. Her interviews and notes improved during the month. She connected well with patients and was able to be flexible in her interviewing style. Her score on the shelf exam was at the 73rd percentile nationwide, reflecting a strong fund of knowledge for her level of training. On the OSCE, she displayed very good communication skills and clinical reasoning. Overall, she did very good work on the rotation and receives a grade of PASS.

NEUROLOGY: HIGH PASS 2/27/2012 - 3/23/2012

Jessika did a very good job on the neurology rotation. She completed this rotation during the third quarter of her M3 year. Her histories consisted of most of the required elements from the routine neurological cases that she evaluated during this rotation. Her neurological examinations were almost complete, although she occasionally missed parts of it. She had good neurological examination technique. Her oral presentations were organized and easy to follow. During case discussion conference with her peers, she presented a case of a lady with vertigo. Her presentation was organized. She appeared to have an adequate fund of knowledge based on her discussions and interactions. She scored in the 71st percentile of the nation on the written neurology shelf examination. Her score on the OSCEs (1 standardized patient case and 2 written short cases, and 2 multiple choice cases- total of 9 stations) was: 89%. Based on performance on the standardized

patient case, she demonstrated excellent history, very good neurological examination and good clinical reasoning skills.
Jessika was pleasant and personable. She was proactive in trying to understand her clinical care environment and she worked independently. She interacted very well with her team and staff members. She had pleasant bedside manners and her patients felt comfortable with her. For overall performance on this rotation, the grade of HIGH PASS is awarded.

SURGERY: PASS 3/26/2012 - 6/15/2012

Ms. Ralph did a very good job on the surgery clerkship and earns a grade of pass. Her knowledge as assessed on the NBME Surgery Subject Exam was very good, as demonstrated by a score of 77 with a class mean of 75 (Std Dev. 7.23). Her clinical skills as measured on the OSCE were very good, achieving an OSCE score of 127 with a class mean of 129 (Std. Dev. 11.08). Her professional behaviors and attitudes as measured on performance appraisals were very good. Her reasoning and judgment were very good. Her communication skills were excellent. Ms. Ralph's preceptors and residents describe her as well prepared, thoughtful and friendly. "A pleasure to have on the service. Made a concerted effort to improve her skills." "Developed thoughtful plans for her patients daily. Good knowledge and confidence in her patient presentations." "Impressed with her ability to gather and organize patient data." In summary Ms. Ralph did a very good job on the surgery clerkship and receives a grade of pass.

MEDICINE SUBINTERNSHIP: HIGH PASS 7/9/2012 - 8/5/2012

I enjoyed working with Jessika. We had a very busy service and Jessika was tremendous. She was thorough with her patients and helpful in getting things done with other patients. She took ownership of her patients and provided excellent care. Most notable was her compassion towards patients and ability to counsel patients so that the patient and the family feel comfortable with plans. Her effort, initiative, patient rapport, and interpersonal skills were all outstanding.

SUMMARY

Jessika has worked diligently and performed well during her career at the Feinberg School of Medicine.

Jessika is one of the students in the Class of 2013 who has received a Physicianship form for exemplary behavior. These forms are filled out by a faculty member when they are impressed by a student's professionalism in a situation. Less than 10% of the class received this recognition.

Based on a comprehensive review of Jessika's academic record, her overall medical school performance has been **very good** in comparison to that of her peers at this institution. Please refer to Appendix D for a description of how we have categorized students this year and to Appendix E for information on the caliber of students accepted to the Feinberg School of Medicine and their performance on USMLE Step1 and Step 2 CK.

We believe that Jessika will be a very good addition to your residency program.

Please feel free to contact us if you would like additional information on this candidate. We also welcome any comments on this Medical Student Performance Evaluation.

Sandra M. Sanguino, MD, MPH
Associate Dean for Student Programs and Career Development

John X. Thomas, PhD.
Senior Associate Dean for Medical Education

APPENDICES

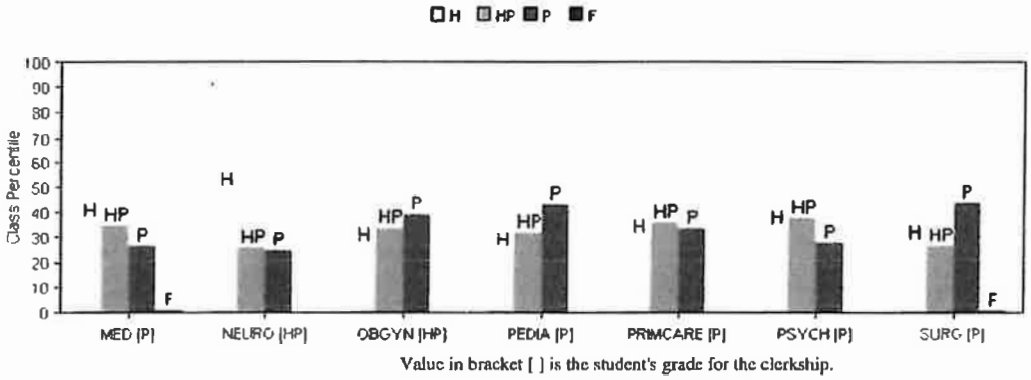
Appendix A: Comparative Performance in Preclinical Coursework

During the first and second years of the curriculum, the only grades assigned to students are Pass or Fail. Students must receive a grade of "Pass", in each preclinical course before beginning the clerkships.

Appendix B: Graphic Representations of Comparative Performance in Core Clinical Clerkships

Grades in Required M3 Clerkships/Courses

Jessika Ann Ralph's grade for each clerkship is indicated inside the bracket beside the clerkship name.



Value in bracket [ ] is the student's grade for the clerkship.

Table 1- Grade Percentages for Each Required M3 Clerkships/Courses

	MED	NEURO	OBGYN	PEDIA	PRIMCARE	PSYCH	SURG
H	37	49	27	25	30	34	28
HP	35	26	34	32	36	38	27
P	27	25	39	43	34	28	44
F	1	0	0	0	0	0	1

Appendix C: Performance in Professional Attributes

Parameters have been measured to assess Professional Performance on a scale from 1 (low) to 9 (high) during each of the required third year clerkships. Each parameter has anchor statements to focus the evaluation to the standards.

Appendix D: Overall Comparative Performance in Medical School

For the Class of 2013, each of the 162 members was placed into one of the following categories based upon overall academic performance in our educational program prior to the M4 year. The approximate percentage of the class in each of the top three categories (Distinguished, Outstanding, and Excellent) is provided. There is no formal designation of class rank.

