# Application - Physician/Surgeon

| | |
|---|---|
| Name | SARAH ANN TRAXLER |
| Credential | Physician/Surgeon |

## Fee Details

| | |
|---|---|
| Fee to Query NPDB | $4.75 |
| Initial Application Fee | $565.00 |
| | **$569.75** |

## Past Connecticut Licensure/Certification

Please do not complete this application if you currently hold or have held a CT license/certificate for this profession.

This application is for individuals APPLYING for a license/certificate for the FIRST TIME. It is not for applicants who are attempting to renew a license/certificate or to reinstate a lapsed license/certificate.

If you are trying to renew a license/certificate and do not have your assigned user ID and password, please DO NOT CONTINUE with this application.

Please email oplc.dph@ct.gov and include, for your protection, your name, profession, date of birth and the last four digits of your Social Security number and your user ID and password will be emailed to you.

Please note that not all profession types allow for online renewal at this time.

To continue this application, select the 'Next' button at the bottom left corner of the screen.

## Application Instructions

Thank you for applying for your license online. Please note that as part of this application, you will be required to upload a recent picture of yourself. Please make sure you have one available on the device you are using to file this application.

Please be advised that application fees submitted to the department are non-refundable.

Please note that you need to arrange for the submission, directly from the source, of a transcript from your medical school, verification of at least 2 years of progressive, post graduate residency training, verification of completion of the required examinations and verification of all licenses held, current or expired.

Applicants who completed medical school outside of the United States are required to arrange for their medical school to send a completed school verification form and a transcript directly to this office verifying completion of medical school. Non-US trained applicants are also required to arrange for the submission of verification of current certification by ECFMG.

For detailed information regarding eligibility and documentation requirements, please visit www.ct.gov/dph/license and select Physician/Surgeon.

As part of this application, you will provide information that will be used to create a profile that will be published on the Department's website. Following issuance of licensure, you will be provided with an opportunity to review and update the profile prior to its publication.

APPLICANTS WHO HAVE HELD A CT PHYSICIAN LICENSE IN THE PAST SHOULD NOT USE THIS SERVICE TO APPLY FOR REINSTATEMENT.

## Demographic Information - Initial Application

1. Maiden Name

2. Please provide your Date of Birth
   05/10/1975

3. U.S. Social Security Number
   [redacted]

4. Gender
Female

5. Race:
White

6. Ethnicity: Please choose one
Not Hispanic or Latino

7. Please attach a recent photo of the applicant.


## Basis of Licensure

Please select a basis for licensure.

Please note the following definitions:

Endorsement: Select this basis of licensure if you were educated in the United States and are, or have been, licensed in any other U.S. state or Canadian province.

Endorsement - FT: Select this basis of licensure if you completed your educational preparation outside of the U.S. and you are, or have been, licensed in any U.S. state or Canadian province.

Exam: Select this basis of licensure if you were educated in the U.S. and this is the first time you are applying for a license in any jurisdiction.

Exam - FT: Select this basis of licensure if you completed your educational preparation outside of the U.S. and this is the first time you are applying for a license in any jurisdiction.

8. Select Basis for Licensure
Endorsement

## Federation Credentials Verification Service (FCVS)

FCVS obtains primary-source verification of medical education, postgraduate training, examination history, board action history, board certification and identity. This repository of information allows a physician and/or physician assistant to establish a confidential, lifetime professional portfolio with FCVS which can be forwarded, at the applicant's request, to any state medical and osteopathic board that has established an agreement with FCVS. Please note that this is optional.

9. If you plan to use the Federation Credentials Verification Service (FCVS) to verify your core credentials, enter your FCVS Packet ID here

## Medical Education

10. Medical School
Oregon Health and Science University

11. Year of Graduation
2009

## Post Graduate Training Information

Please enter any internship, residency or fellowship training you have completed

12. List your postgraduate training:

| Site Name | City | State | Country | Start Date | End Date | Level | Type |
|---|---|---|---|---|---|---|---|
| University of Minnesota | Minneapolis | Minnesota | UNITED STATES | 06/07/2009 | 06/07/2013 | Resident | OB/GYN |
| University of Pennsylvania | Philadelphia | Pennsylvania | UNITED STATES | 07/01/2013 | 06/30/2015 | Fellowship | OB/GYN |

