PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Minnesota Board of Medicine As of Date:3/15/2019

PRACTITIONER INFORMATION

Name:	Sandoval, Selina Marie
DOB:	[redacted]1989
Medical School:	University of Illinois College of Medicine at Peoria Peoria, Illinois, UNITED STATES
Year of Grad:	2016
Degree Type:	MD
NPI:	1336599653

BOARD ACTIONS

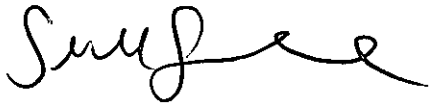
Reporting Entity:	Kansas State Board of Healing Arts
Date of Order:	1/10/2019
Action(s):	CONDITION(S) PLACED ON MEDICAL LICENSE
	The post-graduate permit shall be cancelled. Such cancellation shall be stayed according to the terms of this Summary Order, until Practitioner completes post-gradudate training or is granted a full license.
Basis:	Practicing Outside Scope of Medical Practice

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
KANSAS	94-09052	07/01/2016	06/30/2020	03/01/2019

Addendum to Question 9:

This investigation is closed with no disciplinary action taken. Please see the attached Summary Order and Confidential Communication.



FILED

JAN 10 2019

KS State Board of Healing Arts

BEFORE THE BOARD OF HEALING ARTS
OF THE STATE OF KANSAS

In the Matter of	)	
	)	
SELINA SANDOVAL, M.D.	)	**KSBHA Docket No. 19-HA 00050**
Postgraduate Permit No. 94-09052	)	

SUMMARY ORDER

NOW, on this 10 day of Jan, 2019, this matter comes before Kathleen Selzler Lippert, Executive Director, Kansas State Board of Healing Arts, ("Board"), in summary proceedings pursuant to K.S.A. 77-537.

Pursuant to K.S.A. 77-537, this Summary Order shall become effective as a Final Order without further notice if no written request for a hearing is made within fifteen (15) days of service. Upon review of the agency record and being duly advised in the premises, the following findings of fact, conclusions of law and orders are made for and on behalf of the Board:

Findings of Fact

1. On or about July 1, 2016, Selina Sandoval, M.D. ("Permittee") was issued Postgraduate Permit No. 94-09052 to practice medicine and surgery within a postgraduate training program in Kansas, with an expiration date of June 30, 2020. Permittee is presently engaged in a postgraduate training program at the Kansas University Medical Center ("KUMC") in Kansas City, Kansas.

2. Permittee's last known mailing address provided to the Board is: KUMC Attn: Doran Shelby, 3901 Rainbow Blvd., Mail Stop 2028, Kansas City, Kansas 66160.

3. On or about December 25, 2017, while Permittee was preparing to begin rounding on patients, Permittee was approached by the Chair and Services Chief of the Department of

Obstetrics and Gynecology ("Chair"). The Chair told Permittee that he had a cough that was affecting his ability to sleep and requested that Permittee prescribe codeine to him.

4. At the time this request was made, Permittee was a second-year resident and the Chair served as one of the attending physicians who supervised and evaluated Permittee's practice. Permittee was extremely uncomfortable with the request, but also felt pressured to comply due to the Chair's position of authority over her.

5. When Permittee verbally questioned whether she was authorized to write the prescription, the Chair replied that he just needed ten (10) tablets of codeine. Because the Chair directly supervised her practice and had asked her to do so, Permittee complied by prescribing ten (10) thirty (30) milligram tablets of codeine to the Chair.

6. On or about February 2, 2018, Permittee made a self-report to the Board of her practice outside the scope of her postgraduate permit based on this prescribing occurrence.

7. On or about March 10-11, 2018, Permittee attended the "PBI Prescribing Course" in Chicago, Illinois, at her own expense.

Applicable Law

8. Pursuant to K.S.A. 65-2811(d)(2), a postgraduate permit issued under K.S.A. 65-2811(b) shall be cancelled if the holder thereof has engaged in the practice of the healing arts outside of the postgraduate training program.

Conclusions of Law

9. The Board is the sole and exclusive administrative agency of the State of Kansas authorized to regulate the practice of the healing arts, specifically the practice of medicine and surgery within a postgraduate training program.

10. The Board has jurisdiction over Permittee as well as the subject matter of this proceeding, and such proceeding is held in the public interest.

11. Based on the facts and circumstances set forth herein, the use of summary proceedings in this matter is appropriate and in accordance with the provisions of K.S.A. 77-537(a).

The Board further concludes that Permittee's postgraduate permit shall be Cancelled, as required by K.S.A. 65-2811(d)(2) but that such cancellation shall be stayed until Permittee completes her postgraduate training or is granted a full license

IT IS THEREFORE ORDERED that Permittee's postgraduate permit is hereby **CANCELLED** pursuant to K.S.A. 65-2811(d)(2). Such cancellation shall be immediately and simultaneously **STAYED.** The **STAY** shall remain in effect so long as Permittee does not engage in any additional acts of practice outside the scope of her postgraduate permit, and until:

a. Permittee successfully completes her postgraduate training program; or

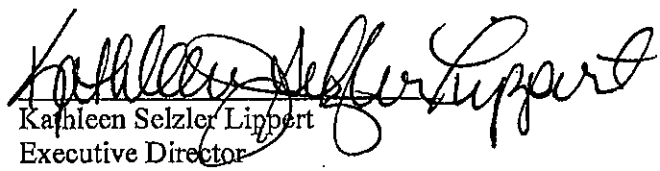
b. Permittee is granted a license to practice in medicine and surgery in Kansas,

whichever occurs first.

