APPLICATION TO PRACTICE MEDICINE

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 400
MINNEAPOLIS, MINNESOTA 55414-3246
(612) 617-2130

Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

R

392.00

SEP 2001 RECEIVED BY MN BD OF MED. PRACTICE

FOR BOARD USE ONLY

APPLICATION #: 15577
CHECK /RECEIPT #:
AMT PAID:
TEMP PERMIT #:
BOARD ACTION:
BOARD DATE: 11-10-01
LICENSE #: 44241

SOURCE CODE	AMOUNT
5200	192.00
5201	200.00

068-6
068-17

DATE OF APPLICATION:

MONTH	DAY	YEAR
3	5	01

INSTRUCTIONS TO APPLICANT

1. Answer all questions completely and accurately or the application will be returned.
2. The name you enter must exactly match the name on your medical diploma, or documentation of formal name change must be submitted.
3. All addresses must include zip code, if requested on the application.
4. Account for all time from the beginning of high school, whether spent in school, practice, or otherwise. Dates must include Month, Day, and Year. Attach a separate sheet if necessary.
5. Enter all dates as MONTH-DAY-YEAR.
6. The application fee is not refundable.
7. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
8. Incomplete applications may be destroyed after six months of inactivity.

TO: The Minnesota Board of Medical Practice:

I hereby make application for a license to practice medicine and surgery in the State of Minnesota and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME: LAST	FIRST	MIDDLE
PACALA	KARA	KORACH

STREET ADDRESS: 4455 DUPONT AVENUE SOUTH

CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:
MINNEAPOLIS	MN	55409	USA

HOME PHONE:	OTHER PHONE:	GENDER	MAIDEN NAME:
[redacted]		☐ MALE ☒ FEMALE	KORACH

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER: [redacted]

BASIS FOR APPLICATION (CHECK ONE) *

- ☐ FEDERATION LICENSING EXAMINATION (FLEX)
- ☐ NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINATION (NBME)
- ☐ NATIONAL BOARD OF OSTEOPATHIC EXAMINERS EXAMINATION (NBOE)
- ☐ LICENTIATE OF MEDICAL COUNCIL OF CANADA EXAMINATION (LMCC)
- ☐ STATE BOARD EXAMINATION (STATE)
- ☑ UNITED STATES MEDICAL LICENSING EXAM (USMLE)
- ☐ COMBINATION FLEX, NBME, USMLE (must be completed by year 2000)

ECFMG CERTIFICATION (FOREIGN ONLY)

NUMBER:

DATE ISSUED:

DRIVERS LICENSE

STATE: MINNESOTA

NUMBER: P-240-461-475-741

44291

YOUR INTENDED ADDRESS (IF KNOWN)

STREET ADDRESS:		
CITY:	STATE OR PROVINCE:	
ZIP CODE:	COUNTRY:	EFFECTIVE DATE:
PHONE:		

RECORD OF BIRTH

BIRTHDATE (Mo/Day/Year)	CITY OF BIRTH:	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH:
[redacted]67	CLEVELAND	CUYAHOGA	OHIO

FULL NAME OF FATHER:	MOTHER'S MAIDEN NAME:	COUNTRY OF BIRTH:
JEFFREY LAWRENCE KORACH	SUE ELLEN WOLF	USA

IDENTIFYING CHARACTERISTICS

HEIGHT (ft./in.):	WEIGHT (lbs):	COLOR HAIR:	COLOR EYES:
5 ft 7 in	135 lbs	BROWN	BROWN

IDENTIFYING MARKS: Ø

PRELIMINARY EDUCATION

NAME OF HIGH SCHOOL: SHAKER HEIGHTS HIGH SCHOOL	CITY: SHAKER HEIGHTS	STATE OR PROVINCE: OHIO		FROM DATE: Month/Day/Year 9/82	TO DATE: Month/Day/Year 6/85
NAME OF COLLEGE: UNIV. OF MINNESOTA	CITY: MINNEAPOLIS	STATE OR PROVINCE: MN	DEGREE: BS	FROM DATE: Month/Day/Year 9/5/85	TO DATE: Month/Day/Year 6/15/90
NAME OF COLLEGE: UNIV. OF MN	CITY: MPLS	STATE OR PROVINCE: MN	DEGREE: None - pre med	FROM DATE: Month/Day/Year 9/1/93	TO DATE: Month/Day/Year 6/1/96