## Specialty/Board Certification

Please enter your specialty, subspecialty and indicate the date on which you were certified by an ABMS ABMOS specialty board

13. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS, if applicable. Board certification is not a requirement for licensure.

| Specialty | Subspecialty | | Certifying Board | Certification Date |
|---|---|---|---|---|
| Obstetrics and Gynecology | Subspecialty | Certification Date | American Board of Obstetrics and Gynecology | 10/27/2017 |

## Other State License

14. Indicate states outside of CT where licenses are held, current or expired

| State | Disciplinary Action |
|---|---|
| Pennsylvania | No |
| South Dakota | No |
| North Dakota | No |
| Minnesota | No |

## Current Practice Information

15. Upon issuance of your Connecticut license, will you practice medicine in Connecticut?
Yes

16. Are you actively involved in patient care?
Yes

17. Enter your practice locations

| Practice Name | Address 1 | Address 2 | Address 3 | City | State | Zip Code | Primary Practice | Languages Spoken at this Location |
|---|---|---|---|---|---|---|---|---|

## Connecticut Hospitals and Nursing Home Privileges

Please enter the Connecticut hospitals and nursing homes where you will have admitting privileges

18. Indicate the Connecticut hospitals or nursing homes for which you have or will have staff privileges

| Facility Name | City | State |
|---|---|---|

## Medical Education Responsibilities

19. Are you a member of the faculty of a Connecticut medical school?
No

20. Select the state medical schools at which you are a member of the faculty.

21. Do you have current responsibility for graduate medical education?
No

## Statement of Professional History

Please answer the following questions. If you answer yes to any of the questions regarding your professional history, please provide details in the space available below and arrange for the submission of supporting documentation (e.g. certified court copy with court seal affixed, complaint, answer, judgment, settlement or disposition) that will assist this office's review. Applicant's answering affirmatively to any question below may be contacted for additional information.

22. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following: Any hospital, nursing home, clinic, or similar institution; Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public; Any professional school, clinical clerkship, internship, externship, preceptorship; or postgraduate training program; Any third party reimbursement program, whether governmental or private?
No

23. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?
No

24. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?
No

25. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction?
No

26. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?
No

27. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit?
No

28. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state?
No

29. Provide details regarding any question(s) above that you may have answered affirmatively.

## Medical Malpractice Payment History

Please indicate below any malpractice payments that you have made or have been made on your behalf during the ten (10) year period immediately preceding the date of this application

30. Indicate your malpractice insurance carrier:
ACORD

31. Indicate the medical malpractice payments that have been made by you or on your behalf within the past ten years.

| Resolved Date | Payment Category | Amount Paid | Specialty | Group Count | Payment Count |
|---|---|---|---|---|---|

## Felony Conviction History

Please list any felony that you have been convicted of during the ten (10) year period immediately preceding the date of this application

32. Please enter any felony convictions within the previous ten years.

| Conviction Date | Conviction |
|---|---|

## Hospital Discipline

Please list any disciplinary action taken against you by a hospital during the ten (10) year period immediately preceding the date of this application

33. Please enter any felony convictions within the previous ten years.

| Conviction Date | Conviction |
|---|---|

## Publications, Services or Awards

Please indicate any publications, services or awards (this section is voluntary)

34. In this section, you may add any publications, professional services, activities, and awards that you would think useful to viewers of your profile.

| Publisher/Issuer | Title/Award Name | Date |
|---|---|---|

## Application Attestation

35. By filing this application online on the date indicated below, I attest that I am the person referred to in this application and that the photograph attached hereto is a true picture of me and that the statements made herein are true in every respect.

12/12/2017

## American Medical Association's Opinions

The Connecticut Medical Examining Board and the Connecticut Department of Public Health encourage you to read the following opinions of the American Medical Association's Code of Medical Ethics related to common reasons for discipline on Connecticut physicians licenses.

AMA Code of Ethics

Opinion 1.2.1 Treating Self or Family

Treating oneself or a member of ones own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.

