Physician and Surgeon Application Summary

Boraas, Christy Marie
300 Halket Street
Pittsburgh, PA 15213

Application #: 108627
Application Rec'd: 05/19/2014
Board Date: 09/13/2014
Basis: USMLE
Legal:

PY DOM

Deposit # : H7B-14426
Amt Paid : 431.20

Deposit # : H7B-14447
Amt Paid : 60.00

Birthdate [redacted]/1978
Birthplace: Willmar, MN USA

Interviewer: _____
Interview Date: _____

58304

Received:	Completed:	
		Exam
06/18/2014	05/28/2014	USMLE1 229 06/15/2006;USMLE2 217 01/29/2008;USMLE3 211 04/13/2010;
		Competency
		Medical School
06/18/2014	05/30/2014	U OF MINNESOTA Minneapolis MN USA - M.D. 05/03/2008
06/18/2014		Diploma
		Medical Training
06/18/2014	06/05/2014	U of Pittsburgh 07/01/2012-07/11/2014 Pittsburgh PA Family Planning non-accredited fellowship - maternity leave break
06/18/2014	06/02/2014	OH State U 07/01/2008-06/30/2012 Columbus OH OB & GY- Obstetrics & Gynecology DARP PG 490, 2008/09
06/18/2014		Certificate
		Licenses
07/01/2014	06/25/2014	OH, USA 06/29/2012
06/09/2014	05/30/2014	PA, USA 12/31/2014
		Hospital Privileges
05/27/2014	05/27/2014	Magee-Womens Hospital
		Recommendations
05/19/2014	05/13/2014	Catherine Chappen
05/19/2014	05/14/2014	Beatrice Chen

Databank Searches

05/20/2014	05/20/2014	AMA
05/20/2014	05/20/2014	Federation
05/27/2014	05/16/2014	the DataBank - NPDB
		HIPDB No longer required, Sep 2013

Miscellaneous

05/19/2014	05/13/2014	Accounting of time
05/19/2014	05/13/2014	Photo
05/19/2014	05/13/2014	Release
06/02/2014	05/28/2014	Malpractice history report UA - needs to be completed
05/19/2014	05/13/2014	Facilities list
		Military papers Branch -
05/19/2014	05/13/2014	Criminal Conviction Check Click Profile to update, if any
05/19/2014		Driver's License
06/18/2014		Marriage certificate

Temporary Permits / Registrations

TP/TR	Number	From:	To:	Approved By:	Date:
TP	107714	7/3/14	9/13/14	[signature]	7-3-14

Minnesota Board of Medical Practice
Addendum to Application
Instructions

431.20

MAY 19 2014
MN BOARD OF MEDICAL PRACTICE

For Board Use Only	
Application #:	108627
Check/Receipt #:	
Amount Paid:	
Temp Permit #:	
Board Action:	
Board Date:	9-13-2014
License #:	58304

Account Code	Amount
635009 lic	192
635010 app	200
635012 tp	
	39.20

Basis for Application (Check One):

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

14426-26

Addendum Instructions. Complete the addendums as instructed below. Return the completed addendums along with this cover page to the Minnesota Board. The Minnesota Board of Medical Practice application fee of $392 plus the e-licensing surcharge of $39.20 ($431.20 total) must be submitted with the Minnesota Addendum to Application.

CB **Addendum 1, Addendum to Application.** Each section must be completed by the applicant. Please either type or print your responses.

CB **Addendum 1a, Questions 1 - 10.** These questions must be completed by the applicant. Please either type or print your responses. If additional space is necessary please attach a separate sheet referencing the question number to which you are responding to.

CB **Addendum 2, Questions 1 – 14.** These questions must be completed by the applicant. Please either type or print your responses. If the answer to any question is "yes", please explain in detail on a separate sheet. Additional documents may be required.

CB **Addendum 3, Facilities List.** Please list all facilities where you have had medical privileges during the last 10 years. List any facility where you are getting (have been) paid outside of a post graduate training program. Sign and date the form, even if not applicable.

n/a **Addendum 3a, Hospital Privileges Verification Form.** This form must be completed by each hospital listed on the Facilities List, Addendum 3, and mailed directly by each facility to the Minnesota Board. Any processing fees are the applicant's responsibility.

CC/BC **Addendum 4, Certificate of Ethical and Moral Character.** This form must be signed by two (2) physicians who are personally acquainted with the applicant. A full face, recent, 2 x 3" photograph must be affixed as indicated on the form and ***notarized***. The notary stamp (seal) must fall partly upon the photograph and partly upon the form.

CC/BC **Addendum 5, Physician Recommendation Form.** This form must be completed and mailed directly to the Minnesota Board by two US or Canadian physicians with whom the applicant has worked during the last five (5) years and has known the applicant for more than one (1) year.

n/a **Addendum 6, Verification of Board Specialty.** This form is for verification of specialty board certification for applicants who have not taken a licensing exam for 10 years. Applicants are required to take and pass the SPEX exam if it has been more than 10 years since taking a licensing exam unless the applicant is specialty certified. This form must be mailed directly to the Minnesota Board by the specialty board. Any fees are the applicant's responsibility.

n/a **Addendum 7, Temporary Permit.** If applying for temporary permit complete this form and return to the Minnesota Board with a non-refundable fee of $60 in U.S. currency. Make checks payable to the Minnesota Board of Medical Practice.

n/a **Addendum 8, Treating Physician Statement.** Applicants who have had certain medical conditions within the last five (5) years must have their treating physician complete this form and return directly to the Minnesota Board.

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Addendum 1

1. Business Address

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide their primary business address at the time of initial application and all subsequent renewals. Your primary business address is public and you are required to submit it for application purposes. Your license will not be issued without it unless you check the box below certifying that you are not currently in the workforce related to your practice.

Facility name Magee-Womens Hospital

Street Address 300 Halket Street

City Pittsburgh State PA Zip 15213

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

---

2. Military Status

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

X No ___Yes. If discharged, please provide discharge date: _____

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3. Criminal Convictions

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has be conviction of a felony or gross misdemeanor occurring on or after July 1, 2013 in any state or jurisdiction. This information shall be posted for new licensees issued a license on or after July 1, 2013 and for current licensees upon license renewal occurring on or after July 1, 2013. This information is public and you are required to submit it for application purposes. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.

If you have more than one item to report please attach additional sheets.

Conviction Date (mm/dd/yyyy): _____
Conviction Type (Check one): O Felony O Gross misdemeanor
Crime Description: _____
City: _____ State: _____ County: _____ Country: _____
Sentence: _____
_____

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

Uniform Application for Physician Licensure

UA Username cboraas **Date Submitted** 5/14/2014
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Boraas
First Name Christy
Middle Name Marie
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix
Christy	Marie	Boraas Alsleben	

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business
[X] **Public Access**
[ ] **Mailing**

Street 300 Halket Street
City Pittsburgh **State/Province** PA **Zip Code** 15213
Country USA
Telephone 412-641-1103
Fax 412-641-1133
Email boraascm@upmc.edu
Alternate Phone 412-270-1063

Home
[ ] **Public Access**
[X] **Mailing**

Street [redacted]
City Pittsburgh **State/Province** PA **Zip Code** 15218
Country USA
Telephone [redacted]
Fax
Email
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

[redacted]1978	Willmar	Minnesota	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	[redacted]	1750544581		
Gender	Social Security Number	NPI	Are you a U.S. Citizen?	[X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1

School Name University of Minnesota Medical School - Minneapolis
Address Box 293
420 Delaware Street, South East

City Minneapolis
State/Province MN
ZIP Code 55455
Country USA
Attendance Dates From (mm/yyyy) 08/2004 To (mm/yyyy) 05/2008
Graduation Date 5/3/2008
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1 **Hospital Name** The Ohio State University
Hospital Address 395 W 12th Avenue