MEDICAL EDUCATION (MEDICAL COLLEGES MUST BE RECOGNIZED BY THE BOARD)

INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE Mo/Day/Year	TO DATE Mo/Day/Year
UNIV. OF MINNESOTA SCHOOL OF MEDICINE	MPLS	MN	55455	8/28/96	5/13/00

ACCOUNTING OF TIME NOT NOTED ELSEWHERE ON THIS APPLICATION

ACTIVITY (ATTACH SEPARATE SHEET, IF NECESSARY)	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
St Paul JCC - Director of Youth Programming	9/1/90	11/15/93

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MEDICAL DIPLOMAS

BACHELOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE Mo/Day/Year
☐ MEDICINE ☐ OSTEOPATHY						
DOCTOR OF:	**NAME OF SCHOOL:**	**CITY:**	**STATE OR PROVINCE**	**ZIP:**	**COUNTRY:**	**DATE : Mo/Day/Year**
☑ MEDICINE ☐ OSTEOPATHY	UNIVERSITY OF MINN. SCHOOL OF MEDICINE	MINNEAPOLIS	MN	55455	USA	5/13/00

US/CANADIAN ACCREDITED GRADUATE CLINICAL MEDICAL INTERNSHIP, RESIDENCY, FELLOWSHIP

NAME OF HOSPITAL:	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)
FUMC - Family Practice Residency	10/23/01	10/23/03

STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
	MPLS	MN		55406

TYPE OF TRAINING: (BE SPECIFIC)
Family Practice

NAME OF HOSPITAL:	FROM DATE (Mo/DayYear)	TO DATE (Mo/Day/Year)

STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:

TYPE OF TRAINING: (BE SPECIFIC)

NAME OF HOSPITAL:	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)

STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:

TYPE OF TRAINING: (BE SPECIFIC)

NAME OF HOSPITAL:	FROM DATE(Mo/Day/Year)	TO DATE (Mo/Day/Year)

STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:

TYPE OF TRAINING: (BE SPECIFIC)

NAME OF HOSPITAL:	FROM DATE(Mo/Day/Year)	TO DATE (Mo/Day/Year)

STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:

TYPE OF TRAINING: (BE SPECIFIC)

MILITARY SERVICE

BRANCH OF SERVICE:	ENTRY DATE (Mo/Day/Year)	RELEASE DATE (Mo/Day/Year)	RANK AT DISCHARGE:	TYPE OF DISCHARGE:

DUTY ASSIGNMENT:	LOCATION:

STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE EVER BEEN LICENSED

STATE/PROVINCE/COUNTRY	LICENSE NUMBER	DATE ISSUED (Mo/Day/Year)	HOW OBTAINED (*)

(*) NATIONAL BOARD OF MEDICAL EXAMINERS (NBME)
STATE BOARD EXAM (STATE)
NATIONAL BOARD OF OSTEOPATHIC EXAMINERS (NBOE)
LICENTIATE OF MEDICAL COUNCIL OF CANADA (LMCC)
FLEX EXAMINATION (FLEX)
UNITED STATES MEDICAL LICENSING EXAM (USMLE)
COMBINATION FLEX, NBME, USMLE

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PRACTICE REFERENCES

STATE BELOW WHERE YOU HAVE PRACTICED OUTSIDE OF A TRAINING PROGRAM, AND LIST TWO REFERENCES FROM EACH FACILITY

NAME OF FACILITY	FROM DATE: (Mo/Day/Year)	TO DATE: (Mo/Day/Year)		
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:

NAME OF FACILITY:	FROM DATE: (Mo/Day/Year)	TO DATE: (Mo/Day/Year)		
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:

NAME OF FACILITY:	FROM DATE: (Mo/Day/Year)	TO DATE: (Mo/Day/Year)		
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:

NAME OF FACILITY:	FROM DATE: (Mo/Day/Year	TO DATE: (Mo/Day/Year)		
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:

NAME OF FACILITY:	FROM DATE: (Mo/Day/Year)	TO DATE: (Mo/Day/Year)		
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:
NAME OF REFERENCE:	STREET ADDRESS:	CITY:	STATE/CNTRY:	ZIP CODE:

PROPOSED PRACTICE PLANS IN MINNESOTA (IF ANY)

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE
AMERICAN ACADEMY OF FAMILY PHYSICIANS	7-1-00	Present