When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

AMA Principles of Medical Ethics

Opinion 9.1.1 Romantic or Sexual Relationships wth Patients

Romantic or sexual interactions between physicians and patients that occur concurrently with the patient physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous

physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

**Review**

## Practitioner Profile for SARAH ANN TRAXLER, 1.060078 view pub update online

### Practitioner Profile Status

| | |
|---|---|
| Prepublication Status | None |
| Publication Status | Published |
| Pending Updates | NO |

### 1. Physician Information update

| | |
|---|---|
| License Number | 60078 |
| Effective Date | 02/23/2018 |
| Expiration Date | 05/31/2021 |
| Currently practicing medicine in CT | YES |
| Actively involved in patient care | YES |

**Practice Locations** add

| | Practice | Address | Languages | Primary? |
|---|---|---|---|---|
| update | Planned Parenthood | 671 Vandalia Street<br>Saint Paul, MN 55114 | | YES |

**Staff Privileges** add

| Facility | Address | Start Date | End Date |
|---|---|---|---|

### 2. Medical School update

| | |
|---|---|
| Medical School | Oregon Health and Science University |
| Year of Graduation | 2009 |

### 3. Post Graduate Training add

| | Start | End | Type | Level | Hospital | Address |
|---|---|---|---|---|---|---|
| update | 07/01/2013 | 06/30/2015 | OB/GYN | Fellowship | University of Pennsylvania | Philadelphia, PA<br>UNITED STATES |
| update | 06/07/2009 | 06/07/2013 | OB/GYN | Resident | University of Minnesota | Minneapolis, MN<br>UNITED STATES |

### 4. Specialty Area and Board Certification add

| | Specialty/Subspecialty | Board Cert Date | Speciality End Date | Certifying Board |
|---|---|---|---|---|
| update | Obstetrics and Gynecology add sub | 10/27/2017 | | American Board of Obstetrics and Gynecology |

### 5. CT Medical Education Responsibility update

| | |
|---|---|
| Member of faculty of a CT medical school | NO |
| Medical School | |
| Current Responsibility for graduate medical education | NO |

### 6. Publications, Professional Services, Activities, Awards add

| Publisher/Issuer | Title/Award Name | Date |
|---|---|---|

### 7. Hospital Discipline add

| Hospital | Address | Date | Discipline |
|---|---|---|---|

### 8. Medical Malpractice Payments add dispute

| Payment Date | Payment Category | Amount Paid | Related Practice Specialty |
|---|---|---|---|

### 9. Felony Convictions add dispute

| Date of Conviction | Conviction |
|---|---|

### 10. CT Licensure Disciplinary Actions dispute

| Date of Action | Action | License Status |
|---|---|---|

# Renewal - 1.060078

| | |
|---|---|
| Name | SARAH ANN TRAXLER |
| Credential | 1.060078 |

## Fee Details

| | |
|---|---|
| Renewal Application Fee | $575.00 |
| | **$575.00** |

## Workforce Survey Introduction

**Dear Licensee:**

**Thank you for renewing your license online.**

**As part of this renewal application, you will be asked to enter your National Provider Identification (NPI) number. Please make sure you have that information available before proceeding. If you do not have your NPI number with you, you can find it online at https://npiregistry.cms.hhs.gov/. You will also be asked to enter information regarding your practice location, specialty and patients served.**

**The purpose of the questions is to allow the Department of Public Health to collect valuable workforce and patient care data that is critical in identifying and addressing healthcare workforce shortage and patient care issues.**

**Thank you for assisting the Department in this important initiative.**

## Demographic Information-Renewal

1. Please provide your Date of Birth
   05/10/1975

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   White

## Email Address Verification

Please be advised that the Department no longer mails hardcopy licenses and renewal notices. Rather, licenses and renewal notices will be sent via email. You will receive an electronic copy of your license via email within a few days of completing this transaction. Renewal notices will be sent via email approximately 60 days prior to your license expiration date.

## Residence Address

Please enter the information below regarding the address of your residence. Please note that entering your address here will not change your mailing address in our system. If you have a change of address, please email it to oplc.dph@ct.gov. For your protection, please include your profession, license number and the last 4 digits of your SSN in your request.