IT IS FURTHER ORDERED that upon the occurrence of Permittee's successful completion of her postgraduate training program, or Permittee being granted a license to practice medicine and surgery in Kansas, the **STAY** of **CANCELLATION** shall be lifted and Permittee's postgraduate permit shall be **ADMINISTRATIVELY CANCELLED** in the same manner set forth in K.S.A. 65-2811 for other permittees once such individuals cease to be engaged in postgraduate training programs, or receive full Kansas licenses.

IT IS SO ORDERED on this 10 day of Jan, 2019.

FOR THE KANSAS STATE BOARD OF HEALING ARTS:



Kathleen Selzler Lippert
Executive Director

NOTICE OF RIGHTS

Permittee is entitled to a hearing pursuant to K.S.A. 77-537 and K.S.A. 77-542 of the Kansas Administrative Procedure Act. If Permittee desires a hearing, Permittee must file a written request for a hearing to:

Kathleen Selzler Lippert
Executive Director
Kansas State Board of Healing Arts
800 SW Jackson Street, Lower Level- Suite A
Topeka, Kansas 66612

The request for hearing must be filed within fifteen (15) days from the date of service of this Summary Order. If Permittee requests a hearing, the Kansas State Board of Healing Arts will notify Permittee of the time and place of the hearing and information regarding the hearing procedures, right of representation, and other rights of the parties relating to the conduct of the hearing before commencement of the same.

If a hearing is not requested in the time and manner stated above, this Summary Order shall become effective as a Final Order upon expiration of the time for requesting a hearing.

PREPARED AND APPROVED BY:

Katie Baylie, #27910
Associate Litigation Counsel
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612
785-296-1479
katie.baylie@ks.gov
ATTORNEY FOR DISCIPLINARY PANEL

Kelli J. Stevens, #16032
Forbes Law Group, LLC
6900 College Boulevard, Suite 840
Overland Park, Kansas 66211
913-303-3411
kstevens@forbeslawgroup.com
ATTORNEY FOR PERMITEE

CERTIFICATE OF SERVICE

I, the undersigned, hereby certify that I served a true and correct copy of the foregoing **Summary Order** by United States mail, postage prepaid, on this 10th day of JAN, 2019, to the following:

Selina Sandoval, M.D.
KUMC Attn: Doran Shelby
3901 Rainbow Blvd, Mail Stop 2028
Kansas City, Kansas 66160
Permittee

Kelli J. Stevens
Forbes Law Group, LLC
6900 College Boulevard, Suite 840
Overland Park, Kansas 66211
Attorney for Permittee

And the original was filed with the office of the Executive Director:

Kathleen Selzler Lippert
Executive Director
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

And a copy was hand-delivered to:

Katie Baylie
Associate Litigation Counsel
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

Licensing Administrator
Kansas Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, Kansas 66612

STATE OF KANSAS

KANSAS STATE BOARD OF HEALING ARTS
800 SW JACKSON, LOWER LEVEL-SUITE A
TOPEKA, KS 66612

PHONE: 785-296-7413
FAX: 785-368-8210
www.ksbha.org
KSBHA_healingarts@ks.gov

January 8, 2019

Kelli Stevens
Forbes Law Group, LLC
6900 College Boulevard, Suite 840
Overland Park, Kansas 66211

RE: Selina Sandoval, M.D.; KSBHA Investigation No. 18-00525
Letter of Concern under K.S.A. 65-2838a

Dear Ms. Stevens

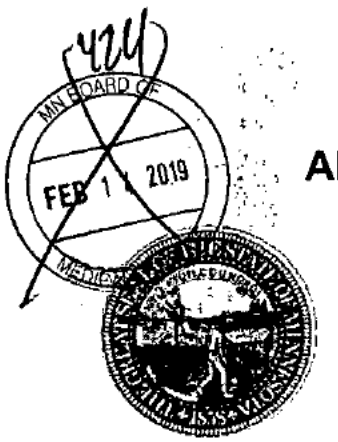
The Board's Disciplinary Panel has reviewed the above-numbered investigation. After careful review of the investigative materials, the Panel recommends that your client's conduct raised some concerns. As you may recall, Case No. 18-00525 arose after your client self-reported to the Board of a prescribing instance where your client wrote a codeine prescription for the then Chair of Obstetrics and Gynecology of Kansas Medical Center, Carl Weiner, M.D., at his request. In your client's self-report, your client admitted to failure to document the encounter with Dr. Weiner.

While the Panel did not authorize disciplinary action be initiated against your client's license, the Panel was concerned about this conduct. The Panel did authorize a non-disciplinary resolution under K.S.A. 65-2838a, in the form of this letter of concern regarding this investigation. This letter of concern is confidential, and does not imply there has been a finding by the Board of any violation of the Healing Arts Act. The case will be kept on your client's file should additional instances occur involving issues of a similar nature or other problems.

Based upon the Panel's recommendations, this investigation is now closed with this Letter of Concern and previously filed Summary Order. Thank you for your cooperation in this matter. Please contact me if you have any questions or concerns.