Are you currently* certified by a specialty board of the (check one):

- ☐ American Board of Medical Specialties
- ☐ American Osteopathic Association Bureau of Professional Education
- ☐ Royal College of Physicians and Surgeons of Canada
- ☐ College of Family Physicians of Canada
- ☑ None of the above

Specialty: ____________

Issue Date: ____________

Expiration Date: ____________

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

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CIRCLE "Y" FOR YES OR "N" FOR NO. ATTACH ADDITIONAL SHEETS TO PROVIDE SUFFICIENT DETAIL. FOR QUESTIONS 1 THROUGH 2 BELOW, 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. NOTE: IF YOU ARE CURRENTLY PARTICIPATING IN HEALTH PROFESSIONALS SERVICES PROGRAM (HPSP) FOR A CONDITION COVERED BY QUESTIONS 1-4 OR IF YOU DO NOT HAVE THAT CONDITION, YOU MAY LEAVE THE QUESTION UNANSWERED AS TO THAT CONDITION. IF RESPONSES TO QUESTIONS CHANGE DURING THE TIME YOUR APPLICATION IS PENDING, YOU MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

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.

1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe.

1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.

2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine or surgery with reasonable skill and safety? Please describe.

3. Are you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe.

Y N 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.

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

4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? If you answer this question "yes", please answer the following:

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

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

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

4d. Please explain._____

4e. Identify your treating physician._____

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

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

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

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

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

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

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

12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.

13 . Have there ever been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed.

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

15. Have you ever applied for licensure in Minnesota before? If so, please give license # and issue date or withdrawal/denial date.

16. Have you ever had a residency permit in Minnesota? If so, please give residency permit number. (Residents are required to have residency permits as of 1993 unless licensed in Minnesota) 14999

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CERTIFICATE OF ETHICAL AND MORAL CHARACTER

THIS CERTIFICATE MUST BE SIGNED BY TWO LICENSED PHYSICIANS WHO ARE PERSONALLY ACQUAINTED WITH THE APPLICANT.

I certify that the photograph attached is a recent one and likeness of Dr. Kara Pacala

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
P. Adam MD	8/31/01	36941	MN

PATRICIA ADAM MD.
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification by Notary Public is required.

State: MINNESOTA County: HENNEPIN

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 AUGUST, 2001.

Notary Public Signature Cheryl Charlynda Gumms

Expiration Date 1 / 31 / 05
Month Day Year

partly upon the applicant's signature.

CHERYL CHARLYNDA GUMMS
NOTARY PUBLIC - MINNESOTA
My Commission Expires Jan. 31, 2005

Applicant's Signature

I certify that the photograph attached is a recent one and likeness of Dr. Kara Pacala

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

SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE
Timothy Ramer	8/31/01	34662	MN

Timothy Ramer
PRINT OR TYPE FULL NAME

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AFFIDAVIT OF APPLICANT:

STATE OF: MINNESOTA

COUNTY OF: HENNEPIN

I, KARA KORACH PACALA, swear 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 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.

Sworn to before me this 28th day of Aug., 2001

CHERYL CHARLYNDA GUNNING
NOTARY PUBLIC-MINNESOTA
My Commission Expires Jan. 31, 2005

Cheryl Charlynda Gunning
Signature of Notary Public

My Commission Expires: 1/31/05

Kara K. Pacala
Signature of Applicant

RIGHTS OF SUBJECTS OF DATA

This information 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, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

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

USMLE United States Medical Licensing Examination™

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 08/22/2001

Minnesota Board of Medical Practice
ATTN: Robert A Leach, JD, Exec Director
University Park Plaza
2829 University Ave SE, Suite 400
Minneapolis, MN 554143246

Examinee: Pacala, Kara Korach
USMLE ID#: 5-039-783-5
DOB: [redacted]67
Alt Name(s): Korach, Kara Bernace

Results for all 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. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	6/9/1998	PASS	195	(179)	80	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
	1/26/2000	PASS	202	(170)	82	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	Three-Digit (Passing)	Two-Digit Score	Two-Digit (Passing)	Comments
MINNESOTA	2/19/2001	PASS	198	(177)	81	(75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

SHS 3:02:01 7515290

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination scores is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES

USMLE transcripts include a complete score history and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first-time examinees from medical schools in the United States was 200 and 20, respectively. Most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 75 on the two-digit scale is the recommended minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 8 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