Distinguished:
These students have met all requirements and have demonstrated their ability to consistently excel. These students have met and exceeded the criteria for excellence in their clinical evaluations in required clerkships (for the most part honors and high pass evaluations in every clerkship). This group constitutes approximately 25% of the Class of 2013.

Outstanding:
These students have met all requirements and have consistently demonstrated their ability to excel in the required clerkships. This group constitutes approximately 25% of the Class of 2013.

Excellent:
In general, these students have met all requirements and have demonstrated their ability to excel in several of the required third year clerkships. This group constitutes approximately 26% of the Class of 2013.

Very Good:
In general, these students have met all requirements. These are students who have passed all of the required clerkships, and on some occasions have excelled.

Good:
In general, these are students who have had some academic difficulty during their four year required curriculum but have successfully remediated their academic difficulty and then progressed to fulfill all graduation requirements.

Appendix E: Medical School Information Page

Medical School Information Page

Feinberg School of Medicine
Medical School Name

Chicago, Illinois
City, State

Special programmatic emphases, strengths, mission/goal(s) of the medical school:

The missions of the Feinberg School of Medicine are education, research and professional services, a major component of the latter being the delivery of high quality patient care. The Medical School supports the overall mission of the University to achieve excellence in its scholarly and service programs and to participate in its framework for distinction. The goal of the medical curriculum at the Feinberg School of Medicine is to prepare broadly educated, responsible physicians capable of pursuing postgraduate medical education in any clinical discipline and/or pursuing a career in medically related research. The curriculum provides for a general professional education and incorporates the fundamental principles of medicine and scientific concepts. The objectives for the educational program require each student to attain facility in the following areas: (1) knowledge of the scientific basis and language of medicine; (2) information management; (3) communication; (4) clinical data gathering; (5) clinical decision making; (6) professional attitudes based on an appreciation of medical ethics and humanities; (7) commitment to health promotion and disease prevention; and (8) commitment to lifelong learning. The educational leadership, which includes the medical school administration, faculty on the curriculum committee and the course and clerkship directors, continuously uses these objectives as an effective guide for educational program planning and evaluation. These objectives are central to the medical school's mission and provide the necessary resources to achieve them has, and will continue to be the highest priority. Education is conducted in such a manner that students are imbued with the commitment to life-long learning, professional and personal growth. Our graduates are trained to be committed to the practice of ethical and humane medicine and contribute to enhancing the ethical status of the profession.

Students are encouraged to consider themselves part of a community of scholars and to pursue research. To that end, the medical school offers several opportunities for students to engage in research, including the Summer Research Program and a number of more intense research programs. Students use a variety of methods to perform in-depth investigations in the basic sciences, clinical sciences, social sciences, public health, medical humanities, medical informatics, history of medicine, bioethics, health policy, patient-physician communication and medical education.

Feinberg Student Attributes:

The Feinberg School of Medicine is fortunate to attract students who possess grade-point averages and MCAT scores which are above the national average. The exact data for the Class of 2013 is shown in the table below:

	GPA Science	GPA Total	MCAT Verbal	MCAT Physical	MCAT Biological
National	3.60	3.66	9.8	10.3	10.8
Feinberg	**3.69**	**3.74**	**10.5**	**11.9**	**12.1**

In addition, the average scores for Feinberg students on the United States Medical Licensing Examination for Step 1 and for Step 2 CK are well above the national average for these examinations. Performance on USMLE Step 2 CS from the most recent annual report and subsequent data indicated that approximately 100% of the students have passed the examination.

In summary, based on the data from external sources and the history of where our graduates match for postgraduate education, students who are at the 50th percentile in our academic setting would rank at a significantly higher percentile within the national cohort of students graduating in 2013.

Special characteristics of the medical school's educational program:

Preclerkship Courses:

Structure-Function (S–F) is a lecture and laboratory course that integrates the basic science topics of biochemistry, cell biology, molecular biology, genetics, embryology, histology, physiology, and gross anatomy in an interdisciplinary approach.

Scientific Basis of Medicine (SBM) is the basic science course that occupies the mornings of the second year. It consists of lectures and a variety of small group activities that focus on organ system pathobiology.

Medical Decision Making (MDM I, II, & III) is a series of courses that address the knowledge and skills that are required in making basic and complex decisions in the practice of medicine. It is taught in three blocks (MDM I, II, and III).

Problem Based Learning (PBL) is an adjunct to the S–F and SBM courses. It takes place in small-group sessions using cases designed to integrate information across the basic sciences in the context of medicine. PBL is a student-centered, self-directed learning experience that promotes a variety of educational objectives. These include learning how to work independently and in groups; to analyze problems; to frame questions; to develop and test hypotheses; to recognize knowledge deficiencies and to pursue strategies for addressing them; to communicate with colleagues; and to develop professional skills and attitudes. There are four PBL "blocks" in the first year and three in the second year

Patient, Physician, and Society (PPS 1 & 2) courses are designed to provide a comprehensive, integrated introduction to professional skills and perspectives. The course meets two afternoons per week throughout the first two years and then once a month in the last two years. For the first two years, one afternoon is devoted to the Patient and Physician relationship; students begin to build clinical skills through learning experiences that provide an integrated, biopsychosocial perspective of patient care. The other afternoon deals with Physician and Society matters and addresses ethics and human values, public health, and health policy.

Unique Courses taught during the Clerkship Years:

M3 Interdisciplinary Medicine (IDM)

In the third year, students have Interdisciplinary Medicine one Friday a month. The overall goal of IDM is to enhance what students learn in their clinical clerkships by applying interdisciplinary perspectives. The curriculum is designed to help students develop knowledge, skills, and professional values in an ongoing reflective manner throughout the clinical years of medical school. Topics include:: Advanced Physical Diagnosis, Nutrition, Health Law, Career Development, Complementary and Alternative Medicine, Ethical, Legal, and Social Implications of Medicine, Geriatrics, Palliative Care, Medical Decision-Making/Evidence Based Medicine, Difficult Conversations, Practice-Based Learning and Quality Improvement, and Patient, Physician & Society III: Professional Perspectives.

M4 Patient, Physician, and Society IV

This course meets once a month for a total of ten times during the year. Students cover the following topics: health economics, teaching skills and professional perspectives. This is the culminating course of the students' four years of Patient, Physician and Society courses.

Average length of enrollment (initial matriculation to graduation) at the medical school:
Four years and three months.