Sincerely,

M. Katie Baylie, #27910
Associate Litigation Counsel



425-25
MN BOARD OF

APPLICATION FOR MEDICAL LICENSE

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

123720 FEB 2 5 2019

APPLICATION #: 123720
CHECK/RECEIPT #: 2600 PRACTICE
AMT PAID:
LICENSE #: 65290
4-4-19

ACCOUNT CODE	AMOUNT
635009 lic	192.00
635010 app	200.00
635064 cbc	33.25

Instructions to Applicant

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

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

Last Name Sandoval
First Name Selina
Middle Name Marie
Maiden Name
All Other Names Used

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

Street 3901 Rainbow Blvd
City Kansas City State KS Zip Code 66160 Country US
Phone 916-208-4861 Email (optional) ssandoval2@kumc.edu

Private Address (cannot be accessed by public)

Street 4428 N Grand Ave
City Kansas City State MO Zip Code 64116 Country US
Phone 916-208-4861 Email (REQUIRED) ssandoval2@kumc.edu

Intended Address (if known) Effective Date

Street
City State Zip Code Country

Applicant Name Selina Sandoval Last 4 digits of SS[redacted] Date 11/28/18

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

Date of Birth (mm/dd/yyyy) [redacted]/1989 Birth City Sacramento Birth State CA

Birth County Sacramento Birth Country United States Gender Female

Driver's license: State MO Number C026272020 SSN [redacted] NPI 1336599653

Height (ft/in) 5'6" Weight (lbs) 125 lb Hair Color Brown Eye Color Brown

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

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

1. School Name University of Illinois College of Medicine at Peoria

Address 1 Illini Drive

City Peoria State IL Zip Code 61605 County United States

Attended from 8/20/2012 (mm/dd/yyyy) to 5/8/2016 (mm/dd/yyyy) Graduation Date 5/8/2016 (mm/dd/yyyy) Degree MD

2. School Name

Address

City State Zip Code Country

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

---

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

Certificate Number Issue Date Valid Through Date

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

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

Rank at Discharge Type of Discharge

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

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

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

Applicant Name Sandoval Last 4 digits of S[redacted] Date 11/28/18

Proposed practice plans in Minnesota (if any): I plan to rotate at Planned Parenthood Minnesota from 3/11/18- 6/2/18.

Current* specialty board certification (check one):

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

Specialty_____
Issue Date_____
Expiration Date_____

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

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

State Kansas License Number 94-09052 Date Issued 6/30/2016
State_____ License Number_____ Date Issued_____
State_____ License Number_____ Date Issued_____
State_____ License Number_____ Date Issued_____
State_____ License Number_____ Date Issued_____
State_____ License Number_____ Date Issued_____
State_____ License Number_____ Date Issued_____

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

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

High school (attach a separate sheet, if necessary)

From (mo/yr): 8/04 High School Saint Francis High School
To (mo/yr): 5/08 City Sacramento State CA Country United States

College education (attach a separate sheet, if necessary)

From (mo/yr): 8/08 College University of Arizona
To (mo/yr): 5/12 City Tucson State AZ Country United States

Applicant Name Sandoval Last 4 digits of SSN [redacted] Date 11/28/18

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

From (mo/yr): ____ Activity____
Address____
To (mo/yr): ____ City____ State____ Country____
Position____ % Clinical____ %Administrative____

From (mo/yr): ____ Activity____
Address____
To (mo/yr): ____ City____ State____ Country____
Position____ % Clinical____ %Administrative____

From (mo/yr): ____ Activity____
Address____
To (mo/yr): ____ City____ State____ Country____
Position____ % Clinical____ %Administrative____

From (mo/yr): ____ Activity____
Address____
To (mo/yr): ____ City____ State____ Country____
Position____ % Clinical____ %Administrative____

From (mo/yr): ____ Activity____
Address____
To (mo/yr): ____ City____ State____ Country____
Position____ % Clinical____ %Administrative____

From (mo/yr): ____ Activity____
Address____
To (mo/yr): ____ City____ State____ Country____
Position____ % Clinical____ %Administrative____

From (mo/yr): ____ Activity____
Address____
To (mo/yr): ____ City____ State____ Country____
Position____ % Clinical____ %Administrative____

Applicant Name Sandoval Last 4 digits of [redacted] Date 11/28/18

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

1. Hospital Name University of Kansas Medical Center

Hospital Address 3901 Rainbow Blvd

City Kansas City State KS Zip Code 66160 Country United States

PGY: (e.g., 1, 2, 3, etc.) ___ Internship X Residency ___Fellowship ___Research ___Other

Department/Specialty Obstetrics and Gynecology

From 07 / 2016 To ____/____ Successfully Completed? ___Yes ___No X In Progress
Month Year Month Year

---

2. Hospital Name

Hospital Address

City State Zip Code Country

PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___Residency ___Fellowship ___Research ___Other

Department/Specialty

From ____/____ To ____/____ Successfully Completed? ___Yes ___No ___In Progress
Month Year Month Year

---

3. Hospital Name

Hospital Address

City State Zip Code Country

PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___Residency ___Fellowship ___Research ___Other

Department/Specialty

From ____/____ To ____/____ Successfully Completed? ___Yes ___No ___In Progress
Month Year Month Year

---

4. Hospital Name

Hospital Address

City State Zip Code Country

PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___Residency ___Fellowship ___Research ___Other

Department/Specialty

From ____/____ To ____/____ Successfully Completed? ___Yes ___No ___In Progress
Month Year Month Year

Applicant Name Selina Sandoval Last 4 digits of SSN [redacted] Date 11/28/18

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 or 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 please attach a separate sheet.

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.

Yes 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.

Yes No 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.

Yes 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.

Yes 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.

Yes 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.

Yes No 3b. If yes, are you not 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.

Yes 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? I you answer this question "yes", please [redacted] the following:

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_____

[redacted]

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

[redacted]

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]

7. Have you ever 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.

[redacted]

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.

[redacted]

[redacted]

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 censure by any medical society or licensing board? If so, give particulars.

[redacted]

Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case on the Malpractice Liability Claims Information form as well as documentation of outcome (insurance papers or court documents).

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

[redacted]

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, submit a personal statement 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.

13. Have there ever been any charges or 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 regarding the date of conduct, state and local jurisdiction in which the charges were filed, explaining in detail the incident and consequences including whether a CD evaluation was done (if so, submit results), and description of current drinking habits.