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

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

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

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

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

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

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

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

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MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza 2829 University Avenue SE Suite 400 Minneapolis, MN 55414-3246
**Telephone (612) 617-2130 *Fax (612) 617-2166*
MN Relay Service for Hearing Impaired (800) 627-3529

AUG2001 RECEIVED BY MN BD OF MED. PRACTICE

CERTIFICATION OF MEDICAL EDUCATION

REC'D JUL 3 0 2001

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 KARA PACALA SS# [redacted]

Signature Kara Pacala Date 7/25/01

Date of Degree 5-13-00 Degree Received MD

****

THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT:(Name of Physician) Kara Pacala

MATRICULATED IN: (Name of School) University of Minnesota

AT:(Location of School) Minneapolis

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

ON:(Month, Day, Year) May 13, 2000

ANY DISCIPLINARY ACTION? Yes*_____ No x

ANY DEROGATORY INFORMATION ON FILE? Yes*_____ No x

School Seal**

President, Secretary, Dean, Registrar:

Print Name Helene M. Horwitz, Ph.D.
Associate Dean Student Affairs

Signature Helene M. Horwitz

Date July 30, 2001

Phone 612-624-8101

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

11/96

44241

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza 2829 University Avenue SE Suite 400 Minneapolis, MN 55414-3246
**Telephone (612) 617-2130 *Fax (612) 617-2166*
MN Relay Service for Hearing Impaired (800) 627-3529

CERTIFICATION OF MEDICAL TRAINING

This form is for certification of all US/Canadian post graduate medical training (i.e. internship, residency and fellowship) and must be completed and mailed directly by the facility 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 KARA PACALA SS# [redacted]

Signature Kara Pacala Date 10/22/01

Training Dates (Month,Day,Year)TO(Month,Day,Year) 10/22/00 – 10/22/01 Birthdate [redacted]67

****

THE HOSPITAL OR INSTITUTION COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT:(Name of Physician) Kara Pacala

SERVED # OF YEARS IN POST GRADUATE TRAINING:(Number of Years) 1

AT:(Name of Hospital or Institution) University of Minnesota/Fairview-University Medical Center Family Practice Residency Program

LOCATED AT:(Address) 2615 E. Franklin Ave Minneapolis MN 55401

FROM:(Month, Day, Year) 10-22-00 – 10-22-01 **TO:**(Month, Day, Year) 10-22-01

ANY DISCIPLINARY ACTION? Yes* [redacted] No [redacted]

ANY DEROGATORY INFORMATION ON FILE? Yes* [redacted] No [redacted]

WAS/WAS NOT (CIRCLE ONE) **ISSUED A CERTIFICATE AS PROOF OF COMPLETION OF SAID TRAINING.** (If not issued certificate, please explain)
still in training

THE TRAINING PROGRAM WAS/WAS NOT (CIRCLE ONE) **COMPLETED. IF TRAINING PROGRAM WAS NOT COMPLETED, UNDER WHAT CIRCUMSTANCES DID THE PHYSICIAN LEAVE?**
still in training

THIS PHYSICIAN WAS PLACED IN A RESIDENCY SLOT IN AN ACCREDITED TRAINING PROGRAM TO PROVIDE GRADUATE, CLINICAL MEDICAL TRAINING DURING THE DATES OUTLINED ABOVE. (CHECK ONE)

- [X] **Accreditation Council of Graduate Medical Education (ACGME)**
- [ ] **American Osteopathic Association (AOA)**
- [ ] **Royal College of Physicians and Surgeons**
- [ ] **College of Family Physicians of Canada**
- [ ] **None of the above** (EXPLAIN) _____

Print Name Ken Kephart MD

Signature Ken Kephart

Title Program Director

SEAL**

Date 10/22/01 Phone 612-333-0774

*Please attach letter of explanation.