City Columbus
State/Province Ohio
ZIP Code 43210
Country USA

PGY: (e.g., 1, 2, 3, etc.) [ ] **Internship** [X] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Obstetrics and Gynecology

From: 07 /2008 **To:** 06 /2012 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]

Month Year Month Year

2 **Hospital Name** University of Pittsburgh
Hospital Address 300 Halket Street

City Pittsburgh
State/Province Pennsylvania
ZIP Code 15213
Country USA

PGY: (e.g., 1, 2, 3, etc.) [ ] **Internship** [ ] **Residency** [X] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Family Planning

From: 07 /2012 **To:** 06 /2014 **Successfully Completed?** [ ] **Yes** [ ] **No** **In Progress** [X]

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/2006	[X] P	[ ] F	1
USMLE Step 2		01/2008	[X] P	[ ] F	1
USMLE Step2 CS		11/2007	[X] P	[ ] F	1
USMLE Step 3		04/2010	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	State/Province	PA	Practitioner Type (MD, DO, etc.)	MD	Type of License (Full, Temporary, etc.)	Full License	
	License Number	MD445822	Status	Active	Issue Date	5/1/2012	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2008 To: Month: 06 Year: 2012 In Progress ☐	**Practice/Employment Name** The Ohio State University Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 395 W. 12th Street **City** Columbus **State/Province** Ohio **ZIP Code** 43210 **Country** USA **Position and Department** Resident Physician-Obstetrics and Gynecology **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other** Residency in Obstetrics and Gyı
2 From: Month: 07 Year: 2012 To: Month: Year: In Progress ☒	**Practice/Employment Name** Univeristy of Pittsburgh School of Medicine, Magee-Womens Hospital (or list non-working time as indicated above) **Practice/Employment Address** Fellowship in Family Planning 300 Halket Street **City** Pittsburgh **State/Province** Pennsylvania **ZIP Code** 15213 **Country** USA **Position and Department** Clinical Instructor and Fellow-Obstetrics, Gynecology and Reproductive Sciences **Percent Clinical:** 80% **Percent Administrative:** 20% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other** Fellowship in Family Planning

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Addendum 1a

1. Alien Registration Number (if applicable): Number [redacted]

2. Driver's License: State PA Number [redacted]
*Submit a copy of your driver's license notarized as a true likeness to the Board. The copy must be legible with a clear photo.

3. Identifying Characteristics (If using FCVS, you do not need to complete this question):
Height (ft/in.) 5/6 Weight (lbs) 145 Hair Color brown Eye Color blue
Identifying marks _____

4. Your intended address (if known):
[redacted]
City MN State/Province 55416 Zip USA Country
[redacted] Phone July 1, 2014 Effective Date
Proposed practice plans in Minnesota (if any): _____

5. Preliminary Education:
Lac qui Parle Valley High School Madison MN
Name of High School City State/Province
9/1/1990 - 6/1/1997
From Date (Mo/Day/Year) To Date

St. Olaf College Northfield MN
Name of College City State/Province
9/2/1997 - 5/3/2001 Bachelor of Arts in Biology & English
From Date (Mo/Day/Year) To Date Degree

Name of College City State/Province
___/___/_____ - ___/___/_____ _____
From Date (Mo/Day/Year) To Date Degree

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

Branch of Service Entry Date (Mo/Day/Year) Release Date (Mo/Day/Year)

Rank at Discharge Type of Discharge

7. Activities between high school and medical school (attach a separate sheet if necessary).

Activity	From Date (Mo/Day/Year)	To Date (Mo/Day/Year)
Research Assistant, University of Minnesota	8/1/2001	9/1/2002
Master's of public Health, University of Minnesota	9/2/2002	5/15/2004

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

Country	License Number	Date Issued (Mo/Day/Year)

9. Are you currently* certified by a specialty board of the (check one):
   - ☐ American Board of Medical Specialties
   - ☐ Royal College of Physicians and Surgeons of Canada
   - ☐ College of Family Physician of Canada
   - ☐ American Osteopathic Assn Bureau of Professional Education
   - ☐ None of the above

   Specialty _____
   Issue Date _____
   Expiration Date _____

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

10. Membership in professional societies and organizations

Name of Organization	From Date	To Date
American Congress of Obstetricians & Gynecologists	2008	present
Society of Family Planning	2012	present

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Addendum 2

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable question(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse.

The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after you renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is necessary please attach a separate sheet.

[redacted] 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.

[redacted] 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.

[redacted] 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.

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

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

[redacted] 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.

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[redacted] 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.

[redacted]. 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:

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

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

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

4d. Please explain _____

4e. Identify your treating physician _____

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

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

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

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

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

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[redacted]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 in the specifics area of the Malpractice Liability Claims Information page within the Uniform Application as well as documentation of outcome (insurance papers or court documents).

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

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

[redacted]13. Have there ever been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemical filed against you? If so, submit a detailed personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, explaining in detail the incident and consequences including whether or not a CD evaluation was done (if so, submit results), and description of current drinking habits.

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

RIGHTS OF SUBJECTS OF DATA

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

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Addendum 3

Facilities List

Minnesota Statute 147.162 requires physicians to submit a list of inpatient and outpatient medical care facilities where you have medical privileges. In addition, the Board requests a list of all facilities where you have had medical privileges during the last 10 years. List any facility where you are getting (have been) paid outside of post graduate internship, residency or fellowship training program. **Submit a Hospital Privilege Form, Addendum 3a, to each facility listed except those clinics which are strictly outpatient.** If you have had no privileges, write **NONE** and sign and date the form.

Current Privileges

Facility	City and State	Type of Privilege

Past Privileges (Last 10 Years)

Facility	City and State	Type of Privilege

NONE

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

Print Name Boraas, Christy M.

Signature _____ Date 5/13/14

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Addendum 4

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. Bovaas

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

Colleen Chappell — Signature
CATHERINE CHAPPELL — Print or type name
5/13/14 — Date
MD442077 — License Number
PA — State of Issue

Certification of Identification

Certification of Notary Public is required.

State Pennsylvania County Allegheny

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 13th day of May, 2014.

The im... seal may be partially upon the photo

Notary Public Signature Leyha M Crawford

Expiration Date: 3/26/15 (Month / Day / Year)

Applicant's Signature [redacted]

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Leyha M. Crawford, Notary Public
O'Hara Twp., Allegheny County
My Commission Expires March 26, 2015
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

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

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

Signature
Beatrice Chen — Print or type name
5/14/14 — Date
MD424836 — License Number
PA — State of Issue

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Send this form to the state board you are applying to. Do not send this to FSMB.

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB.

Doing so will cause a delay with your state board application.

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

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

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

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

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

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

[redacted]

Appli[redacted] signed in the presence of a notary)

Boraas

Applicant's printed last name

Christy M.

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

May 13, 2014

Date of signature (must correspond to date of notarization)

Notary

State of Pennsylvania, County of Allegheny

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

The statements on this document are subscribed and sworn to before me by the applicant on this 13th day of May, 2014.