14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.

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. Selina Sandoval

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
	11/28/18	94-09052	KS

Selina Sandoval
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

State: KANSAS County: WYANDOTTE

I certify that on the date set forth below, the individual named above did appear Personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant on this 28TH day of NOVEMBER, 2018

Notary Public Signature

STATE NOTARY PUBLIC KANSAS
Melissa Vazzano SEA
Notary Public
State of Kansas
My Appointment Expires on 12/03/2018

Expiration Date 12 / 03 / 2018
Month Day Year

Applicant's Signature

2.

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

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
	1/17/19	04-32147	KANSAS

MADHURI REDDY
PRINT OR TYPE FULL NAME

Applicant Name Selina Sandoval Last 4 digits of SSN [redacted] Date 11/28/18

Affidavit and Release

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

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

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

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

State of: KANSAS, County of: WYANDOTTE

Sworn to before me this 28 day of NOVEMBER, 2018.

Signature of Applicant

11/28/18
Date of signature (must correspond to date of notarization)

Signature of Notary Public

Melissa Vazzano
Notary Public
State of Kansas
My Appointment Expires on 12/03/2018

My Commission Expires: 12/03/2018

#1101201

RIGHTS OF SUBJECTS OF DATA

The information on your application is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, omission or falsification of material fact, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

Applicant Name Selina Sandoval Last 4 digits of SSN [redacted] Date 11/28/18

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

Recipient: MINNESOTA BOARD OF MEDICAL PRACTICE

Date: 11/05/2018

Examinee: Sandoval, Selina Marie
Alt Name(s):

Examinee ID: 5-324-867-0
Date of Birth: [redacted]989

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
06/16/2014	Pass	219	(192)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/15/2015	Pass	247	(209)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
11/03/2015	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
03/09/2017	Pass	210	(196)	

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.

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

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 Selina Sandoval Birthdate [redacted]989 Last 4 digits of SSN [redacted]

Signature Selina Sandoval Date 11/19/18

Date of Degree 5/8/2016 Degree Received Doctor of Medicine

THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) Selina Sandoval

MATRICULATED IN:(Name of School) University of Illinois - College of Medicine

AT:(Location of School) Peoria, Illinois

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

ON:(Month, Day, Year) 05/08/2016

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 Eileen P. Doherty
Signature Eileen P Doherty
Date 11-20-18
Phone Number 309/671-8410
Fax Number 309/671-8480

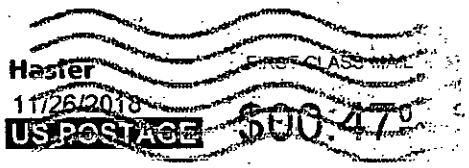
*Please attach letter of explanation.

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

03/15

University of Illinois College of Medicine
Office of Student Affairs
1 Illini Dr.
Peoria, IL 61605

PEORIA, IL 616
26 NOV 2018 PM 1 T



Minnesota Board of Medical Practice
University Park Plaza
2829 University Ave SE, Suite 500
Minneapolis, MN 55414-3246.

55414$3246

STATE OF: KANSAS
COUNTY OF: WYANDOTTE
I CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF A DOCUMENT IN THE POSSESSION OF SELINA SANDOVAL
DATED: 11/28/2018

Melissa Vazzano
Notary Public
State of Kansas
My Appointment Expires on 12/06/2018

#1106201

By authority of the Board of Trustees of the

UNIVERSITY OF ILLINOIS

and upon recommendation of the Senate

at Chicago

Selina Marie Sandoval

has been admitted to the Degree of

Doctor of Medicine

and is entitled to all rights and honors thereto appertaining
Witness the Seal of the University and the Signatures of its Officers
this eighth day of May, two thousand and sixteen.

UNIVERSITY OF ILLINOIS LEARNING & LABOR CHARTERED 1867

Chair of the Board of Trustees

President of the University of Illinois

Secretary of the Board of Trustees

Chancellor, University of Illinois at Chicago
Vice President, University of Illinois

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 Selina Sandoval Birthdate [redacted]/1989 Last 4 digits of SSN [redacted]3

Signature [signature] Date 11/28/18

Training Dates (Month,Day,Year) 7/1/2016- Current

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

It is hereby certified that:(Name of Applicant) SELINA SANDOVAL, MD

Received credit for post graduate training:(# Months) _____ from date: 07/01/16 to date: 06/30/2020

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) UNIVERSITY OF KANSAS MEDICAL CENTER

located at 3901 RAINBOW BLVD, MS 2028, KANSAS CITY, KS 66160
(Street Address, City, State, Zip, Country)

Affiliated Medical School Name UNIVERSITY OF KANSAS Specialty OB/GYN PGY 3

Training Program (Check One): Internship ___ Resident X Chief Resident ___ Fellowship ___ Research ___

Did the applicant complete all required years of the post graduate training program?
___Program was completed X Anticipated date of completion 06/30/2020

___Program was not completed because _____

Was this individual issued a certificate as proof completion of training?	Yes ___	No ___
Did the individual take a leave of absence or break during training?	Yes* ___	No 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 CARRIE L. WIENEKE, MD

Signature [signature]

Date 12/4/18 Phone 913-588-6250

Fax 913-588-6271 Email cwieneke@kumc.edu

#1154423

Melissa Vazzano
Notary Public
State of Kansas
My Appointment Expires on 12/08/2022

[signature]

*Attach letter of explanation

1/2011

Kansas State Board of Healing Arts
800 SW Jackson, Suite A-Lower Level
Topeka, KS 66612

Kansas

Phone: 785-296-7413
1-888-686-7205
Fax: 785-296-0852
www.ksbha.org

Kathleen Selzler Lippert
Executive Director

Sam Brownback, Governor

November 19, 2018

Minnesota Board of Medical Practice
University Park Plaza
2829 University Ave SE, Suite 500
Minneapolis, MN 55414-3246

This is to certify that: Selina Marie Sandoval has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

License Number:	94-09052
Date of Birth:	[redacted]1989
Profession:	Postgraduate Permit (MD)
License Status:	Current
Original License Date:	07/01/2016
License Cancellation Date:	06/30/2020
Disciplinary Action:	None

This license information was last updated on: 11/19/2018

Unless otherwise indicated, this licensee has not been subject to disciplinary proceeding by the Kansas Board of Healing Arts.