Description of the evaluation system used at the medical school:
Preclerkship courses in the first two years are evaluated on a Pass or Fail basis. Therefore, whether the performance in an individual course is exemplary or satisfactory, the grade of Pass is assigned. A passing score on the M2 Clinical Skills Assessment examination is required at the end of the second year prior to entering the clerkships.
Required Clerkships are evaluated using Honors, High-Pass, Pass and Fail. Specific criteria for the grade of Honors or High Pass have been established for each clerkship as opposed to assigning an arbitrary percentage. The distribution of grades for the class of 2013 is shown in Table 1. The grade of Pass is given to all other students who satisfactorily meet the objectives of the clerkship. In some instances, extra time was required to fulfill all requirements of the clerkship or to remediate a particular aspect; in which case the grade of "Pass after remediation" is given. Required M3 Clerkships: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, Neurology, Primary Care, (or an Education Centered Medical Home), and Psychiatry. Required M4 Clerkships: Sub-internship (Medicine, Pediatrics, Surgery or Ob-Gyn), Emergency Medicine, Intensive Care Unit Rotation, and Physical Medicine & Rehabilitation.

Elective Clerkships are usually evaluated using Honors, Pass and Fail. In some elective clerkships, the only grades awarded are Pass or Fail; this situation is usually noted in the narrative evaluation for the clerkship. Three months of elective credit can be granted for research, providing the research is approved and deemed meritorious by the Student Research Committee.

There is no formal designation of class rank. About 2% of the students in the Class of 2013 have received a course grade of Fail at one time or another. Any failed course or clerkship must be repeated, in which case both courses and final grades are shown on the transcript. In the remediated courses or clerkships, the only grade possible is a Pass. The remediated course is indicated with a P* on the transcript.

Medical school requirements for successful completion of USMLE Step 1, 2 (check all that apply):

USMLE Step 1:

- ☐ Required for promotion
- ☑ Required for graduation
- ☐ Required, but not for promotion/graduation
- ☐ Not required

USMLE Step 2:

- ☐ Required for promotion
- ☑ Required for graduation
- ☐ Required, but not for promotion/graduation
- ☐ Not required

Medical school requirements for successful completion of Objective/Observed Structured Clinical Evaluation (OSCE) at medical school. OSCEs are used for (check all that apply):

- ☑ Completion of course
- ☑ Completion of clerkship
- ☐ Completion of third year
- ☐ Graduation
- ☐ Other: _____

Utilization of the course, clerkship, or elective director's narrative comments in composition of the MSPE. The narrative comments contained in the attached MSPE can best be described as (check one):

- ○ Reported exactly as written
- ◉ Edited for length or grammar, but not for content
- ○ Edited for content or included selectively

Utilization by the medical school of the AAMC "Guidelines for Medical Schools Regarding Academic Transcripts." This medical school is:

(•) Completely in compliance with Guidelines' recommendations

( ) Partially in compliance with Guidelines' recommendations

Exceptions:

( ) Not in compliance with Guidelines' recommendations

Description of the process by which the MSPE is composed at the medical school (including number of school personnel involved in composition of the MSPE).

The MSPE for individual students is the product of collection and assimilation of all objective and subjective formal evaluations during the undergraduate medical education period. Other information included is supplied by the student regarding his or her extracurricular and research experiences. All MSPEs are prepared by the Associate Dean for Student Programs & Professional Development and the Senior Associate Dean for Medical Education and selected members of their respective staffs.

Students are permitted to review the MSPE prior to its transmission:

(•) Yes

( ) No

Northwestern University, Feinberg School of Medicine Transcript

Tuesday, October 25, 2016

Student: Ralph, Jessika Ann
Degree: MD 5/23/2013
USMLE1: 6/14/2011 P
USMLE2 CK: 12/13/2012 P
USMLE2 CS: 11/8/2012 P

M1 2009-10 Academic Year	Grade
Problem Based Learning I	P
Medical Decision Making I	P
Medical Decision Making II	P
Structure-Function	P
Patient, Physician & Society I	P

M2 2010-2011 Academic Year	Grade
Problem Based Learning II	P
Scientific Basis of Medicine	P
Medical Decision Making III	P
Patient,Physician & Society II	P

M3 2011-2012 Academic Year	# Weeks	Grade
Intro to Clinical Clerkships	1.0	P
Medicine	12.0	P
Pediatrics	6.0	P
Obstetrics & Gynecology	6.0	HP
Primary Care	4.0	P
Psychiatry	4.0	P
Neurology	4.0	HP
Interdisciplinary Medicine III	4.0	P
Surgery	12.0	P

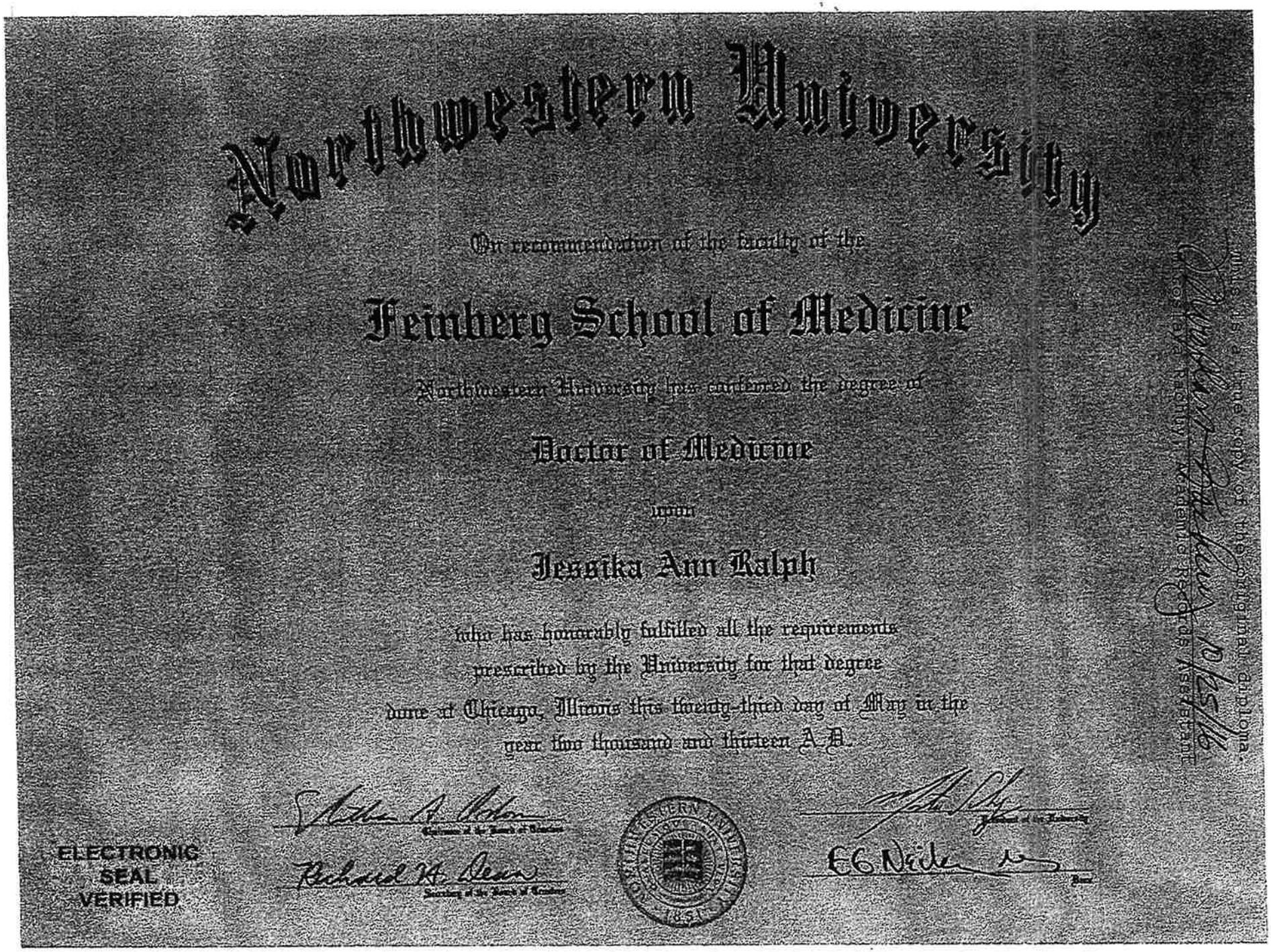
M4 2012-2013 Academic Year	# Weeks	Grade
Medicine Subinternship	4.0	HP
Reproductive Genetics	4.0	H
Intensive Care	4.0	HP
Emergency Medicine	4.0	HP
Cardiology Consult	4.0	H
Family Medicine	4.0	H
Ed Centered Medical Home II	4.0	P
Physical Med & Rehabilitation	2.0	HP
Patient,Physician &Society IV	0.5	P
Teaching Selective	0.5	P