Notary Public Signature: Leyha M Crawford

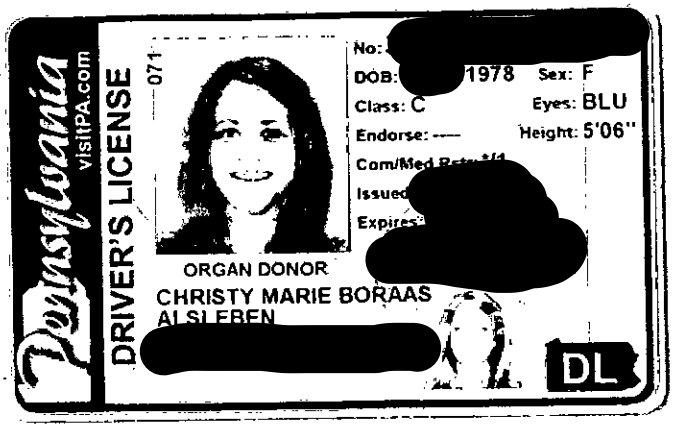
My Notary Commission Expires: 3/26/15

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Leyha M. Crawford, Notary Public
O'Hara Twp., Allegheny County
My Commission Expires March 26, 2015
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

CHRISTY M. BORAAS

[redacted]

May 13, 2014



Leyha M. Crawford

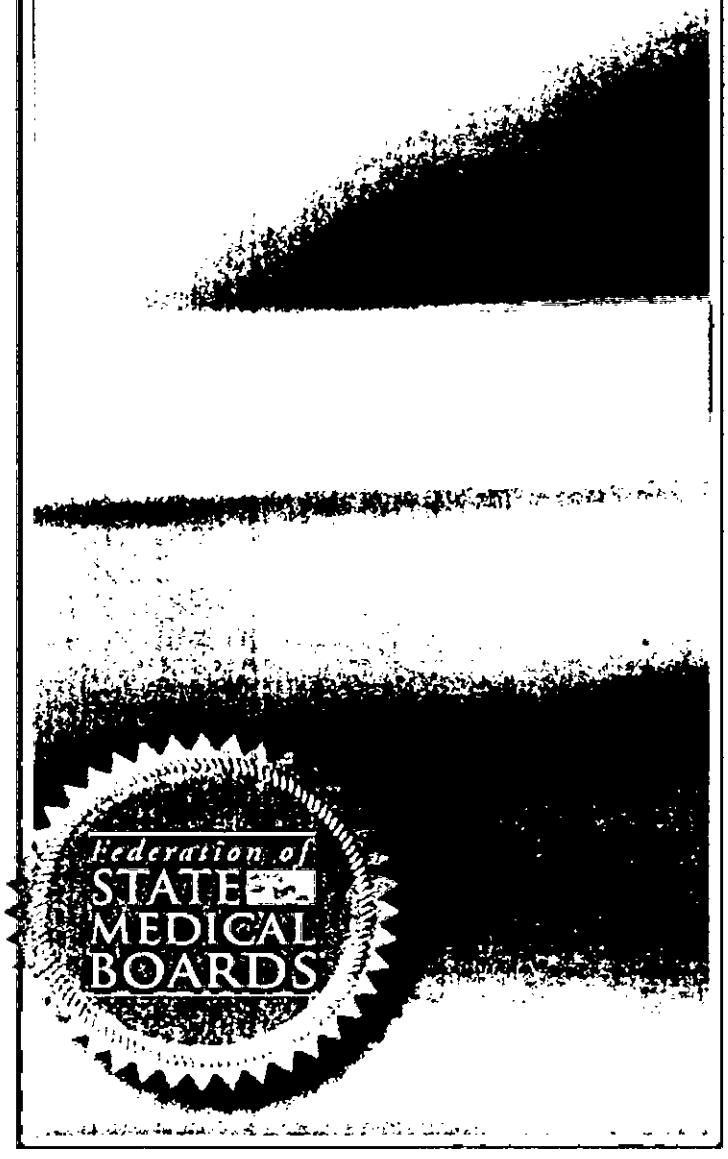
Leyha M Crawford

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Leyha M. Crawford, Notary Public
O'Hara Twp., Allegheny County
My Commission Expires March 26, 2015
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

5/13/14

FCVS

FEDERATION
CREDENTIALS
VERIFICATION
SERVICE



Medical Professional Information Profile

This report provides credentialing information for

Name: **Christy Marie Boraas**

Social Security Number: [redacted]

Date of Birth: [redacted] **1978**

FID#: **215194325**

Recipient: **MN - Minnesota Board of Medical Practice**

ABOUT THIS PROFILE

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

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

This FCVS Medical Professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis Report for further details on the unresolved items

Medical Professional Name: **Christy Marie Boraas**
Date of Birth: **November 27, 1978**
Social Security Number: [redacted]
FID: 215194525

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate OR Copy w/ Cert. of Identification

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

University of Minnesota Medical School - Minneapolis
1. Medical Education Form and Translation
2. Medical Education Transcript and Translation
3. Medical Education Diploma and Translation

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

Ohio State University Hospital
1. GME Form
2. GME Completion Certificate

University of Pittsburgh
X 1. GME Form

VI. Licensure Examination History

A. FSMB Exam Transcript

End of report for: Christy Marie Boraas

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FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Table of Contents

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Section I

FCVS Reports

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FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name: **Christy Marie Boraas**

Documentation: Certified Birth Certificate OR Copy w/ Cert. of Identification

Variation of Name: **Christy Marie Boraas Alsleben**

Documentation: Photocopy of Marriage Certificate and Translation if not in English

Gender: Female

Date of Birth: [redacted] 1978

Place of Birth: Willmar, MN, UNITED STATES

Social Security Number: [redacted]

FID: 215194325

Physical Description: Height: 5 ft. 6 in.

Weight: 145 lbs.

Eye Color: Blue

Hair Color: Brown

Contact Information

Mailing Address: 7210 WHIPPLE ST
PITTSBURGH, PA 15218-2010
UNITED STATES

Permanent Address: 7210 WHIPPLE ST
PITTSBURGH, PA 15218-2010
UNITED STATES

Telephone Numbers: Primary: [redacted]
Secondary:
Fax: N/A
Other: [redacted]

Pre-medical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **St Olaf College**
Address: Northfield, MN 55057-1098
UNITED STATES
Dates of Attendance: 08/--/1997 To 05/--/2001
Degree Conferred/Issued: Bachelor of Arts

(Provided by Applicant. Not verified with the primary source.)

Institution: **University of Pittsburgh**
Address: Pittsburgh, PA 15260
UNITED STATES
Dates of Attendance: 09/--/2000 To 12/--/2000
Degree Conferred/Issued: Applicant did not graduate

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **University of Minnesota Medical School - Minneapolis**
Address: 420 Delaware St SE
Minneapolis, MN 55455
UNITED STATES

Dates of Attendance: 08/09/2004 to 05/03/2008
Date Certificate Issued: 05/03/2008
Degree Conferred/Issued: Doctor of Medicine

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **Ohio State University Hospital**
Address: 395 West 12th Avenue, 5th Floor

Columbus, OH 43210
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/2008 To 06/30/2009
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2 - 3
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/2009 To 06/30/2011
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 4
Program Type: Chief Resident
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/2011 To 06/30/2012
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Institution:	**University of Pittsburgh**
Address:	300 Halket Street
	Pittsburgh, PA 15213
	UNITED STATES
Training Level:	5 - 6
Program Type:	Fellowship
Specialty:	Family Planning
Dates of Attendance:	07/01/2012 To 07/11/2014
Completed Successfully:	In Progress
Accreditation:	None of these

Unusual Circumstances

Leave of Absence/Extension:	**Yes**
Dates:	**Not Reported by Primary Source**
Comments:	**Maternity leave**
Probation:	**No**
Disciplined:	**No**
Negative Reports:	**No**
Limitations:	**No**

Licensure Examinations

FSMB Transcript USMLE Step 1	Date: 06/2006	Passed the Exam
FSMB Transcript USMLE Step 2 CS	Date: 11/2007	Passed the Exam
FSMB Transcript USMLE Step 2 CK	Date: 01/2008	Passed the Exam
FSMB Transcript USMLE Step 3	Date: 04/2010	Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

A report of the results from a search of the Board Action Data Bank is enclosed.

End of report for: Christy Marie Boraas FID: 215194325

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, Post Graduate Training program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Medical Professional Identification

Medical Professional Name:	**Christy Marie Boraas**
Date of Birth:	[redacted]978
Social Security Number:	[redacted]
FID:	**215194325**

Omissions

There are no omissions identified.