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

4/99

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

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.*

New Search

Professional Profile: Kara Korach Pacala

License: Physician and Surgeon - #44241

Print

Licensee Public Information

Licensure Designated Address: 4455 Dupont Ave. S.
Minneapolis, MN 55419

Web Site:

E-mail: pacal002@umn.edu

Birth Year: 1967

Gender: Female

License Information

License Number:	44241	**License Type:**	Physician and Surgeon
Expiration Date:	09/30/2021	**Grant Date:**	11/10/2001
License Status:	Active		
Disciplinary Action:	No		
Corrective Action:	No		

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

Public - Other: No

Education

Medical School:	UNIVERSITY OF MINNESOTA MEDICAL SCHOOL MINNEAPOLIS USA	**Degree:**	M.D.
Location:	Minneapolis, MN USA	**Date:**	05/13/2000

Practice Locations (Self-Reported Information)

Primary Location: SMILEY'S CLINIC
2020 28th Street E.
MINNEAPOLIS, MN 55407
Phone: 612-333-0770

Secondary Location: FAIRVIEW UNIVERSITY MED CTR
2450 RIVERSIDE AVE
MINNEAPOLIS, MN 55454
Phone: 612-333-0770

Post-Graduate Training (Self-Reported Information, Not Verified by Board of Medical Practice)

Program	Specialty	Start Date	End Date	Completed
Fairview-University Family Medicine Residency Program	Family Medicine	10/23/2000	01/22/2004	Yes

Area of Specialty (Certified by American Board of Medical Specialties or American Osteopathic Specialty Boards; Refer to the Note at the End of this Page)

Source	Board	Certification / Sub-Certification
ABMS	Family Medicine	Family Medicine

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 12/4/2020 11:55:12 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.

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Kara Pacala	Start Date:	9/4/2020 7:38:48 AM
Service Name:	License Renewal - PY	Complete Date:	9/4/2020 7:46:15 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	9/4/2020 7:38:51 AM	• Please read notice and then answer.
1	Information	9/4/2020 7:38:56 AM	
2	Verify Information	9/4/2020 7:39:02 AM	
3	Privileges & Continuing Medical Education	9/4/2020 7:39:05 AM	
4	Practice Questions	9/4/2020 7:39:55 AM	
5	Profiling - Practice Addresses	9/4/2020 7:40:05 AM	PracticeAddress
5	Profiling - Post Graduate Training	9/4/2020 7:40:11 AM	Bypass Case
5	Profiling - Post Graduate Training	9/4/2020 7:40:11 AM	
5	Profiling - ABMS/AOA	9/4/2020 7:40:19 AM	
5	Profiling - ABMS/AOA	9/4/2020 7:40:19 AM	
5	Profiling - Criminal Convictions	9/4/2020 7:40:23 AM	
6	Review	9/4/2020 7:40:34 AM	
7	Prescription Monitoring Program Registration	9/4/2020 7:41:08 AM	
9	Payment	9/4/2020 7:44:55 AM	

1

Verification Page

The following is a copy of the verification page that was presented to the user upon completion of the Online Service

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Use your browser's Print command to print this summary for your records.

Application for License Renewal

License Number: PY 44241
Name: Kara Korach Pacala

Drivers License: MN - V-572-298-316-514
Is license current? Yes

Designated Address: 4455 Dupont Ave. S. Minneapolis, MN 55419
Phone: (612) 825-4634
Email Address: pacal002@umn.edu
Web Site:

Private Address: [redacted]

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Fairview University Medical Center	Minneapolis	MN	Staff

Continuing Education

Pursuant to Governor Tim Walz' Emergency Executive Order 20-23, the Board of Medical Practice will defer completion and reporting of continuing education requirements for regulated professionals until the end of the first full continuing education reporting cycle following termination of the Peacetime Emergency declared by Emergency Executive Order 20-01. At that time, the cumulative number of required continuing education hours for both reporting cycles will be due.

Practice Questions

Please answer all questions by selecting "Yes" or "No" and provide an explanation when requested. Questions 3-4 do not have "No" as an option for confidentiality reasons. **If you have a condition addressed by questions 3-4 and you are NOT participating in the Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable questions(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s).** For question 4, the term "impaired" includes but is not limited to impairments or 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 renewal application is pending, and public after your renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling.