H - Honors (M3/M4 only)
HP - High Pass (Required M3/M4 only)
P - Pass
P^ - Pass after Remediation
P* - Pass Repeated Course
F - Fail
W - Withdraw
I - Incomplete
R - Registered
C - Credit

This transcript is official only with signature and raised seal.

Miroslava Rachuy
Academic Records Assistant 3
Registration and Records

ELECTRONIC SEAL VERIFIED



Northwestern University

On recommendation of the faculty of the

Feinberg School of Medicine

Northwestern University has conferred the degree of

Doctor of Medicine

upon

Jessika Ann Ralph

who has honorably fulfilled all the requirements prescribed by the University for that degree

done at Chicago, Illinois this twenty-third day of May in the year two thousand and thirteen A.D.

ELECTRONIC SEAL VERIFIED

This is a true copy of the original diploma.
Registrar
Feinberg School of Medicine
Northwestern University

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: **2205631307**
Institution: **Medical College of Wisconsin Affiliated Hospitals Program**
Location: Milwaukee, WI
UNITED STATES

Accreditation ID: **None**
Institution: **Prentice Women's Hospital**
Location: Chicago, IL
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:
The Verification of Post Graduate Training Form from Prentice Women's Hospital dated 07/01/2017 to 06/30/2019 reported in the Chronology of Activities is not included in the Profile.

Solution(s):
FCVS does not obtain verification of non-accredited training programs.

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5099 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: Medical College of Wisconsin Affiliated Hospitals Program
Specialty: Obstetrics & Gynecology
Address: Milwaukee, WI

Attention: **Program Director**
Affiliated University:

Verification For:

Name: Jessika Ralph
DOB [redacted]1987
Individual's Name on Record (if different from above):

Program Participation:

Important: Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1
☑ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB/GYN
From: 7/1/2013 To: 06/30/2014
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ■ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 2-3
☐ Internship ☑ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB/GYN
From: 7/1/2014 To: 06/30/2016
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ■ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: 4
☐ Internship ☐ Residency ☑ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OB/GYN
From: 7/1/2016 To: 06/30/2017
Successfully Completed?: ☑ Yes ☐ No ☐ In Progress
Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training?	☐ Yes	☑ No
2. Was this individual ever placed on probation?	☐ Yes	☑ No
3. Was this individual ever disciplined or placed under investigation?	☐ Yes	☑ No
4. Were any negative reports for behavioral reasons ever filed by instructors?	☐ Yes	☑ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐ Yes	☑ No

Please explain any "Yes" response from above:

ELECTRONIC SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Paul Lemen, MD Signature:
Title: Program Director Date of Signature: 4-17-19
Tel: 414-805-6600 Fax: 414-805-6622 E-Mail: plemen@mcw.edu

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Ralph, Jessika
Accreditation ID:	2205631307
Institution:	Medical College of Wisconsin Affiliated Hospitals Program
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/2013 - 6/30/2017 **Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Ralph, Jessika

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

Medical College of Wisconsin Affiliated Hospitals, Inc.

Milwaukee, Wisconsin

This is to certify that

Jessika A. Ralph, MD

has faithfully completed the prescribed program of experience and study as a resident in

Obstetrics and Gynecology Residency Program

from July 1, 2013 to June 30, 2017

Joseph E. Kerschner, MD
Dean, School of Medicine and Executive Vice President
Medical College of Wisconsin

Kenneth B. Simons, MD
Executive Director and Designated Institutional Official
Medical College of Wisconsin Affiliated Hospitals, Inc.
Senior Associate Dean for GME and Accreditation
Medical College of Wisconsin

SEAL

Janet S. Rader, MD
Professor and Chairman
Department of Obstetrics and Gynecology
Medical College of Wisconsin

Paul M. Lemen, MD
Program Director, Associate Professor
Department of Obstetrics and Gynecology
Medical College of Wisconsin

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Licensure / Examinations

fsmb

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

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

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

Date: 06/07/2019

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 466679

Examinee: Ralph, Jessika Ann
Alt Name(s): Hopson, Jessika Ann
Ralph, Jessika

Examinee ID: 5-267-422-3
Date of Birth: [redacted]987

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. 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	Score	Minimum Pass	Comments
06/14/2011	Pass	239	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
12/13/2012	Pass	251	(196)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
11/08/2012	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/05/2014	Pass	243	(190)	

End of Exam History

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

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

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

Examinee: Ralph, Jessika Ann

Examinee ID: 5-267-422-3
Date of Birth: [redacted]1987

INTERPRETATION OF RESULTS
USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)
Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"
Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"
Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"
The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:6/7/2019