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Discrepancies

Discrepancy 1:

Section of Profile: **Post Graduate Training**

Discrepancy: **FCVS has identified discrepant information relating to the applicant provided responses and the Post Graduate Training Form from University of Pittsburgh, Family Planning in the Unusual Circumstance questions listed below.**

Leave of Absence/Extension

Action Taken: **FCVS does not follow up with the applicant or the institution with inconsistent information on Unusual Circumstances questions. Any supporting information provided by the applicant and/or institution is included in the Medical Professional Information Profile.**

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Christy Marie Boraas

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Christy Marie Boraas**
Date of Birth: **November 27, 1978**
Social Security Number: **XXX-XX-6044**
FID#: **215194325**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
08/2004	05/2008	Medical Education Record	University of Minnesota Medical School - Minneapolis,420 Delaware St SE Minneapolis, MN 55455 UNITED STATES		
07/2008	06/2012	GME Record	Ohio State University Hospital,395 West 12th Avenue, 5th Floor Columbus, OH 43210 UNITED STATES		
07/2012	06/2014	GME Record	University of Pittsburgh,300 Halket Street Pittsburgh, PA 15213 UNITED STATES		

End of report for: Christy Marie Boraas

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Section II

FSMB and Other Reports

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FPDC | FEDERATION PHYSICIAN DATA CENTER

Board Action Clearance Report

June 16, 2014

Attn:

Re: Board Action Query Dated: June 16, 2014
FSMB Batch Number: BQ2453106

The following is a report of the search results from the Board Action Data Bank as of June 16, 2014 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of June 16, 2014

Name	DOB	School	Yr/Grad	Provider ID
Christy Marie Boraas	[redacted]978	024030	2008	232601

License History

Licensing Entity
PENNSYLVANIA

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes

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Section III

Identity

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

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

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

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

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

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

[redacted] (Applicant's signature must be made in the presence of a notary)

Boraas

Applicant's Printed Last Name

Alsleben Christy, M

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

May 2, 2014

Date of Signature (must correspond to date of notarization)

State of Pennsylvania, County of Allegheny

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 2nd day of May, 2014.

Notary Public Signature: Leyha M Crawford

My Notary Commission Expires: 3/26/15

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Leyha M. Crawford, Notary Public
O'Hara Twp., Allegheny County
My Commission Expires March 26, 2015
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

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

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

232601 215194325

RECEIVED
MAY 05 2014
By

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Boraas Alsleben (Last) Christy (First) Marie (Middle)

FCVS ID Number: 232601

Notary – Please complete the section below:

State of Pennsylvania County of Allegheny

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

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 2, of (Month) May, (Year) 2014.

Notary Public Signature: Leyha M Crawford

Commission Expiration Date* (Month) 5 /(Day) 2 /(Year) 2014

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

Notary Stamp Here

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Leyha M. Crawford, Notary Public
O'Hara Twp., Allegheny County
My Commission Expires March 26, 2015
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

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

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

232601 BC 215194325

STATE OF MINNESOTA

CERTIFICATION OF VITAL RECORD

CERTIFICATE OF BIRTH

STATE FILE NUMBER [redacted]

FULL NAME	CHRISTY MARIE BORAAS
DATE OF BIRTH	[redacted] 1978
SEX	FEMALE
PLACE OF BIRTH	WILLMAR KANDIYOHI MINNESOTA
PARENT	JANE CAROL
NAME AT BIRTH	OLSON
PARENT	GARY ABNER BORAAS

ANY AMENDMENT MADE PRIOR TO 03/11/2001 FOR THIS RECORD IS NOT NOTED ON THIS CERTIFICATE.

THIS IS A TRUE AND CORRECT RECORD OF BIRTH REGISTERED IN THE MINNESOTA OFFICE OF THE STATE REGISTRAR.

MR&C Certificate ID
7543973

002742527

FILED: DECEMBER 04, 1978

Steve Elkins

STEVE ELKINS
STATE REGISTRAR

232601

ISSUED: MARCH 07, 2012 MINNESOTA DEPT OF HEALTH

THIS CERTIFICATION IS VALID ONLY WHEN REPRODUCED ON WATERMARKED SECURITY PAPER WITH A RAISED BORDER AND RAISED STATE SEAL OF MINNESOTA.

Director of Licensing
Hennepin County, MN

Receipt Number: 109-00009879

Cartridge/Image number: 0998-4317

Marriage *Certificate*

I hereby certify, that on July 9 *, 20* 05 *, at (address of ceremony)* Green Lake Bible Camp Chapel

Spicer , Kandiyohi *(County), Minnesota, I the undersigned, did join in marriage*

ADAM RANDALL ALSLEBEN of the County of HENNEPIN State of MINNESOTA

and

CHRISTY MARIE BORAAS of the County of HENNEPIN State of MINNESOTA

The names of the parties after their marriage shall be:

ADAM RANDALL BORAAS ALSLEBEN — Signature of Bridegroom (affirming name after marriage and date of marriage) 7/9/05

and

CHRISTY MARIE BORAAS ALSLEBEN — Signature of Bride (affirming name after marriage and date of marriage) 7/9/05

This marriage is only valid if the marriage is performed on or after 07/03/2005 and on or before 12/30/2005

All parties signing this document attest to the fact that this marriage did take place within these dates.

In the presence of:

(Signature of witness)

Megan Sabrzadeh
(Type or print Name of witness)

(Signature of witness)

Erik Boraas
(Type or print Name of witness)

(Signature of Officiant)

Timothy R. Larson
(Type or print name of officiant & Title)

302 Olena Avenue
(Address of officiant)

Willmar MN 56201

If Religious officiant Credentials Recorded at: Lyon (County), MN

JUL 13 2005 PATRICK H. O'CONNOR

This License is not valid until it is reviewed for compliance and accepted for filing by the State of Minnesota

Section IV

Medical Education

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Instruction to the Dean

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

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

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

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

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

Institution Name: University of Minnesota Medical School - Minneapolis

Address Line 1:
420 Delaware Street SE

Address Line 2:
B604 Mayo Bldg, MMC 293

City: Minneapolis **State/Province:** MN **Zip Code (Postal Code):** 55455-0310
Country: US

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

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

Enrollment and Participation: Our records indicate that Borgss Christy Marie
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 152 weeks of medical education on the following dates: From: 8/9/04 (Month Day Year) To: 5/3/08 (Month Day Year)

This individual
Was awarded the degree of MD on 5/3/08 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix institutional Seal Here

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

Watermark
For FCVS internal use only.

SEAL VERIFIED

Name: Christine Oseland
Signature: [signature]
Title: Executive Student Services Specialist
Date of Signature: 5/30/14 Phone: (612) 626-0163
Fax: (612) 626-4205 Email: lund0151@umn.edu

232601 232601 2288 2288 215194325

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? ___ YES X NO

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

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

Please Specify:

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

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

Academic Probation	From (Mo/Yr)___/___	To (Mo/Yr)___/___
Probation for unprofessional conduct/behavioral	From (Mo/Yr)___/___	To (Mo/Yr)___/___
Probation for other reason	From (Mo/Yr)___/___	To (Mo/Yr)___/___

Please specify a reason:

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

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

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

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

___ YES ✓ NO

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

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

232601 232601 2288 215184325

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

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Christy Marie Boraas

University of Minnesota Medical School - Minneapolis

Unusual Circumstances

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

End of report for: Christy Marie Boraas

PROVIDED BY APPLICANT

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UNIVERSITY OF MINNESOTA
OFFICE OF THE REGISTRAR

TRANSCRIPT RECORD

Name : Borsas Alaleben,Chrissy Marie
Student ID: 1837709
Birthdate : [redacted]