Verified by:

Reese H. Hays
Interim Licensing Administrator
Kansas State Board of the Healing Arts
John.Nichols@ks.gov
800 SW Jackson
Lower Level-Suite A
Topeka, Kansas 66612
(785) 296-8563

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 (1)

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

Applicant Print Name Selina Sandoval

Applicant Signature [signature] Date 11/28/18

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant) Selina Sandoval

1. How long have you known the applicant? 3 years
2. What has been the nature of your relationship with the applicant? Program Director, Faculty
3. How would you characterize the moral and professional conduct of the applicant? No Concerns
4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine? Applicant is current resident (PGY3)
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 Carrie Wierda, MD Signed [signature]

Health Profession MEDICAL DOCTOR/PROFESSOR License # 04-33431 State KS

Date 12/5/2018 Phone# 913-588-6245 Fax 913-588-6271

Email CWierda@KUMC.edu

01/14

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 (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 Selina Sandoval

Applicant Signature [signature] Date 11/28/18

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant) SELINA SANDOVAL, MD

1. How long have you known the applicant? 3 YEARS
2. What has been the nature of your relationship with the applicant? ASSOCIATE PROGRAM DIRECTOR, FACULTY PROFESSOR
3. How would you characterize the moral and professional conduct of the applicant? NO CONCERNS
4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine? CURRENT RESIDENT (PGY-3), EXPECTED COMPLETION 6/2020
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 MADHURI REDDY, MD Signed [signature]

Health Profession MEDICAL DOCTOR/PROFESSOR License # 04-32147 State [illegible]

Date 12/7/2018 Phone# 913-588-6248 Fax 913-588-6271

Email mreddy2@kumc.edu

01/14

AMA Physician Profile

PREPARED FOR

Minnesota Board of Medical Practice, Minneapolis, MN

Name and Mailing Address

SELINA MARIE SANDOVAL
UNIV OF KANSAS MED CTR
MAIL STOP 2028
3901 RAINBOW BLVD
KANSAS CITY, KS 66160-0001

Birth date [redacted]/1989

Primary Office Address

SAME AS MAILING ADDRESS

Phone UNKNOWN

Physician's major professional activity HOSPITAL BASED RESIDENTS - ALL YEARS

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 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
1336599653	06/17/2016	NOT RPTD	NOT RPTD	NOT RPTD	02/15/2019

Current and/or historical medical school

UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF MEDICINE

Degree Awarded: YES

AMA
AMERICAN MEDICAL ASSOCIATION

Degree Year: 2016

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:	UNIVERSITY OF KANSAS SCHOOL OF MEDICINE
Sponsoring State:	KANSAS
Program name:	UNIVERSITY OF KANSAS SCHOOL OF MEDICINE PROGRAM
Specialty:	OBSTETRICS & GYNECOLOGY
Training Type:	SPECIALTY
Dates:	7/2016 - 6/2020 (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
94-09052	MD	KS	07/01/2016	06/30/2020		ACTIVE	RES	03/01/2019

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 Certfication

Applicant Number:

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

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:3/15/2019
Practitioner Name:	Sandoval, Selina Marie	

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

SANDOVAL, SELINA MARIE - SELF-QUERY RESPONSE

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

Practitioner Name:	SANDOVAL, SELINA MARIE
Date of Birth:	[redacted]/1989
Gender:	FEMALE
Delivery Address:	4428 N GRAND AVE, KANSAS CITY, MO 64116-2169
Social Security Number:	***-**[redacted]3
DEA:	FS6120098
NPI:	1336599653
License:	PHYSICIAN (MD), 94-09052, KS, OBSTETRICS & GYNECOLOGY
Professional School(s):	UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE (2016)

B. PAYMENT INFORMATION

Credit Card Information:	XXXXXXXXXXXX3255 (05/2022)		
NPDB Charge:	$4.00	**NPDB Bill Reference Number:**	N60248215
Transaction Date:	11/19/2018	**Additional Paper Copies Requested:**	0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 11/19/2018

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 ----------

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

https://www.npdb.hrsa.gov

5500000140924059
Process Date: 11/19/2018
Page: 1 of 1

To: SANDOVAL, SELINA MARIE

4428 N GRAND AVE

KANSAS CITY, MO 64116-2169

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.