PRACTITIONER INFORMATION

Name:	Ralph, Jessika Ann
Alternate Name(s):	Hopson, Jessika Ann
	Ralph, Jessika
DOB:	[redacted]1987
Medical School:	Northwestern University Medical School Chicago, Illinois, UNITED STATES
Year of Grad:	2013
Degree Type:	MD
NPI:	1871835025

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ILLINOIS	036142418	02/15/2017	07/31/2020	05/30/2019
NEBRASKA	31823	05/30/2019	10/01/2020	06/04/2019
WISCONSIN	63093-20	10/09/2014	10/31/2017	06/03/2019

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:6/7/2019
Practitioner Name:	Ralph, Jessika Ann	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

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

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

NPDB Report

RALPH, JESSIKA ANN **DCN: 5500000147953114**

FOR AUTHORIZED USE BY: Minnesota Board of Medical Practice

Process Date: 6/7/2019

The following is a render of data received by National Practitioner Data Bank (NPDB) as interpreted by FSMB

RALPH, JESSIKA ANN

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

Practitioner Name:	RALPH, JESSIKA ANN
Date of Birth:	[redacted]/1987
Gender:	FEMALE
Work Address:	WOMEN'S HEALTH SPECIALISTS CLINIC RIVERSIDE PROFES 606 24TH AVE. S MINNEAPOLIS, MN 55454
Home Address:	[redacted]
National Provider Identifiers (NPI):	1871835025
License(s):	Physician (MD), 036142418, IL Physician (MD), 31823, NE
Professional School(s):	NORTHWESTERN UNIVERSITY MEDICAL SCHOOL (2013)

B. QUERY INFORMATION

Statutes Queried:	Title IV, Section 1921, Section 1128E
Query Type:	This is a One-Time query response. Your organization will only receive future reports on this practitioner if another query is submitted.
Entity Name:	Minnesota Board of Medical Practice
Authorized Agent:	Federation of State Medical Boards, (817) 868 - 4000
Customer Use:	217277334

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 6/7/2019

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

STATE OF WISCONSIN
Department of Safety and Professional Services
1400 E Washington Ave
Madison WI 53703-8935
Governor Scott Walker Secretary Laura Gutierrez

Mail to:
PO Box 8935
Madison WI 53703-8935

Email: dsps@wisconsin.gov
Web: http://dsps.wi.gov
Phone: 608-266-2112

CERTIFICATION

DATE: 06/07/2019

I, Aloysius F. Rohmeyer, do hereby certify that I am the Record Custodian in the Department of Safety and Professional Services, a department of the government of the State of Wisconsin; that I am the custodian of the records relating to Medicine and Surgery and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	RALPH, JESSIKA A
CREDENTIAL TYPE:	MEDICINE AND SURGERY, MD
WAS ISSUED LICENSE NO:	63093-20
STATUS:	CREDENTIAL LICENSE IS NOT CURRENT (EXPIRED)
ISSUE DATE:	10/09/2014
EXPIRATION DATE:	10/31/2017

Credential Holder History

Date	Code	Description
NO DATE	EXAM	USMLE Passed
05/23/2013	GRADUATED FROM	Graduated from NORTHWESTERN UNIVERSITY MEDICAL SCHOOL

According to our records, this credential holder has not been disciplined.

The information above is the only certification information provided by this Department. **We strongly encourage you to verify the license status of this individual by checking the DSPS online license look-up at http://app.wi.gov/licensesearch.** To expedite the certification process, the above format is the standard format for all professions regulated by this Department.

Aloysius F. Rohmeyer

Aloysius F. Rohmeyer
Record Custodian
Department of Safety and Professional Services

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Deborah Hagan
Acting Secretary

Jessica Baer
Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

233 E UPPER WACKER DR
#2905
CHICAGO, IL 60601

Licensee: License	JESSIKA ANN RALPH MD
Number:	036.142418
Profession:	LICENSED PHYSICIAN AND SURGEON
Date of Issuance:	02/15/2017
Expiration Date:	07/31/2020
License Status:	ACTIVE
License Method:	ENDORSEMENT
Disciplinary History:	Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 04/04/2019

Jessica Baer
Director
Division of Professional Regulation

04/04/2019
Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

STATE OF WISCONSIN
Department of Safety and Professional Services
1400 E Washington Ave
Madison WI 53703-8935
Governor Scott Walker Secretary Laura Gutierrez

Mail to:
PO Box 8935
Madison WI 53703-8935

Email: dsps@wisconsin.gov
Web: http://dsps.wi.gov
Phone: 608-266-2112

CERTIFICATION

DATE: 06/07/2019

I, Aloysius F. Rohmeyer, do hereby certify that I am the Record Custodian in the Department of Safety and Professional Services, a department of the government of the State of Wisconsin; that I am the custodian of the records relating to Medicine and Surgery and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	RALPH, JESSIKA A
CREDENTIAL TYPE:	TEMPORARY EDUCATION TRAINING PERMIT
WAS ISSUED LICENSE NO:	4883-850
STATUS:	CREDENTIAL LICENSE IS NOT CURRENT (EXPIRED)
ISSUE DATE:	07/01/2014
EXPIRATION DATE:	06/30/2015

According to our records, this credential holder has not been disciplined.

The information above is the only certification information provided by this Department. **We strongly encourage you to verify the license status of this individual by checking the DSPS online license look-up at http://app.wi.gov/licensesearch.** To expedite the certification process, the above format is the standard format for all professions regulated by this Department.

Aloysius F. Rohmeyer
Record Custodian
Department of Safety and Professional Services

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

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 Jessika Ralph

Signature [signature] Date 6/6/19

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Physician) Jessika Ralph

1. How long have you known the applicant? 2 years
2. What has been the nature of your relationship with the applicant? Attending physician
3. How would you characterize the moral and professional conduct of the applicant? Excellent
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 Jessica Kilroy MD Phone 312 695 4458

Address 675 N. St Clair #14-200 Chicago IL 60611

Signature [signature] Date 6/10/19

*Please attach letter of explanation.

01/02

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Print Name Jessika Ralph

Signature [signature] Date 6/6/19

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Physician) Jessika Ralph

1. How long have you known the applicant? 2 yrs
2. What has been the nature of your relationship with the applicant? Fellowship director
3. How would you characterize the moral and professional conduct of the applicant? Excellent
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 Cassina Hammond Phone 312 926 8678

Address 677 N St Clair Suite 19-205 Chicago IL 60611

Signature [signature] Date 6-7-19

*Please attach letter of explanation.