Print Date : 06-03-2014

MOST RECENT PROGRAMS
Campus : University of Minnesota, Twin Cities
Program : Medical School
Plan : Medicine M D Major
Degree Sought : Doctor of Medicine

Student also has transcripts from the University of Minnesota at levels:
Graduate
Undergraduate

----- University of Minnesota Degrees and Certificates Awarded -----

Degree : Doctor of Medicine
Confer Date : 05-03-2008
Acad Program : Medical School
Plan : Medicine M D

----- Beginning of Medicine Record -----

Fall Semester 2004
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
BIOC	6001	Biochem Molecular/Cell Biol	7.00	7.00	P	
BIOC	6002	MedBiochem Nutrition	1.00	1.00	P	
GCD	6103	Human Histology	5.00	5.00	P	
GCD	6110	Medical Genetics, Year 1	2.00	2.00	P	
IBMD	6050	Phys & Soc I	3.00	3.00	P	
IBMD	6150	Gross Anat & Embryo	8.00	8.00	P	

TERM GPA : 0.000 TERM TOTALS : 26.00 26.00 0.000

Spring Semester 2005
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
CSPH	5000	Explore Comp Ther/Heal Prac	1.00	1.00	S	
Course Topic(s): Homeopathic Practice						
IBMD	6051	Phys & Soc II	2.00	2.00	P	
IBMD	6100	Phys & Pt I - H & P	4.00	4.00	P	
MICB	6105	Micro-Med Students	7.00	7.00	P	
NSCI	6111	Medical Neuroscience	5.00	5.00	P	
PMBL	6161	Human Physiology	5.00	5.00	P	

TERM GPA : 0.000 TERM TOTALS : 24.00 24.00 0.000

Summer Semester 2005
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
ADPY	6107	Human Behavior	3.00	3.00	P	
FMCH	6233	Human Sexuality	2.00	2.00	P	
LAMP	6101	General Path	3.00	3.00	P	
PMCL	6118	Pharmacology	1.00	1.00	P	

TERM GPA : 0.000 TERM TOTALS : 9.00 9.00 0.000

Fall Semester 2005
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
IBMD	6052	Phys & Soc III	3.00	3.00	P	
IBMD	6101	Phys. & Pat. II	3.00	3.00	P	
IBMD	6201	Pathophysiology I	15.00	15.00	P	
LAMP	6102	Systemic Path	2.00	2.00	P	
LAMP	6103	Systemic Path	2.00	2.00	P	
PMCL	6111	Pharmacology	4.00	4.00	P	

TERM GPA : 0.000 TERM TOTALS : 27.00 27.00 0.000

Spring Semester 2006
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
IBMD	6053	Phys & Soc IV	2.00	2.00	P	
IBMD	6102	Phys. & Pat. III IntMed	2.00	2.00	P	
IBMD	6103	Phys. & Pat. III:Family Prac	2.00	2.00	P	
IBMD	6104	Phys. & Pat. III Peds	2.00	2.00	P	
IBMD	6202	Pathophysiology II	12.00	12.00	P	
LAMP	6104	Systemic Path	2.00	2.00	P	
LAMP	6290	Laboratory Medicine	1.00	1.00	P	
PMCL	6112	Pharmacology	3.00	3.00	P	

TERM GPA : 0.000 TERM TOTALS : 26.00 26.00 0.000

Summer Semester 2006
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
FMCH	7170	Rural Rotation in Family Med	3.00	3.00	H	
OTOL	7200	Surg Spec: Otol	2.00	2.00	P	
UROL	7280	Urology Externship	2.00	2.00	P	

TERM GPA : 0.000 TERM TOTALS : 7.00 7.00 0.000

Fall Semester 2006
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
ADPY	7500	Psychiatry Externship	6.00	6.00	H	
MED	7530	Med I Externship	6.00	6.00	H	
PED	7301	Pediatric Externship	6.00	6.00	H	

TRANSCRIPT KEY PRINTED ON BACK

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THIS OFFICIAL UNIVERSITY TRANSCRIPT IS PRINTED ON SECURITY PAPER AND DOES NOT REQUIRE A RAISED SEAL

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

SEAL VERIFIED

232601 7288

Susan Van Voorhis, Registrar
University of Minnesota

In accordance with the Family Educational Rights and Privacy Act of 1974, non-public information about a student will not be released to a third party without written consent of the student. Transcript key and authenticity confirmation information on back.

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UNIVERSITY OF MINNESOTA
OFFICE OF THE REGISTRAR

TRANSCRIPT RECORD

Name : Boreas Alsleben, Christy Marie
Student ID: 1817709
Birthdate : [redacted]

TERM GPA : 0.000 TERM TOTALS : 10.00 10.00 0.000

Spring Semester 2007
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

***** End of Transcript *****
Page 2 of 2

Course		Description	Attempted	Earned	Grade	Points
MED	7521	Infect Dis Elec	4.00	4.00	S	
OBGY	7540	Ob/Gyn Externship	6.00	6.00	S	
SURG	7500	Surgery Externship	6.00	6.00	S	

TERM GPA : 0.000 TERM TOTALS : 16.00 16.00 0.000

Summer Semester 2007
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
IDMD	7565	Clin Exp in Int'l Med I	4.00	4.00	S	
NEUR	7518	Neurology Externship	4.00	4.00	S	
ORSU	7192	Orthopaedic Elec	3.00	3.00	S	

TERM GPA : 0.000 TERM TOTALS : 11.00 11.00 0.000

Fall Semester 2007
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
IDMD	7508	Clin Med IV: Prim Care	4.00	4.00	S	
IDMD	7509	Clin Med IV: Prim Care	4.00	4.00	S	
MED	7501	Med II Externship	6.00	6.00	S	
OBGY	7591	Women's Health Rotation	4.00	4.00	S	

TERM GPA : 0.000 TERM TOTALS : 18.00 18.00 0.000

Spring Semester 2008
University of Minnesota, Twin Cities
Medical School
Medicine M D Major

Course		Description	Attempted	Earned	Grade	Points
ANES	7101	Anesthesiology Elec	3.00	3.00	S	
EMMD	7508	Emergency Med Elec	4.00	4.00	S	

TERM GPA : 0.000 TERM TOTALS : 7.00 7.00 0.000

University of Minnesota Summary Information

Medicine Career Totals

			Attempted	Earned	Points
CUM GPA :	0.000	CUM TOTALS :	189.00	189.00	0.000
GPA UNITS :	0.000	CUM TOTALS :	189.00		

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Susan Van Voorhis, Registrar
University of Minnesota

Transcript key

Academic calendar

The semester system started Fall 1999 for all University of Minnesota campuses. Prior to Fall 1999 the University used a quarter system with these exceptions: Law school started on semesters Fall 1981, and some College of Continuing Education courses were taught on a semester calendar but the credits reported as quarter credits.

Accreditation

The University of Minnesota is accredited by the Higher Learning Commission of the North Central Association of Colleges and Schools.