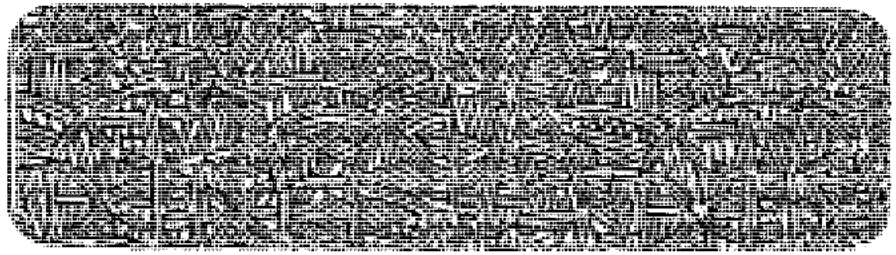
If you require additional assistance, visit the NPDB web site (https://www.npdb.hrsa.gov) or contact the NPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time.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

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

Address Service Requested

NEOPOST FIRST-CLASS MAIL
11/20/2018
USPOSTAGE $000.47º

ZIP 20151
041M11280584



6411632169 C030
6411632169 C030

CONFIDENTIAL INFORMATION
TO BE OPENED BY ADDRESSEE ONLY

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

MALPRACTICE HISTORY REPORT

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

NAME AND ADDRESS OF PROFESSIONAL LIABILITY INSURER IN OTHER STATE:

1. _____

2. _____

3. _____

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

Number	Date	Disposition
None		

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

Print Name Selina Sandoval

Signature _____ Date 11/28/18

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

01/14

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

Malpractice Liability Claims Information
(copy the form to report additional claims)

Malpractice: Give a detailed clinical explanation of each case as well as documentation of outcome (Insurance papers or court documents.

Name of patient involved_____

In which state did the action take place?_____ Which court?_____

Current status of this claim:

___ Open (pending) ___Closed (settled) ___Dismissed (no money paid out ___Other_____

Amount of judgment of settlement $_____ Amount paid on your behalf $_____

Date of event precipitating claim_____/_____ Date of lawsuit_____/_____ Case number_____
Month Year Month Year

Insurance carrier at time_____

What is/was your status? ___Primary defendant ___Co-defendant ___Other_____

Please provide specifics in reference to the adverse even including the allegations and your role in the event.

_____

_____

_____

_____

_____

_____

Name of patient involved_____

In which state did the action take place?_____ Which court?_____

Current status of this claim:

___ Open (pending) ___Closed (settled) ___Dismissed (no money paid out ___Other_____

Amount of judgment of settlement $_____ Amount paid on your behalf $_____

Date of event precipitating claim_____/_____ Date of lawsuit_____/_____ Case number_____
Month Year Month Year

Insurance carrier at time_____

What is/was your status? ___Primary defendant ___Co-defendant ___Other_____

Please provide specifics in reference to the adverse even including the allegations and your role in the event.

_____

_____

_____

_____

_____

_____

Applicant Name Selina Sandoval Last 4 digits of SSN [redacted] Date 11/28/18

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

FACILITIES LIST

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

CURRENT PRIVILEGES

Facility	City and State	Type of Privilege
NONE		

PAST PRIVILEGES (LAST 10 YEARS)

Facility	City and State	Type of Privilege

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

Print Name Selina Sandoval

Signature [signature] Date 11/28/18

01/14

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

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 University of Kansas Medical Center

Street Address 3901 Rainbow Blvd

City Kansas City State MO Zip 66160

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

2. MILITARY STATUS

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

__X__No

___Yes, discharged less than six months ago. Discharge date: _____

___ Yes, still in active military duty.

3. CRIMINAL CONVICTIONS

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has 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 one item to report please attach additional sheets.

Conviction Date (mm/dd/yyyy): _____

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

Crime Description: _____

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

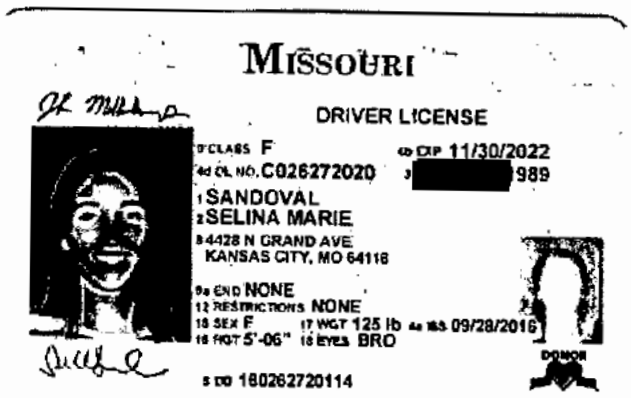
Sentence: _____

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

Applicant Name (printed): Selina Sandoval

Applicant Signature: _____ Date 11/28/18

11/16



MISSOURI

DRIVER LICENSE

9 CLASS F 4b EXP 11/30/2022
4d DL NO. C026272020 [redacted]989
1 SANDOVAL
2 SELINA MARIE
8 4428 N GRAND AVE
KANSAS CITY, MO 64116
9a END NONE
12 RESTRICTIONS NONE
15 SEX F 17 WGT 125 lb 4a ISS 09/28/2016
16 HGT 5'-06" 18 EYES BRO
5 DD 180262720114
DONOR

STATE OF: KANSAS
COUNTY of: WYANDOTTE
I CERTIFY THAT THIS IS A TRUE AND CORRECT
COPY of A DOCUMENT IN THE POSSESSION
of SELINA SANDOVAL
DATED: 11/28/2018

#11016201

Melissa Vazzano
Notary Public
State of Kansas
My Appointment
Expires on 12/03/2018

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

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_____

SELINA M. SANDOVAL
4428 N Grand Ave. • Kansas City, MO 64116 • 916.208.4861 • ssandoval2@kumc.edu

PROFESSIONAL EDUCATION/TRAINING

2016-2020 **University of Kansas Department of Obstetrics and Gynecology**
Residency Training

2016 **University of Illinois College of Medicine at Peoria (UICOMP)**
Doctor of Medicine

2012 **University of Arizona, Tucson, AZ**
Bachelor of Science in Biology, Chemistry and Humanities Minors

AWARDS AND HONORS

2008-2012 **National Hispanic Scholar**
- Academic honor awarded to a minority of Hispanic PSAT and SAT takers to identify academic excellence in Latino students