01/02

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PHYSICIAN RECOMMENDATION FORM (2)

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 Jessika Ralph

Applicant Signature Jessika Ralph Date 4/4/2019

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING.

RECOMMENDATION FOR: (Print Name of Applicant)_____

1. How long have you known the applicant? 2 years
2. What has been the nature of your relationship with the applicant? Supervisory physician
3. How would you characterize the moral and professional conduct of the applicant? Excellent
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 Jessica Kiley Signed [signature]

Health Profession OB/GYN License # 036-112-2110 State IL

Date 4/4/19 Phone# 312-695-0053 Fax 312-695-4112

Email jkiley2@nm.org

01/14

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

PHYSICIAN RECOMMENDATION FORM (2)

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 Jessika Ralph

Applicant Signature Jessika Ralph Date 4/4/2019

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant) Jessika Ralph

1. How long have you known the applicant? 3 years
2. What has been the nature of your relationship with the applicant? Fellowship Director
3. How would you characterize the moral and professional conduct of the applicant? Excellent
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 Cassing Hammond Signed

Health Profession OB/GYN License # 036090424 State IL

Date Phone# 312-695-4672 Fax 312-695-4112

Email chammond@nm.org

01/14

AMA Physician Profile

PREPARED FOR

Minnesota Board of Medical Practice, Minneapolis, MN

Name and Mailing Address

JESSIKA ANN RALPH

[redacted]

CHICAGO, IL 60601-5113

Birth date [redacted]1987

Primary Office Address

Phone UNKNOWN

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
None Reported					

Current and/or historical medical school

NORTHWESTERN UNIVERSITY

Degree Awarded: YES
Degree Year: 2013

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.

Beginning with the 2016/2017 cycle of the National GME Census post-graduate training segments will include a training type of specialty (residency) or subspecialty (fellowship). Training types for programs reported prior to 2016 will not include this designation.

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.

If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.

Sponsoring Institution:	MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS INC
Sponsoring State:	WISCONSIN
Program name:	MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS PROGRAM
Specialty:	OBSTETRICS & GYNECOLOGY
Training Type:	SPECIALTY
Dates:	7/2013 - 6/2017 (Verified)

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 0

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.

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

Certificate:
Certificate type:

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC

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.

Current and/or historical medical licensure

License No.	MD / DO	Jurisdiction	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported
0063093	MD	WI	10/09/2014	10/31/2017	10/31/2017	INACTIVE	UNLTD	05/03/2019

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 Administration or the US Department of Justice.

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration Date	Last Reported Date	Address

None Reported

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.

ECFMG Certification

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/

Profile Information

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 in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

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

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Minnesota Board of Medicine	As of Date:6/5/2019

PRACTITIONER INFORMATION

Name:	Ralph, Jessika Ann
Alternate Name(s):	Hopson, Jessika Ann
	Ralph, Jessika
DOB:	[redacted]1987
Medical School:	Northwestern University Medical School Chicago, Illinois, UNITED STATES
Year of Grad:	2013
Degree Type:	MD
NPI:	1871835025

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ILLINOIS	036142418	02/15/2017	07/31/2020	05/30/2019
WISCONSIN	63093-20	10/09/2014	10/31/2017	06/03/2019

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Minnesota Board of Medicine	As of Date:6/5/2019
Practitioner Name:	Ralph, Jessika Ann	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

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

NATIONAL PRACTITIONER DATA BANK
NPDB
P.O. Box 10832
Chantilly, VA 20153-0832

https://www.npdb.hrsa.gov

550000145483647
Process Date: 04/04/2019
Page: 1 of 1

RALPH, JESSICA ANN 1987 - SELF-QUERY RESPONSE

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

Practitioner Name: RALPH, JESSICA ANN 1987
Date of Birth: [redacted]/1987 **Gender:** FEMALE
Delivery Address: 1310 N RITCHIE CT APT 18D, CHICAGO, IL 60610-8403
Social Security Number: [redacted] **DEA:** FR4903286
NPI: 1871835025
License: PHYSICIAN (MD), 036.142418, IL, OBSTETRICS & GYNECOLOGY
Professional School(s): NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE (2013)

B. PAYMENT INFORMATION

Credit Card Information: XXXXXXXXXXX3004 (10/2022)
NPDB Charge: $4.00 **NPDB Bill Reference Number:** N62261604
Transaction Date: 04/04/2019 **Additional Paper Copies Requested:** 0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 04/04/2019

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 preceding cover page.

---------- No Reports Found Based on the Subject Information Submitted ----------

CONFEDERATION OF SWITZERLAND
CANTON AND CITY OF GENEVA
CONSULAR AGENCY OF THE
UNITED STATES OF AMERICA } S.S.

On 17 APR 2019, before me, Cheryl Overcash Consular Agent, personally appeared,

Jessika Ann Ralph,

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/~~are~~ subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity(~~ies~~), and that by ~~his~~/her/~~their~~ signature(s) on the instrument the person(~~s~~), or entity upon behalf of which the person(~~s~~) acted, executed the instrument.

In witness whereof I have hereunto set my hand and official seal the day and year last above written.

Cheryl Overcash
Consular Agent

My commission does not expire

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

NATIONAL PRACTITIONER DATA BANK

NPDB

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

https://www.npdb.hrsa.gov

5500000145483647
Process Date: 04/04/2019
Page: 1 of 1

To: RALPH, JESSIKA ANN 1987

1310 N RITCHIE CT APT 18D

CHICAGO, IL 60610-8403

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 (https://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.

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

FACILITIES LIST

Minnesota Statute 147.162 requires physicians to submit a list of inpatient and outpatient medical care facilities where you have medical privileges. In addition, the Board requests 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
NONE		

PAST PRIVILEGES (LAST 10 YEARS)

Facility	City and State	Type of Privilege
NONE		

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 Jessika Ralph

Signature Jessika Ralph Date 4/5/2019

01/02

MINNESOTA BOARD OF MEDICAL PRACTICE

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Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

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_____

Uniform Application for Physician State Licensure Checklist

All of the following requirements must be met or your entire application will be returned.

Please note: All verification forms must be submitted before your application is complete. It is your responsibility to make sure these forms are completed and received by our office.

The Board must receive separate verification forms completed by medical schools attended, all post graduate internship, residency, fellowship, research or other medical training programs, specialty boards, each hospital where you have held privileges outside a post graduate training program during the last ten years, each state board where you have held a medical license and recommendations from two of the physicians you named as references during your last five years of practice who can testify to your character, personal reputation, background, and professional ability. A verification must be received from every board issuing any type of license to you, including training, locum tenens, and temporary permit. If you are using FCVS for credentials verification, some of the verifications will be completed and sent to the Board on your behalf.