5. Street Address
   671 Vandalia Street

6. Unit/Apartment Number

7. City
   St. Paul

8. State (two letter abbreviation)

MN

9. Zip Code
55144

## Medical Education

10. Medical School
Oregon Health and Science University

11. Year of Graduation
2009

## Specialty/Board Certification

12. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS, if applicable. Board certification is not a requirement for licensure.

| Specialty | Subspecialty | | Certifying Board | Certification Date |
|---|---|---|---|---|
| Obstetrics and Gynecology | **Subspecialty** | **Certification Date** | American Board of Obstetrics and Gynecology | 10/27/2017 |

## Current Workforce Status in Medicine

13. What is your current work status in medicine?
Full Time - (40 hours or more per week)

14. In the next 12 months, do you plan to (please mark all that apply):
None

15. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:

16. If your response to the previous question was other, please enter additional comments here.

## National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions. NPIs have replaced all separately issued identifiers, including Medicaid PINs and Medicare UPINs, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI has been put in place so that each provider has one unique, United States federal government-issued identifier to be used in transactions with all health plans with which the provider conducts business.

17. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at https://npiregistry.cms.hhs.gov.) If you do not have an NPI number, please enter ten (10) zeros):
1538301650

## Physician Renewal Practice Location

18. Please indicate the name and address of your primary practice location as well as languages spoken at that location. Please note that you can add additional practice locations but you may only select one (1) primary practice location.

| Practice Name | Address 1 | Address 2 | Address 3 | City | State | Zip Code | Primary Practice | Languages Spoken at this Location |
|---|---|---|---|---|---|---|---|---|
| Planned Parenthood | 671 Vandalia Street | | | Saint Paul | Minnesota | 55114 | Yes | |

19. Approximately how many physicians are associated with your practice (If you are in residency training, please enter zero (0) here)?
7

20. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?
No

21. Please select the best choice for the type of ownership of your practice.
Other corporation

## Practice Ownership - Organization

22. Please enter the name of the organization/person that owns the practice where you work.
Planned Parenthood Orange & San Bernadino Counties, INC

23. City
Orange

24. State (two letter abbreviation)
CA

## New Patients

25. Please select the best response that describes your patient care practice status:
I cannot accept any new patients; my practice is full

26. Are you accepting new patients covered by:
Neither

## Primary Source of Payment

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

What percent of your patients have the following source of payment?

27. Medicare
None

28. Medicaid
None

29. Self-Pay
None

30. Private Insurance
None

31. Other
None

32. Does your practice offer sliding fee scale based on ability to pay?
No

33. Approximately what percentage of your patients use sliding fee schedules?
None

## Populations Served

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

Please approximate the percentage of patients at your primary practice location that are:

34. Homeless
None

35. Migrant/Seasonal Farm Workers
None

36. Native Americans
None

## Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

37. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
03/28/2018

## Physician Attestation

38. Within the last year, have you been convicted of a felony?
No

39. If yes, please provide details here

40. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

41. If yes, please provide details here

42. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.
Yes

43. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
03/28/2018

## American Medical Association's Opinions

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In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

## Important Note

**To continue processing your transaction, please click "Add to Invoice" on the NEXT screen (read the rest of this information first).**

On the top right of the invoice screen, select **"Pay Invoice".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Thank you for processing your application online.

## Review

## Renewal - 1.060078

| | |
|---|---|
| Name | SARAH ANN TRAXLER |
| Credential | 1.060078 |

### Fee Details

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   05/10/1975

2. Gender
   Female

3. Ethnicity: Please choose one
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4. Race:
   White

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### Residence Address

Please enter the information below regarding the address of your residence. Please note that entering your address here will not change your mailing address in our system. If you have a change of address, please email it to oplc.dph@ct.gov. For your protection, please include your profession, license number and the last 4 digits of your SSN in your request.