2015- Present **Gold Humanism Honor Society (GHHS)**
- GHHS recognized medical students, residents and faculty who serve as examples of compassionate patient care and leaders in their medical practice

LEADERSHIP EXPERIENCE

2015-2016 **Student Government Association President** Peoria, IL
- M2 Student government representative 2013-2014, Vice President 2014-2015
- Planned university wide activities and represented classmates in decisions affecting the Medical College
- Performed interviews for University of Illinois College of Medicine applicants

2015-2016 **M1 Curriculum Work Group** Peoria, IL
- Worked to develop the medical school curriculum for the UICOMP campus's first incoming M1 Class

2015-2016 **OB/Gyn Interest Group Co-President** Peoria, IL

2011-2012 **Global Medical Brigades, Vice President** Tucson, AZ
- Organized a Medical Brigade to Ghana including a group of undergraduate students, pharmacy students, nurses, and physicians
- Established a medical clinic in a rural village with little access to healthcare providing pharmaceuticals and screening exams including pap smears

RESEARCH EXPERIENCE

2017-Present **Ultrasound evaluation of adnexal findings in medically treated ectopic pregnancy**
Pending IRB Approval

2017-Present **Discharge instruction reminders via text messages after benign gynecologic surgery: a feasibility study**
Data Collection in process

2016-Present **Endometrial mediators of abnormal uterine function. Evaluating miR-451a levels in endometrial tissue and serum of women with infertility**
Data collection in process

2015 **Retrospective chart review to determine the average amount of time elapsed from the diagnosis of ectopic pregnancy to initiation of treatment or intervention and the compared outcomes, Principle Investigator Kaleb Jacobs** OSF Saint Francis Medical Center, Peoria, IL

2015 **Retrospective chart review to determine the influence of amniotic fluid index after preterm premature rupture of membranes on maternal and neonatal outcomes, Principle Investigator Amy Hertz** OSF Saint Francis Medical Center, Peoria, IL

ACTIVITIES AND HOBBIES

2016-Present **KC Pet Project Volunteer** Kansas City, Missouri
Trained volunteer at the local animal shelter, providing care for the animals
Assist in adoption events and socialization of animals

1997-Present **Sewing and Needle Art**
Enjoy quilting, knitting, crochet, and fine needle work

NATIONAL PRACTITIONER DATA BANK

NPDB

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

https://www.npdb.hrsa.gov

5500000140924059
Process Date: 11/19/2018
Page: 1 of 1

SANDOVAL, SELINA MARIE - SELF-QUERY RESPONSE

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

Practitioner Name:	SANDOVAL, SELINA MARIE
Date of Birth:	[redacted]/1989
Gender:	FEMALE
Delivery Address:	4428 N GRAND AVE, KANSAS CITY, MO 64116-2169
Social Security Number:	***-**-[redacted]
DEA:	FS6120098
NPI:	1336599653
License:	PHYSICIAN (MD), 94-09052, KS, OBSTETRICS & GYNECOLOGY
Professional School(s):	UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE (2016)

B. PAYMENT INFORMATION

Credit Card Information:	XXXXXXXXXXXX3255 (05/2022)		
NPDB Charge:	$4.00	**NPDB Bill Reference Number:**	N60248215
Transaction Date:	11/19/2018	**Additional Paper Copies Requested:**	0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 11/19/2018

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 ----------

Selina Sandoval, MD
11/28/18

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

NATIONAL PRACTITIONER DATA BANK

NPDB

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

https://www.npdb.hrsa.gov

5500000140924059
Process Date: 11/19/2018
Page: 1 of 1

To: SANDOVAL, SELINA MARIE

4428 N GRAND AVE

KANSAS CITY, MO 64116-2169

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.

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

https://www.npdb.hrsa.gov

To: SANDOVAL, SELINA MARIE

4428 N GRAND AVE

KANSAS CITY, MO 64116-2169

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.

NATIONAL PRACTITIONER DATA BANK

NPDB

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

https://www.npdb.hrsa.gov

5500000140924059
Process Date: 11/19/2018
Page: 1 of 1

SANDOVAL, SELINA MARIE - SELF-QUERY RESPONSE

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

Practitioner Name:	SANDOVAL, SELINA MARIE
Date of Birth:	[redacted]/1989
Gender:	FEMALE
Delivery Address:	4428 N GRAND AVE, KANSAS CITY, MO 64116-2169
Social Security Number:	***-**-[redacted]3
DEA:	FS6120098
NPI:	1336599653
License:	PHYSICIAN (MD), 94-09052, KS, OBSTETRICS & GYNECOLOGY
Professional School(s):	UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE (2016)

B. PAYMENT INFORMATION

Credit Card Information:	XXXXXXXXXXXX3255 (05/2022)		
NPDB Charge:	$4.00	**NPDB Bill Reference Number:**	N60248215
Transaction Date:	11/19/2018	**Additional Paper Copies Requested:**	0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 11/19/2018

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 ----------

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

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 University of Kansas Medical Center

Street Address 3901 Rainbow Blvd

City Kansas City State KS Zip 66160

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

2. MILITARY STATUS

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

X No

___ Yes, discharged less than six months ago. Discharge date: _____

___ Yes, still in active military duty.

3. CRIMINAL CONVICTIONS

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has 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 one item to report please attach additional sheets.