Mail the following items to the Board.	Not Using FCVS	Using FCVS
- Application fee of $425.25 ($200 processing fee, $33.25 criminal background check fee and, $192 annual registration fee) sent to the Board. *These fees are not refundable and must be in U.S. currency.* Make checks payable to the **Minnesota Board of Medical Practice.**	☐	☐
- Completed Uniform Application Addendum and all related documentation.	☐	☐
- Notarized copy of driver's license as a true likeness. The copy must be legible with a clear photo.	☐	☒
- Notarized copy of military discharge papers (DD Form 214), if applicable.	☐	☐
- Supporting documentation of any legal name change (marriage certificate, divorce decree, or court document) sent to the Board.	☐	n/a
- Copy of your postgraduate training certificate(s).	☐	n/a
- Notarized "UA Affidavit and Authorization for Release of Information" form. A full face, recent 2"x3" photograph must be affixed as indicated and notarized next to the picture as a true likeness. The notary seal must fall partly on the photograph and partly on the form.	☐	☒
- Facilities List form.	☐	☒
- Form for Treating Physician Statement.	☐	☒
- Form of Moral and Ethical Character.	☐	☒
- U.S. / Canadian Graduates only: An 8 ½" x 11" copy of medical diploma and first year postgraduate training certificate, if issued.	☐	☒
- International Medical Graduates only: Copies of the following original documents with certified translations.		
a. **Notarized** birth record/passport	☐	n/a
b. **Notarized** medical diploma	☐	n/a
c. U.S./Canadian postgraduate certificates	☐	n/a
d. ECFMG certificate	☐	n/a

Uniform Application for Physician State Licensure Checklist (continued)

Complete the following items. Forms are included in this packet.	Not Using FCVS	Using FCVS
- Online Uniform Application. *Please note: The name in the UA and on the medical school diploma must be the same. All of your time from high school (not medical school graduation) to the date of application must be accounted for on the Chronology of Activities page.*	☐	☒
- Request a National Practitioner Data Bank Self-Query to be sent to the Board. Visit http://www.npdb-hipdb.hrsa.gov/pract/hasAReportBeenFiledOnYou.jsp and click on "Start a Self-Query on an Individual (Search on Myself)." Complete the required information on the Self-Query Input screens and generate a **Response to Self Query** online. A PDF will be sent to you by NPDB, for your records and a hard copy envelope will follow in the mail. Alternatively, print a copy of the generated Self-Query, sign the formatted copy (in ink) in the presence of a notary public and mail the notarized form to The Data Bank, requesting a mailed copy so that The Data Bank will mail the Self Query report directly to you. The **Response to Self Query (Response)** must be forwarded directly to this office in one of the following ways: 1. Submit the unopened hard copy **Response** envelope; or 2. If opened, submit a notarized copy of the **Response**. Call 800-767-6732 or email help@npdb-hipdb.hrsa.gov for assistance.	☐	☒
- Contact your examination entity(ies) and request transcripts to be sent to the Board. Contact information is available in the UA FAQ at http://www.fsmb.org/uniform-application/ua-faq/	☐	n/a
- International Medical Graduates only: Contact ECFMG and request a Status Report to be sent to the Board.	☐	n/a
Form for Certification of Medical Education. Send this form to each medical school attended, even if you did not graduate. Medical schools must send the completed forms **directly** to the Board. Some schools will also provide a copy of your diploma upon request.	☐	n/a
Form for Verification of Postgraduate Training. Send this form to each training program whether or not it was accredited or completed. The training programs must send the completed forms **directly** to the Board.	☐	n/a
Form for Physician Verification of Licensure. Verification must be received from every board issuing any type of medical license, training permit, locum tenens, or temporary permit. Make photocopies as necessary. Use the Licensure Verification Information resource at https://www.fsmb.org/uniform-application/ to determine a verifying board's preferred method and fees, if applicable. Verifications through VeriDoc are also accepted. Log on to www.veridoc.org and follow the onscreen instructions.	☐	☒
Form for Hospital Privileges Verification. Submit the Hospital Privileges form to each hospital listed on the Facilities list. The Hospital must send the completed forms **directly** to the Board.	☐	☐ na
Form for Verification of Specialty Board Certification. If it has been ten years since you passed the licensing exam, you must be currently specialty board certified by ABMS, AOA/BOS, RCPSC, or CFPC. Submit this form to the appropriate specialty board. The verification must be sent **directly** to the Board from the specialty board.	☐	☐ na
Form for Physician Recommendation. Obtain recommendations from two physicians you have known for at least one year and practiced with during the last five years who can testify to your character, personal reputation, background, and professional ability. The physicians must send the completed forms **directly** to the Board.	☐☐	☒☒

Confederation of Switzerland
Canton and City of Geneva
Consular Service of the United States of America } SS

The undersigned Consular Agent of the United States of America, duly commissioned and qualified, do hereby certify that the foregoing is a true and faithful copy of the original ~~copy~~ this day exhibited to me, the same having been carefully examined by me and compared with the said original ~~copy~~ and found to agree therewith word for word and figure for figure.

IN WITNESS WHEREOF I have hereunto set my hand and affixed the seal this 17th day of APRIL 2019

Cheryl Overcash
Consular Agent

MINNESOTA
BOARD OF MEDICAL PRACTICE

June 7, 2019

Jessika A. Ralph, M.D.
1310 N Ritchie Ct #18D
Chicago, IL 60610

Dear Dr.Ralph:

This letter acknowledges receipt of your application for Physician licensure. The following information/document(s) are required to complete your file:

- Direct verification of USMLE scores
- Direct verification of medical education
- Direct verification of medical training From Prentice Womens Hospital and medical College of Milwaukee
- Direct verification of medical license/credential from WI
- Two physician recommendation forms (we received copies, we need the original form)
- Missing accounting of time from high school to start of med school

Forms are available on our website: www.bmp.state.mn.us.

Minnesota Statute 214.074 requires that all new applicants for licensure must complete a fingerprint-based criminal background check (CBC). The CBC must be completed and reviewed prior to an application being considered complete and license being issued.

Once you are licensed, your designated address becomes public record and will be on our website. If you have privacy concerns and wish to change your address, you will need to provide the Board with a signed written request.

A certified package, containing your medical license card, wall certificate etc. will be mailed to you after your license is granted.