5. Street Address
   671 Vandalia Street

6. Unit/Apartment Number

7. City
   Saint Pau

8. State (two letter abbreviation)

MN

9. Zip Code
55114

## Medical Education

10. Medical School
Oregon Health and Science University

11. Year of Graduation
2009

## Specialty/Board Certification

12. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS, if applicable. Board certification is not a requirement for licensure.

| Specialty | Subspecialty | | Certifying Board | Certification Date |
|---|---|---|---|---|
| Obstetrics and Gynecology | **Subspecialty** | **Certification Date** | American Board of Obstetrics and Gynecology | 10/27/2017 |

## Current Workforce Status in Medicine

13. What is your current work status in medicine?
Full Time - (40 hours or more per week)

14. In the next 12 months, do you plan to (please mark all that apply):
None

15. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:

16. If your response to the previous question was other, please enter additional comments here.

## National Provider Identifier

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17. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at https://npiregistry.cms.hhs.gov.) If you do not have an NPI number, please enter ten (10) zeros):
1538301650

## Professional Liability Insurance

Your professional practice act requires that a practitioner providing direct patient care services must maintain professional liability insurance or other indemnity against liability for professional malpractice. You may find information regarding professional liability insurance requirements by selecting this **link** and choosing your profession from the list.

## Physician Renewal Practice Location

18. Please indicate the name and address of your primary practice location as well as languages spoken at that location. Please note that you can add additional practice locations but you may only select one (1) primary practice location.

| Practice Name | Address 1 | Address 2 | Address 3 | City | State | Zip Code | Primary Practice | Languages Spoken at this Location |
|---|---|---|---|---|---|---|---|---|
| Planned Parenthood | 671 Vandalia Street | | | Saint Paul | Minnesota | 55114 | Yes | |

19. Approximately how many physicians are associated with your practice (If you are in residency training, please enter zero (0) here)?
2

20. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?
No

21. Please select the best choice for the type of ownership of your practice.
Healthcare system

## Practice Ownership - Organization

22. Please enter the name of the organization/person that owns the practice where you work.
Planned Parenthood Minnesota, North Dakota, South Dakota

23. City
St. Paul

24. State (two letter abbreviation)
MN

## New Patients

25. Please select the best response that describes your patient care practice status:
I can accept some new patients; my practice is far from full

26. Are you accepting new patients covered by:
Neither

## Primary Source of Payment

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

What percent of your patients have the following source of payment?

27. Medicare
None

28. Medicaid
None

29. Self-Pay
76 - 100%

30. Private Insurance
None

31. Other
None

32. Does your practice offer sliding fee scale based on ability to pay?
No

33. Approximately what percentage of your patients use sliding fee schedules?
None

## Populations Served

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

Please approximate the percentage of patients at your primary practice location that are:

34. Homeless
None

35. Migrant/Seasonal Farm Workers
None

36. Native Americans
11-25%

## Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

37. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
02/25/2019

## Physician Attestation

38. Within the last year, have you been convicted of a felony?
No

39. If yes, please provide details here

40. Within the last year, have you had any disciplinary action taken against you or any such actions pending by any State, federal government jurisdiction, District of Columbia, United States possession or territory or foreign jurisdiction?s licensing/certification authority?
No

41. If yes, please provide details here

42. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.
Yes

43. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
02/25/2019

## American Medical Association's Opinions

The Connecticut Medical Examining Board and the Connecticut Department of Public Health encourage you to read the following opinions of the American Medical Association's Code of Medical Ethics related to common reasons for discipline on Connecticut physicians licenses.

AMA Code of Ethics

Opinion 1.2.1 Treating Self or Family

Treating oneself or a member of ones own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.

When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

AMA Principles of Medical Ethics

Opinion 9.1.1 Romantic or Sexual Relationships wth Patients

Romantic or sexual interactions between physicians and patients that occur concurrently with the patient physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

## Important Note

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Thank you for processing your application online.

## Review

## Renewal - 1.060078

| | |
|---|---|
| Name | SARAH ANN TRAXLER |
| Credential | 1.060078 |

### Fee Details

| | |
|---|---|
| Renewal Fee | $575.00 |
| | **$575.00** |

### Workforce Survey Introduction

**Dear Licensee:**

**Thank you for renewing your license online.**

**As part of this renewal application, you will be asked to enter your National Provider Identification (NPI) number. Please make sure you have that information available before proceeding. If you do not have your NPI number with you, you can find it online at https://npiregistry.cms.hhs.gov/. You will also be asked to enter information regarding your practice location, specialty and patients served.**

**The purpose of the questions is to allow the Department of Public Health to collect valuable workforce and patient care data that is critical in identifying and addressing healthcare workforce shortage and patient care issues.**