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

2. Since your last renewal, have you been diagnosed with/or treated for any substance use disorder that may affect your ability to practice with reasonable ski and safety and you have not reported the condition or illness to HPSP?
Response: [redacted]

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

4. Since your last renewal, have you 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 with reasonable skill and safety?
Response: [redacted]

5. Since your last renewal, have you been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders?
Response: [redacted]

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

7. Since your last renewal, have you been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditionec license been issued to you by any state medical board or licensing authority?
Response: [redacted]

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

9. Since your last renewal, have you been notified of any investigations by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board?
Response: [redacted]

10. Since your last renewal, have your hospital privileges been restricted or revoked?
Response: [redacted]

11. Since your last renewal, have there been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domesti 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 or state district court judges. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Response: [redacted]

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

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

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

Profile - Practice Addresses

Primary: SMILEY'S CLINIC
2020 28th Street E.
MINNEAPOLIS, MN 55407
Phone: (612) 333-0770

Secondary: FAIRVIEW UNIVERSITY MED CTR
2450 RIVERSIDE AVE
MINNEAPOLIS, MN 55454
Phone: (612) 333-0770

Military Status: No

Profile - Education-Post Graduate

Program	Specialty	Start Date	End Date	Completed
Fairview-University Family Medicine Residency Program	Family Medicine	10/23/2000	01/22/2004	Yes

Profile - ABMS/AOA Specialty Certification

Source	Board/Certificate	Sub Certificate	Verify
ABMS	Family Medicine/Family Medicine		

Profile - Criminal Convictions [redacted]

Certification by Licensee

*Indicates required field

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

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

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

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

< Previous Submit

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Kara Pacala	Start Date:	9/10/2019 8:31:40 PM
Service Name:	License Renewal - PY	Complete Date:	9/10/2019 8:35:05 PM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	9/10/2019 8:31:45 PM	• Please read notice and then answer.
1	Information	9/10/2019 8:31:49 PM	
2	Verify Information	9/10/2019 8:31:55 PM	
3	Privileges & Continuing Medical Education	9/10/2019 8:31:58 PM	
4	Practice Questions	9/10/2019 8:32:46 PM	
5	Profiling - Practice Addresses	9/10/2019 8:32:58 PM	PracticeAddress
5	Profiling - Post Graduate Training	9/10/2019 8:33:02 PM	Bypass Case
5	Profiling - Post Graduate Training	9/10/2019 8:33:02 PM	
5	Profiling - ABMS/AOA	9/10/2019 8:33:07 PM	
5	Profiling - ABMS/AOA	9/10/2019 8:33:07 PM	
5	Profiling - Criminal Convictions	9/10/2019 8:33:12 PM	
6	Review	9/10/2019 8:33:21 PM	
7	Prescription Monitoring Program Registration	9/10/2019 8:33:26 PM	
9	Payment	9/10/2019 8:33:34 PM	

1

Verification Page

The following is a copy of the verification page that was presented to the user upon completion of the Online Service

The information you have submitted in the previous steps is provided below.

If any information is incomplete or incorrect, return to the appropriate step to make additions or corrections by clicking the Previous button located at the end of this section. Note: Do not use the Back button on your browser.

Use your browser's Print command to print this summary for your records.

Application for License Renewal

License Number: PY 44241
Name: Kara Korach Pacala

Drivers License: MN - V-572-298-316-514
Is license current? Yes

Designated Address: 4455 Dupont Ave. S.
Minneapolis, MN 55419

Phone: (612) 825-4634
Email Address: pacal002@umn.edu
Web Site:

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Fairview University Medical Center	Minneapolis	MN	Staff

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 09/30/2020.

Practice 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 are currently participating in Health Professionals Services Program (HPSP) for a condition covered by questions 1-4 or if you do not have that condition, leave the question unanswered as to that condition.** 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 renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling.

1. Since your last renewal, has your cognitive, communicative, or physical ability to engage in the practice of medicine or surgery with reasonable skill and safety been impaired or limited in any way?
Response: [redacted]

2. Since your last renewal, has your use of alcohol or chemical substance(s), including prescription medications, in any way impaired or limited your ability to practice with reasonable skill and safety?
Response: [redacted]

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

4. Since your last renewal, have you 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 with reasonable skill and safety?
Response: [redacted]

5. Since your last renewal, have you been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders?
Response: [redacted]

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

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

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

9. Since your last renewal, have you been notified of any investigations by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board?
Response: [redacted]

10. Since your last renewal, have your hospital privileges been restricted or revoked?
Response: [redacted]

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

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

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

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

Profile - Practice Addresses

Primary: SMILEY'S CLINIC
2020 28th Street E.
MINNEAPOLIS, MN 55407
Phone: (612) 333-0770