Sincerely,

Alex Gardner
Licensure Specialist, Licensure Unit
alex.gardner@state.mn.us

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name: Jessika Ralph Start Date: 2/3/2020 9:28:42 PM
Service Name: License Renewal - PY Complete Date: 2/3/2020 9:44:05 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	2/3/2020 9:28:54 PM	
2	Verify Information	2/3/2020 9:30:27 PM	
2	Verify Information	2/3/2020 9:30:46 PM	
3	Privileges & Continuing Medical Education	2/3/2020 9:31:39 PM	
4	Practice Questions	2/3/2020 9:33:01 PM	
5	Profiling - Practice Addresses	2/3/2020 9:33:27 PM	PracticeAddress
5	Profiling - Post Graduate Training	2/3/2020 9:33:56 PM	PostGrad • Specialty • Successful Completion is not selected • Start Year must be 4 digits • End Year must be 4 digits
5	Profiling - Post Graduate Training	2/3/2020 9:34:30 PM	PostGrad
5	Profiling - Post Graduate Training	2/3/2020 9:34:42 PM	PostGrad • Specialty • Successful Completion is not selected • Start Year must be 4 digits • End Year must be 4 digits
5	Profiling - Post Graduate Training	2/3/2020 9:35:13 PM	PostGrad
5	Profiling - Post Graduate Training	2/3/2020 9:35:18 PM	Bypass Case
5	Profiling - Post Graduate Training	2/3/2020 9:35:18 PM	
5	Profiling - ABMS/AOA	2/3/2020 9:36:01 PM	
5	Profiling - ABMS/AOA	2/3/2020 9:36:01 PM	
5	Profiling - Criminal Convictions	2/3/2020 9:36:12 PM	
6	Review	2/3/2020 9:37:01 PM	
7	Prescription Monitoring Program Registration	2/3/2020 9:37:10 PM	
9	Payment	2/3/2020 9:42:51 PM	

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 prov ded 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 65910
Name: Jessika Ann Ralph
Alternate Name: Hopson

Drivers License: MN - W000-015-320-300
Is license current? Yes

Designated Address: Womens Health Specialists Riverside Professional Building 606 24th Ave S, Suite 300 Minneapolis, MN 55454
Phone: (612) 273-7111
Email Address:
Web Site:

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
University of Minnesota	Minneapolis	MN	Inpatient and Surgical

Continuing Education

You are not required to report Continuing Medical Educat on hours this renewal per od. You will be required to report CE hours the next renewal period ending 02/28/2023.

Practice Questions

Please answer all quest ons by selecting "Yes" or "No" and provide an explanation when requested. Quest ons 3-4 do not have "No" as an option for confidentiality reasons. **If you have a condition addressed by questions 3-4 and you are NOT participating in the Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable questions(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s).** For question 4, the term "impaired" includes but is not limited to impairments or lim tat ons related to phys cal, psycholog cal, or emotional disorders or cond t ons, or chem cal dependency or chem cal abuse.

The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your renewal application is pending, and publ c after your renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This informat on will NOT be included in the profiling.

1. 1. Since your last renewal, have you been diagnosed and/or treated for any mental, physical or cognitive condition that may affect your abil ty to practice with reasonable skill and safety and you have not reported the cond t on or illness to HPSP?
[redacted] [redacted]

2. Since your last renewal, have you been diagnosed with/or treated for any substance use disorder that may affect your abil ty to pract ce with reasonable skill and safety and you have not reported the condit on or illness to HPSP?
[redacted] [redacted]

3. Since your last renewal, have you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)?
[redacted]

4. Since your last renewal, have you been advised by your treating phys cian that you have a mental, phys cal, or emot onal condition, which, if untreated, would be likely to impair your abil ty to practice with reasonable skill and safety?
[redacted]

5. Since your last renewal, have you been diagnosed as having or have you been treated for pedophilia, exhib t onism, voyeurism, or other sexual behav or disorders?
[redacted]

6. Since your last renewal, have you been the subject of an investigation by any Federal, State, or Local agency having jurisd ction over controlled substances?
[redacted]

7. Since your last renewal, have you been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state med cal board or licensing author ty?
[redacted]

8. Since your last renewal, has your license to practice in any state or country been voluntarily or involuntarily (i.e. by Medical Board Order or any other form of disciplinary act on) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority?
[redacted]

9. Since your last renewal, have you been notified of any investigations by any state med cal board, medical society, or any hospital of any complaints against you relative to the practice of med cine, or have you been reprimanded or censured by any med cal society or l censing board?
[redacted]

10. Since your last renewal, have your hosp tal privileges been restricted or revoked?
[redacted]

11. Since your last renewal, have there been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses wh ch have been expunged or otherwise removed from your record by executive pardon or state district court judges. If so, give part culars including the date of conduct, state and local jurisd ct on in which the charges were filed.
[redacted]

12. Since your last renewal, have there been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chem cals filed against you? If so, give part culars, including the date of conduct, state and local jurisd ct on in which the charges were filed.
[redacted]

13. Since your last renewal, have you voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances?
[redacted]

Do you dispense for profit legend drugs that are to be administered orally, are ordinarily dispensed by a pharmacist, and are not a vaccine? This information is classified as public. It is unlawful to dispense these legend drugs for prof t after July 1, 1990 unless a statement has been filed with the Board of Medical Practice.
[redacted]

Profile - Practice Addresses

Primary: Womens Health Specialists
Riverside Professional Building
606 24th Ave S, Suite 300
Minneapolis, MN 55454

Phone: (None)

Secondary: (None)

Military Status: No

Profile - Education-Post Graduate

Program	Specialty	Start Date	End Date	Completed
Northwestern University McGaw Medical Center	Family Planning	07/00/2017	06/00/2019	Yes
Medical College of Wisconsin	Obstetrics and Gynecology	07/00/2013	06/00/2017	Yes

Profile - ABMS/AOA Specialty Certification

The Board doesn't have a current certif cate of yours on file.

Profile - Criminal Convictions

Since your last renewal, or, on or after July 1, 2013, have you been conv cted of a felony or gross misdemeanor?
[redacted]

Certification by Licensee

*Indicates required field

* ☑ **I certify that all information provided is complete, accurate and true.**

Submission of this online application does not automatically result in approval of your license. If all requirements are satisfied, a license will be mailed within 2 weeks. If additional information is needed, the Board will contact you.

All information provided is private until your application has been approved. Once it has been approved, all information is public except as noted in the application. Public information is available to any person upon request.

Click the submit button to complete the application. You will be prompted to a MDH workforce survey on the next page. After completing the survey, please proceed to credit card processing. **Your renewal won't be complete until you receive a 15 digit payment confirmation.**

< Previous Submit