Course (class) numbering system (from Fall 1999)

0000 to 0999 remedial courses
1000 to 1999 primarily for undergraduates in first year
2000 to 2999 primarily for undergraduates in second year
3000 to 3999 primarily for undergraduates in third year
4000 to 4999 primarily for undergraduates in fourth year, may be applied to a Graduate School degree with approval by the student's major field and if taught by a member of the graduate faculty or an individual authorized by the program to teach at the graduate level
5000 to 5999 primarily for graduate students but third and fourth year undergraduates may enroll
6000 to 7999 for postbaccalaureate professional degree students
8000 to 9999 for graduate students

Prior course numbering systems

For Fall 1970 through Summer 1999 (course numbering prior to 1970 is noted in parentheses):
0000 to 0999 noncredit courses
1000 to 1999 (01 - 49) introductory courses primarily for freshmen and sophomores
3000 to 3999 (50 - 99) intermediate courses primarily for juniors and seniors
5000 to 5999 (100 - 199) advanced courses for juniors, seniors, and graduate students
8000 to 8999 (200 and higher) for graduate and professional school students

Credit

Starting Fall 1999 – units are semester credit
Prior to Fall 1999 – units generally are quarter credit (see calendar for exceptions)
Thesis credit – an asterisk (*) will appear following the course title of courses numbered 8777, 8888, or 8999 if the degree award is shown
An asterisk (*) indicates graduate credit taken through College of Continuing Education (Continuing Education and Extension prior to Fall 1999)

Grading policy (complete)

Available online at policy.umn.edu/Policies/Education/Education/GRADINGTRANSCRIPTS.html

Grading definitions

A – achievement that is outstanding relative to the level necessary to meet course requirements
B – achievement that is significantly above the level necessary to meet course requirements
C – achievement that meets the course requirements in every respect
D – achievement that is worthy of credit even though it fails to meet fully the course requirements
E – achievement that is significantly greater than the level required to meet the basic course requirements but not judged to be outstanding
F (or N) – represents failure (or no credit) and signifies that the work was either (1) completed but at a level of achievement that is not worthy of credit or (2) was not completed and there was no agreement between the instructor and the student that the student would be awarded an I (see also I)
H – Honors (used by Law School and Medical School only)
I – (Incomplete) assigned at the discretion of the instructor when, due to extraordinary circumstances, e.g., hospitalization, a student is prevented from completing the work of the course on time. Requires a written agreement between instructor and student
K – assigned by an instructor to indicate the course is still in progress and that a grade cannot be assigned at the present time
LP – low pass (used by Law School only)
NG – no grade required
NR – grade not reported
O – represents outstanding achievement for Doctor of Medicine and Doctor of Veterinary Medicine programs
P – achievement designating passing work
Q – achievement designating passing work
R – a course related registration symbol
S – achievement that is satisfactory, which is equivalent to a C- or better for undergraduate students (C or better on the Duluth campus). Graduate and professional programs may establish higher standards for earning a grade of S.
T – test credit
V – registration as an auditor or visitor (a non-grade non-credit registration)
W – entered by the registrar's office when the student officially withdraws from a course after the second week
X – reported by the instructor for a student in a sequence course where the grade cannot be determined until the sequence is complete – the instructor is to submit a grade for each X when the sequence is complete
Y – assigned from Fall 1929 to Summer 1959 to indicate the student canceled while doing passing work
Z – assigned from Fall 1929 to Summer 1959 to indicate the student canceled while doing failing work

On the Twin Cities campus from Fall 1972 through Summer 1977 and on the Morris campus from Fall 1972 through Summer 1985, the official University transcript included only positive academic achievements. Courses in which the student received a grade of N or a registration symbol of I or W did not appear on the transcript.

Grade/Numeric Point Average formula

Effective Fall 1997, grade point values were standardized for the University. All units except Law use: A = 4.000, A- = 3.667, B+ = 3.333, B = 3.000, B- = 2.667, C+ = 2.333, C = 2.000, C- = 1.667, D+ = 1.333, D = 1.000, F = 0.000, I = 0.000, K = 0.000, X = 0.000. Effective Fall 2004, the Twin Cities campus Law School uses University standard grading, with the addition of A+ = 4.333 and excluding D+.
Before 1997, most units did not use +/-. But the Duluth campus and the School of Management used: A = 4.0, A- = 3.6, B+ = 3.3, B = 3.0, B- = 2.6, C+ = 2.3, C = 2.0, C- = 1.6, D+ = 1.3, D = 1.0, F = 0.0 and the Twin Cities General College used A = 4.0, A- = 3.6, B = 3.2, B- = 2.8, C+ = 2.4, C = 2.0, C- = 1.6, D = 1.2, D- = 0.8, F = 0.0
Prior to Fall 2004, the Twin Cities campus Law School used a numeric rather than a grade point average for the *juris doctor (J.D.)* degree program. Grades ranged from 4-16 points based on the following: 14-16: Excellent/Outstanding; 11-13: Substantially better than average; 8-10: Minimally acceptable; 5-7: Inadequate (credits count towards degree completion, and NPA); 4: Failing; 0: Non-performance. Classes for which a 0 grade was earned are not included in NPA calculation. Grades earned in the *LL.M.* (Master of Laws) program were: A=4.00, B=3.00, C=2.00, D=1.00, F=0.00. No +/- distinctions are given.

Symbols following course numbers

C – certificate credit
E – on Duluth campus, registration in Continuing Education, or on Twin Cities campus, an MBA course
G – honors course for extra credit
H – honors course
J – evening MBA course for extra credit
K – evening MBA course by independent study
L – honors course by independent study
M – extra credit by independent study
Q – evening MBA extra credit by independent study
R – honors extra credit by independent study
S – semester registration (pre-1999)
T – semester honors course (pre-1999)
U – special term course taken for extra credit
V – honors and writing intensive
W – writing intensive
X – extra credit
Y – independent study
Z – special term registration

Additional notations

Canceled means that all course registration was canceled (i.e., dropped) before the end of the second week of the term.

Degree with distinction indicates graduation with high GPA; degree with honors (laude) indicates completion of honors program.

Second Language Proficiency means demonstrated intermediate proficiency in reading, writing, listening, and speaking.

For more information, visit www.umn.edu

Campus records office locations:

University of Minnesota, Crookston
9 Hill Hall
Crookston, MN 56716-5001
218-281-8548
Dept of Educ Inst cd 004069

University of Minnesota, Duluth
184 Darland Administration Building
Duluth, MN 55812-3011
218-726-8000
Dept of Educ Inst cd 002388

University of Minnesota, Morris
212 Behmler Hall
Morris, MN 56267-2132
320-589-6030
Dept of Educ Inst cd 002389

University of Minnesota, Twin Cities
333 Science Teaching & Student Services, Minneapolis, MN 55455, 612-624-1111 or 130 Coffey Hall, St. Paul, MN 55108, 612-624-1111 or 130 West Bank Skyway, Minneapolis, MN 55455, 612-624-1111
Dept of Educ Inst cd 003969

University of Minnesota, Rochester
111 South Broadway
Rochester, MN 55904
507-258-8153
Dept of Educ Inst cd: 003969

The University of Minnesota, Waseca campus closed in 1992. For information on Waseca student transcripts, contact the St. Paul office.

The Regents of the University of Minnesota, upon recommendation of the faculty of the Medical School, confer upon

Christy Marie Boraas Alsleben

the degree of

Doctor of Medicine

with all its privileges and obligations.

In the spirit of Hippocrates, this degree is granted to a person well qualified in the study, discipline, art, and science of medicine.

Given at Minneapolis, in the State of Minnesota, this third day of May two thousand eight.