Conviction Date (mm/dd/yyyy): _____

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

Crime Description: _____

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

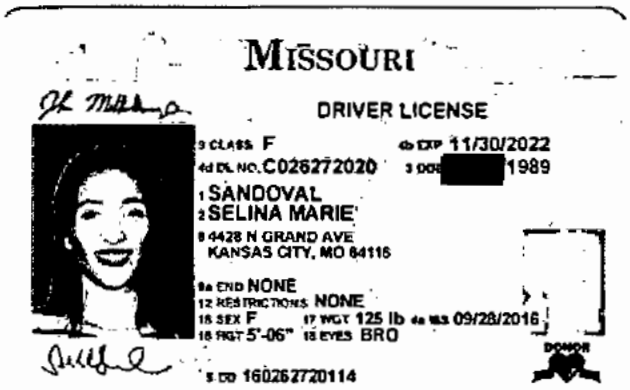
Sentence: _____

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

Applicant Name (printed): Selina Sandoval

Applicant Signature: _____ Date 11/20/18

11/16



MISSOURI

DRIVER LICENSE

9 CLASS F
4d DL NO. C026272020
4b EXP 11/30/2022
3 DOB [redacted]1989
1 SANDOVAL
2 SELINA MARIE
8 4428 N GRAND AVE
KANSAS CITY, MO 64116
9a END NONE
12 RESTRICTIONS NONE
15 SEX F
17 WGT 125 lb
4a ISS 09/28/2016
16 HGT 5'-06"
18 EYES BRO
5 DD 160262720114
DONOR

KU SCHOOL OF MEDICINE
The University of Kansas

December 3, 2018

Re: Selina Sandoval, MD

To Whom It May Concern:

This letter will serve as verification that Dr. Selina Sandoval is in good standing in the Department of Obstetrics and Gynecology at the University of Kansas Medical Center. Dr. Sandovals's residency dates are from 7/1/2016 to 6/30/2020.

If you have any questions or problems, please do not hesitate to contact me at 913-588-6245.

Sincerely,

Carrie Wieneke, MD
Program Director
Department of Obstetrics and Gynecology
University of Kansas Medical Center

Obstetrical & Gynecological Foundation
Mail Stop 2028 | 3901 Rainbow Blvd. | Kansas City, KS 66160 | (913) 588-6250 | Fax (913) 588-6271 | www.kumc.edu

KU OFFICE OF THE GENERAL COUNSEL
The University of Kansas

September 4, 2018

RE: Selina M. Sandoval, M.D.

To Whom It May Concern:

Please be advised that Selina M. Sandoval, M.D. is provided professional liability coverage as a resident at the University of Kansas School of Medicine through the Kansas Health Care Stabilization Fund pursuant to K.S.A. § 40-3401, et seq. for resident sanctioned activities.[1]

This is a statutory self-insurance program that provides "tail" coverage.[2] The coverage amount is $1,000,000.00/$3,000,000.00. Dr. Sandoval's coverage began 07/01/2016 and will remain in effect through 06/30/2019.

Respectfully,

Kim Gibbens
Deputy General Counsel

KKG/plp

[1] Moonlighting activities are not covered by the state self-insurance program referenced above. A resident must obtain his/her own individual professional liability policy to cover moonlighting activities.
[2] Tail coverage only applies to coverage provided by the Kansas Health Care Stabilization Fund.

NPI

Doran Shelby

From: customerservice@npienumerator.com
Sent: Friday, June 17, 2016 6:04 AM
To: Doran Shelby
Subject: National Provider Identifier

DOB 11/30/89

Follow Up Flag: Follow up
Flag Status: Flagged

Enumeration Date: June 17, 2016

A request for a National Provider Identifier for Selina Sandoval M.D. was recently submitted to https://nppes.cms.hhs.gov, and you were listed as the contact person. This is to inform you that the request was successfully processed and the following NPI has been assigned: 1336599653.

Practice Location:
3901 Rainbow Blvd
Kansas City, KS 66160-2169

Provider Taxonomies:
Taxonomy: 207V00000X
License: 94-09052 State: KS
Details: Obstetrics & Gynecology
This is the Primary Taxonomy.

If you have any questions about this notification you may contact the NPI Enumerator at:
NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059
1-800-465-3203 (NPI Toll-Free)
1-800-692-2326 (NPI TTY)
customerservice@npienumerator.com

You may view or change this provider's NPPES information by logging onto the NPPES website at https://nppes.cms.hhs.gov.

Please note: If you are not the provider, you are required to inform the provider of the information in this e-mail and furnish a copy of this notification to the provider.

MINNESOTA
BOARD OF MEDICAL PRACTICE

March 15, 2019

Selina M. Sandoval, M.D.
4428 N Grand Ave
Kansas City, MO 64116

Dear Dr.Sandoval:

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

- Criminal Background Check (CBC) (CBC Program will email the applicant an instructional packet for completing the criminal background check)

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,

Paul Luecke
Licensure Coordinator, Licensure Unit
Paul.Luecke@state.mn.us

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Monday, July 06, 2020

Home Online Services My Services Search Log In

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: Selina Marie Sandoval New Search

License: Physician and Surgeon - #65290 Print

Licensee Public Information

Licensure Designated Address: 3901 Rainbow Blvd.
Kansas City, KS 66160
Web Site: **Birth Year:** 1989
E-mail: **Gender:** Female

License Information

License Number:	65290	**License Type:**	Physician and Surgeon
Expiration Date:	11/30/2019	**Grant Date:**	04/04/2019
License Status:	Resigned Inactive		
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:	UNIVERSITY OF ILLINOIS, COLLEGE OF MEDICINE AT PEORIA, PEORIA USA	**Degree:**	M.D.
Location:	Peoria, IL USA	**Date:**	05/08/2016

Practice Locations (Self-Reported Information)

Primary Location: University of Kansas Medical Center
3901 Rainbow Blvd.
Kansas City, MO 66160
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

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 7/6/2020 10:14:43 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.