**Thank you for assisting the Department in this important initiative.**

### Demographic Information-Renewal

1. Please provide your Date of Birth
   05/10/1975

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   White

### Address

5. Please update any changes to your mailing address:

   **Address 1:** 671 Vandalia Street

   **Address 2:**

   **City:** Saint Paul **State:** MN **Zip Code:** 55411 **Country:** UNITED STATES

6. Please update any changes to your primary address:

   **Address 1:** 671 Vandalia Street

   **Address 2:**

   **City:** Saint Paul **State:** MN **Zip Code:** 55411 **Country:** UNITED STATES

   **Telephone Number:** 651-696-5534

### Email Address Verification

Please be advised that the Department no longer mails hardcopy licenses and renewal notices. Rather, licenses and renewal notices will be sent via email. You will receive an electronic copy of your license via email within a few days of completing this transaction. Renewal notices will be sent via email approximately 60 days prior to your license expiration date.

## Residence Address

Please enter the information below regarding the address of your residence. Please note that entering your address here will not change your mailing address in our system. If you have a change of address, please email it to oplc.dph@ct.gov. For your protection, please include your profession, license number and the last 4 digits of your SSN in your request.

7. Street Address
   671 Vandalia Street

8. Unit/Apartment Number

9. City
   St. Paul

10. State (two letter abbreviation)
    MN

11. Zip Code
    55411

## Medical Education

12. Medical School
    Oregon Health and Science University

13. Year of Graduation
    2009

## Specialty/Board Certification

14. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS, if applicable. Board certification is not a requirement for licensure.

| Specialty | Subspecialty | | Certifying Board | Certification Date |
|---|---|---|---|---|
| Obstetrics and Gynecology | **Subspecialty** | **Certification Date** | American Board of Obstetrics and Gynecology | 10/27/2017 |

## Current Workforce Status in Medicine

15. What is your current work status in medicine?
    Full Time - (40 hours or more per week)

16. In the next 12 months, do you plan to (please mark all that apply):
    None

17. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:

18. If your response to the previous question was other, please enter additional comments here.

## National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions. NPIs have replaced all separately issued identifiers, including Medicaid PINs and Medicare UPINs, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI has been put in place so that each provider has one unique, United States federal government-issued

identifier to be used in transactions with all health plans with which the provider conducts business.

19. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at https://npiregistry.cms.hhs.gov.) If you do not have an NPI number, please enter ten (10) zeros):
1538301650

## Professional Liability Insurance

Your professional practice act requires that a practitioner providing direct patient care services must maintain professional liability insurance or other indemnity against liability for professional malpractice. You may find information regarding professional liability insurance requirements by selecting this **link** and choosing your profession from the list.

## Physician Renewal Practice Location

20. Please indicate the name and address of your primary practice location as well as languages spoken at that location. Please note that you can add additional practice locations but you may only select one (1) primary practice location.

| Practice Name | Address 1 | Address 2 | Address 3 | City | State | Zip Code | Primary Practice | Languages Spoken at this Location |
|---|---|---|---|---|---|---|---|---|
| Planned Parenthood | 671 Vandalia Street | | | Saint Paul | Minnesota | 55114 | Yes | |

21. Approximately how many physicians are associated with your practice (If you are in residency training, please enter zero (0) here)?
24

22. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?
No

23. Please select the best choice for the type of ownership of your practice.
Other corporation

## Practice Ownership - Organization

24. Please enter the name of the organization/person that owns the practice where you work.
Planned Parenthood Minnesota North Dakota South Dakota

25. City
St Paul

26. State (two letter abbreviation)
MN

## New Patients

27. Please select the best response that describes your patient care practice status:
I can accept some new patients; my practice is far from full

28. Are you accepting new patients covered by:
Neither

## Primary Source of Payment

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What percent of your patients have the following source of payment?

29. Medicare
None

30. Medicaid
less than 10%

31. Self-Pay
51 - 75%

32. Private Insurance
11 - 25%

33. Other
None

34. Does your practice offer sliding fee scale based on ability to pay?
Yes

35. Approximately what percentage of your patients use sliding fee schedules?
26-50%

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36. Homeless
Less than 10%

37. Migrant/Seasonal Farm Workers
Less than 10%

38. Native Americans
Less than 10%

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04/26/2020

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No

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04/26/2020

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## Review