Secretary, Board Of Regents

Dean, Medical School

Robert H. Bruininks
President

Frank B. Cerra
Senior Vice President for Health

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2328

2326601

Section V

Graduate Medical Education

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Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Ohio State University Hospital

Attention: PROGRAM DIRECTOR

Specialty: Obstetrics and Gynecology

Affiliated University: _____

Address: Columbus, OH

Verification For:

Name: Boraas, Christy Marie

DOB: [redacted]1978

Individual's Name on Record (If different from above): _____

Program Participation:

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

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

Training Level: 1 (e.g., 1, 2, 3, etc.)
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: Obstetrics & Gynecology
From: 7/1/2008 **To:** 6/30/2009
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: 2 & 3 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: Obstetrics & Gynecology
From: 7/1/2009 **To:** 6/30/2011
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: 4 (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☒ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: Obstetrics & Gynecology
From: 7/1/2011 **To:** 6/30/2012
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

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

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

Please explain any "Yes" response from above:

_____

_____

Certification:

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

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

Name: Philip Samuels, MD

Signature: Philip Samuels, MD

Title of Signatory: Program Director (e.g., Program Director)

Date of Signature: 6/2/14

Tel: 614-293-3773 Fax: 614-293-5877 E-Mail: samuels.8@osu.edu

ELECTRONIC SEAL VERIFIED

Rev. 05/30/2014

FCVS ID: 232601 FID: 215194325 CODE: 109103

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name: Christy Marie Boraas
Ohio State University Hospital
Obstetrics and Gynecology

Unusual Circumstances

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

End of report for: Christy Marie Boraas

PROVIDED BY APPLICANT

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

The Ohio State University Wexner Medical Center
Mount Carmel Health System

This document certifies that

Christy Boraas Alsleben, MD, MPH

has successfully completed a Graduate Medical Education program in

Obstetrics and Gynecology

awarded this date

June 30, 2012

Program Director

Associate Program Director
Mount Carmel Health System

Professor and Chair

Associate Dean for GME

Director of Medical Education
Mount Carmel Health System

Chief Medical Officer

Senior Vice President for Health Sciences
CEO, The Ohio State University
Wexner Medical Center

President and Chief Executive Officer
Mount Carmel Health System

Dean, College of Medicine
Vice President for Health Sciences

Wexner Medical Center

MOUNT CARMEL

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: University of Pittsburgh

Attention: Program Director

Specialty: Family Planning

Affiliated University: University of Pittsburgh

Address: Pittsburgh, PA

Verification For:

Name: Boraas, Christy Marie

DOB: 11/27/1978

Individual's Name on Record (If different from above): _____

Program Participation:

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

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

Training Level: 5-6 (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☒ Fellowship
☐ Research

Specialty/Subspecialty: Family Planning

From: 07/01/2012 **To:** 07/11/2014

Successfully Completed?: ☐ Yes ☐ No ☒ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☒ None of these

---

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: _____

From: / / **To:** / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

---

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research

Specialty/Subspecialty: _____

From: / / **To:** / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

---

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

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

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

Please explain any "Yes" response from above:

maternity leave

Certification:

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

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

Name: Beatrice A. Chen, MD MPH

Signature: Beatrice A. Chen, MD MPH

Title of Signatory: Fellowship director (e.g., Program Director)

Date of Signature: 6/5/14

Tel: 412-641-1403 Fax: 412-641-1133 E-Mail: chenba@upmc.edu

ELECTRONIC SEAL VERIFIED

Rev. 06/05/2014

FCVS ID: 232601 FID: 215194325 CODE: 122559

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name: Christy Marie Boraas
University of Pittsburgh
Family Planning

Unusual Circumstances

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

End of report for: Christy Marie Boraas

PROVIDED BY APPLICANT

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

Section VI

Licensure Examination History

(State Licensing Authorities Only)

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

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Date : 05/28/2014

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 232601

Examinee: Boraas, Christy Marie
Alt Name(s): Boraas Alsleben, Christy Marie

Examinee ID#: 5-170-123-3
Date of Birth: [redacted]1978

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	06/15/2006	Pass	229	(182)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	01/29/2008	Pass	217	(184)	

Clinical Skills (CS)*

	Test Date	Pass/Fail	Total	MP	Comments
	11/09/2007	Pass			

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
OHIO	04/13/2010	Pass	211	(187)	

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 – Telephone (817) 868-4000

Examinee: Boraas, Christy Marie

Examinee ID#: 5-170-123-3
Date of Birth: [redacted]/1978

INTERPRETATION OF RESULTS

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

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

STEP 2 CLINICAL SKILLS (CS)

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

ANNOTATIONS APPEARING UNDER "COMMENTS"

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

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

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

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

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

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.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

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 Data 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. **4/2013**

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

VERIFICATION OF LICENSURE

This is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 06/25/2014:

Identification Information

Name and Address:	Dr. Christy Marie Boraas Alsleben 700 Ackerman Road Suite #570 Columbus, OH 43202
Date of Birth:	11/27/1978
Place of Birth:	Willmar, MN
School of Graduation:	University of Minnesota Medical School - Minneapolis
Date of Graduation:	05/03/08

License Information

Type of License:	MD Training Certificate
License Number:	57. 014608
How Issued:	
Original Licensure Date:	07/28/2008
Expiration Date:	06/29/2012
Status:	INACTIVE
Formal Disciplinary Action:	No

Jonathan Blanton
Interim Executive Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

May 30, 2014

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs.

NAME:	CHRISTY MARIE BORAAS ALSLEBEN
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD445822
ORIGINAL LICENSURE DATE:	05/16/2012
EXPIRATION DATE:	12/31/2014
STATUS:	Active

The license is in good standing and the records indicate no derogatory information.

SEAL

Travis N. Gery

Commissioner
Bureau of Professional and Occupational Affairs

49-CERTOFLIC-100 01/12

MAILING ADDRESS:	STATE BOARD OF MEDICINE	COURIER ADDRESS:
PO BOX 2649 Harrisburg, PA 17105-2649	st-medicine@pa.gov 717-783-1400 or 717-787-2381	2601 North Third Street Harrisburg, PA 17110

REQUEST FOR CERTIFICATION OF LICENSURE

- FEE: To obtain a certification of your license, you must complete this form and return it to the mailing address listed above with a $15 fee (check or money order payable to the "Commonwealth of Pennsylvania."
- There is a $20 charge for all checks returned "NOT PAID" regardless of the reason for non-payment.

LICENSEE INFORMATION

LICENSEE'S NAME:	Last: Boraas Alsleben	First: Christy	Middle: Marie	Maiden: Boraas
LICENSE NUMBER:	MD 44582 2	SOCIAL SECURITY NUMBER:	[redacted]	
EMAIL ADDRESS:	[redacted]	TELEPHONE NUMBER:	[redacted]	
LICENSEE'S ADDRESS:	[redacted]			
	City: [redacted]	State: PA	Zip Code: 15218	

MAY 30 2014

By

MAILING INFORMATION

PLEASE PROVIDE THE NAME AND ADDRESS WHERE THE COMPLETED CERTIFICATION SHOULD BE MAILED

PLEASE NOTE: Effective May 19, 2008, Letters of Good Standing/Verifications of Licensure will only be sent to another licensing board directly from our office. These verification documents will no longer be provided to licensees or credentialing agencies. Licensing boards in the United States have been made aware of this policy.

If you provide an address OTHER than an official state board or licensing authority address, your request will not be completed and will be returned to you.

NAME of BOARD:	Minnesota Board of Medical Practice				
STREET:	University Park Plaza, 2829 University Ave. SE, Suite 500				
CITY:	Minneapolis	STATE:	MN	ZIP CODE:	55414-3246

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Licensure Verification (UA Form #1)

Applicant: Send this form to each board with which you have ever held a license.

Applicants:

Complete Section 1. In the Authorization area, list the board that needs to verify your license as well as your license number. Type or print legibly.

Send this form and any required fee for this verification to the authorizing board.

Copy this form for multiple licenses.

Section 1: Applicant Information

Last name: Boraas Alsleben Suffix: _____

First name: Christy

Middle name: Marie

Date of birth: [redacted]1978 Social Security number*: [redacted]

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

In listing the Board information below, please reference http://www.fsmb.org/directory_smb.html.

Name of Board applying to: Minnesota Board of Medical Practice

Board address: University Park Plaza, 2829 University Ave. SE, Suite 500

Board city/state/zip code: Minneapolis, MN 55414-3246

Authorization: I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of Pennsylvania to provide any and all information pertaining to license number MD445822 to the Board listed above.

Applicant signature: _____ Date: 5/13/2014

State Licensing Board or Canadian Province:

Please complete Section 2. Send this form to the board at the address listed in Section 1. Do not send this form to FSMB.