Secondary: FAIRVIEW UNIVERSITY MED CTR
2450 RIVERSIDE AVE
MINNEAPOLIS, MN 55454
Phone: (612) 333-0770

Military Status: No

Profile - Education-Post Graduate

Program	Specialty	Start Date	End Dale	Completed
Fairview-University Family Medicine Residency Program	Family Medicine	10/23/2000	01/22/2004	Y

Profile - ABMS/AOA Specialty Certification

Source	Board/Certificate	Sub Certificate	Verify
ABMS	Family Medicine/Family Medicine		

Profile - Criminal Convictions

[redacted]

Certification by Licensee

*Indicates required field

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

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

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< Previous Submit

Minnesota Health Licensing Boards

Minnesota Board of Medical Practice

Minnesota.gov

User Admin Search and maintain all registered users

Online Service History Detail

(Use Back button to return to summary page)

User Name:	Kara Pacala	Start Date:	8/30/2018 8:16:05 AM
Service Name:	License Renewal - PY	Complete Date:	8/30/2018 8:25:38 AM

Step #	Step Title	Step Submitted	Reported Errors
1	Information	8/30/2018 8:16:16 AM	
2	Verify Information	8/30/2018 8:16:28 AM	
3	Privileges & Continuing Medical Education	8/30/2018 8:16:48 AM	
4	Practice Questions	8/30/2018 8:17:42 AM	
5	Profiling - Practice Addresses	8/30/2018 8:18:02 AM	PracticeAddress
5	Profiling - Post Graduate Training	8/30/2018 8:18:08 AM	Bypass Case
5	Profiling - Post Graduate Training	8/30/2018 8:18:08 AM	
5	Profiling - ABMS/AOA	8/30/2018 8:18:20 AM	
5	Profiling - ABMS/AOA	8/30/2018 8:18:20 AM	
5	Profiling - Criminal Convictions	8/30/2018 8:18:27 AM	
6	Review	8/30/2018 8:18:45 AM	
7	Prescription Monitoring Program Registration	8/30/2018 8:18:59 AM	
9	Payment	8/30/2018 8:24:25 AM	

Verification Page

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Use your browser's Print command to print this summary for your records.

Application for License Renewal

License Number: PY 44241
Name: Kara Korach Pacala

Drivers License: MN - V-572-298-316-514
Is license current? Yes

Designated Address: 4455 Dupont Ave. S.
Minneapolis, MN 55419

Phone: (612) 825-4634
Email Address: pacal002@umn.edu
Web Site:

Private Address: (Same as mailing address)

Hospital Staff Privileges

Facility	City	State	Type of Privilege
Fairview University Medical Center	Minneapolis	MN	Staff

Continuing Education

You are not required to report Continuing Medical Education hours this renewal period. You will be required to report CE hours the next renewal period ending 09/30/2020.

Practice 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 are currently participating in Health Professionals Services Program (HPSP) for a condition covered by questions 1-4 or if you do not have that condition, leave the question unanswered as to that condition.** 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.

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1. Since your last renewal, has your cognitive, communicative, or physical ability to engage in the practice of medicine or surgery with reasonable skill and safety been impaired or limited in any way?

Response: [redacted]

2. Since your last renewal, has your use of alcohol or chemical substance(s), including prescription medications, in any way impaired or limited your ability to practice with reasonable skill and safety?
Response: [redacted]

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

4. Since your last renewal, have you 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 with reasonable skill and safety?
Response: [redacted]

5. Since your last renewal, have you been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders?
Response: [redacted]

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

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

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

9. Since your last renewal, have you been notified of any investigations by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board?
Response: [redacted]

10. Since your last renewal, have your hospital privileges been restricted or revoked?
Response: [redacted]

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

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

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

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Response: [redacted]

Profile - Practice Addresses

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2020 28th Street E.
MINNEAPOLIS, MN 55407
Phone: (612) 333-0770

Secondary: FAIRVIEW UNIVERSITY MED CTR
2450 RIVERSIDE AVE
MINNEAPOLIS, MN 55454
Phone: (612) 333-0770

Military Status: No

Profile - Education-Post Graduate

Program	Specialty	Start Date	End Date	Completed
Fairview-University Family Medicine Residency Program	Family Medicine	10/23/2000	01/22/2004	Y

Profile - ABMS/AOA Specialty Certification

Source	Board/Certificate	Sub Certificate	Verify
ABMS	Family Medicine/Family Medicine		

Profile - Criminal Convictions

[redacted]

Certification by Licensee

*Indicates required field

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

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< Previous Submit