Section 2: Licensure Verification

Name of Licensee: _____
Last First Middle Suffix

License type: _____ License number: _____

Issue date: _____ Expiration date: _____

Is this license current? ☐ Yes ☐ No If not current, please explain: _____

1. Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? ☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law

RECEIVED
MAY 30 2014

If yes, please explain: _____

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: _____

AFFIX BOARD SEAL HERE

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

Print name: _____

Title: _____

Date: _____

Email: _____

UPMC

FAX COVER SHEET

To:	Minnesota Board of Medical Practice Fax: 612-617-2166
From:	Yvette Taylor, MTS Medical Staff Office Magee-Womens Hospital of UPMC 300 Halket Street, Room 2206 Pittsburgh, PA 15213
Fax number:	412-641-5497
Telephone number:	412-641-4075
Date:	May 27, 2014
Re:	Christy Boraas, MD
Number of pages:	2(including cover page)

Magee-Womens Hospital
of University of Pittsburgh Medical Center

May 27, 2014

RE: Christy Boraas, MD
Yvette Taylor
Credentialing Coordinator, Medical Staff Office
Magee-Womens Hospital of UPMC

In response to your request for information regarding the above Referenced practitioner, we are able to verify the following:

Department: Obstetrics and Gynecology
Section:
Primary Specialty: Obstetrics and Gynecology
Expertise:
Current Status: Resignation Pending
Staff Category: Courtesy
Admitting Privileges: Yes
Temporary Privileges: 07/01/2012
Appointment Date: 07/09/2012
Resignation Date: 07/09/2012

The practitioner is/was in good standing at Magee-Womens Hospital with no disciplinary actions or reduction in clinical privileges/scope of practice, having met all requirements for Medical Staff/Professional Staff membership/affiliation, including professional, moral, ethical and physical requirements.

Magee-Womens Hospital is accredited by the Joint Commission and is a Medicare Participating Facility. This letter shall serve as attestation that the above listed practitioner has been fully credentialed in accordance with requirements as established by the Joint Commission, NCQA, HFAP and CMS as applicable. The file maintained for this practitioner is complete, accurate and up to date.

If you need additional information, please contact the Medical Staff Office by phone at 412-641-4075, by fax 412-641-5497 or by e-mail at CVOMagee-Womens@upmc.edu.

Sincerely,

The Magee-Womens Hospital Medical Staff Office.

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

Addendum 5

Physician Recommendation Form (1)

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed in Addendum 7. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name Boraas, Christy M.

Signature [redacted] Date 5/13/14

The physician serving as a reference completes the following:

Recommendation for: (print name of physician applicant) Christy Boraas

1. How long have you known the applicant? 2 years
2. What has been the nature of your relationship with the applicant? Colleagues at the University of Pittsburg
3. How would you characterize the moral and professional conduct of the applicant? Dr. Boraas always conducted herself professionally & morally.
4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine? Yes. Absolutely
5. Circle the word(s) which best describes this applicant. *Please attach a letter of explanation

A.	Marginal*	(Fully Meets Standards)	-	Clinical Skills
B.	YES*	(NO)	-	Any indication of chemical dependency?
C.	YES*	(NO)	-	Any indication of malprescribing?

Completed by:

Printed Name Catherine Chappell Signature Catherine Chappell

Health Profession MD - ob/gyn License # MD442077 State PA

Date 5/13/14 Phone 214-356-1725 Fax 412-641-1133

Email chappellca@upmc.edu

*NOTE: The physician serving as a reference for the applicant must forward the completed form **directly** to the Minnesota Board of Medicol Practice, University Pork Plaza, 2829 University Avenue SE, Suite 500, Minneapolis, MN 55414-3246*

C Bonnaa MD MPH
Magee-Womens Hospital
of University of Pittsburgh Medical Center

300 Halket Street
Pittsburgh, PA 15213-3180

PITTSBURGH PA 150

14 MAY 2014 PM 5 L

Equality
FOREVER

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

55414324699

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

Addendum 5

Physician Recommendation Form (2)

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed in Addendum 7. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name Boraas, Christy M.

Signature [redacted] Date 5/13/14

The physician serving as a reference completes the following:

Recommendation for: (print name of physician applicant) Christy Boraas

1. How long have you known the applicant? 2 yrs
2. What has been the nature of your relationship with the applicant? Fellow ship director, direct supervisor
3. How would you characterize the moral and professional conduct of the applicant? Very conscientious, dedicated to patient care, highly professional
4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine? Yes
5. Circle the word(s) which best describes this applicant. *Please attach a letter of explanation

a.	Marginal*	(Fully Meets Standards)	-	Clinical Skills
b.	YES*	(NO)	-	Any indication of chemical dependency?
c.	YES*	(NO)	-	Any indication of malprescribing?

Completed by:

Printed Name Beatrice Chen Signature [signature]
Health Profession Ob Gyn License # MD42836 State PA
Date 5/14/14 Phone 412-641-1403 Fax 412-641-1133
Email chenba@upmc.edu

*NOTE: The physician serving as a reference for the applicant must forward the completed form **directly** to the Minnesota Board of Medical Practice, University Park Plaza, 2829 University Avenue SE, Suite 500, Minneapolis, MN 55414-3246*

Magee-Womens Hospital
of University of Pittsburgh Medical Center
300 Halket Street
Pittsburgh, PA 15213-3180

PITTSBURGH PA 152

16 MAY 2014 PM 2 L

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

5541432469 

AMA Physician Profile

Name and Mailing Address
CHRISTY M BORAAS ALSLEBEN MD
7210 WHIPPLE ST
PITTSBURGH PA 15218-2010

Primary Office Address
300 HALKET ST
PITTSBURGH PA 15213-3108

Phone UNKNOWN

Birth date [redacted]/1978

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)
UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration date	Deactivation date	Reactivation date	Replacement number	Last reported date
1750544581	07/02/2008	NOT RPTD	NOT RPTD	NOT RPTD	05/18/2014

Current and/or historical medical school

UNIV OF MN MED SCH, MINNEAPOLIS MN 55455
Degree Awarded: Yes
Degree Year: 2008

AMA AMERICAN MEDICAL ASSOCIATION

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: OH STATE UNIV HOSP
Sponsoring State: OHIO
Program name: OHIO STATE UNIVERSITY HOSPITAL PROGRAM
Specialty: OBSTETRICS & GYNECOLOGY
Dates: 07/2008 - 06/2012 (Being Reverified)

If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or historical medical licensure

Jurisdiction	MD/ DO	Date granted	Expiration date	Status	License type	Last reported
PENNSYLVANIA	MD	05/16/2012	12/31/2014	ACTIVE	UNLIMITED	04/24/2014
OHIO	MD	07/28/2008	06/29/2012	INACTIVE	RESIDENT	05/06/2014

ECFMG Certfication

Applicant Number:

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

AMA AMERICAN MEDICAL ASSOCIATION

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration date	Last Reported date	Address:
XXXXXX711	22N 33N 4 5	07/31/2015	05/05/2014	300 Halket St, Pittsburgh, PA 15213-3108

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

AMA AMERICAN MEDICAL ASSOCIATION

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

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information.

Action notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Adminstration or the US Public Health Service.

AMA
AMERICAN
MEDICAL
ASSOCIATION

Additional Information

To date, there is no additional information for this physician on file.

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log onto our website **(www.ama-assn.org/go/amaprofiles)** and go to the order detail page. Select the 'D' following the physician's name and enter the data in questions. Or you can mark the issues on a copy of the profile and mail or fax to:

American Medical Association
Division of Database Products
Attn: Physician Products Portfolio
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

Fax: (312) 464-5900

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

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	Minnesota Board of Medicine	As of Date:5/20/2014

PRACTITIONER INFORMATION

Name:	Christy Marie Boraas Alsleben
DOB:	11/27/1978
Medical School:	University of Minnesota Medical School - Minneapolis Minneapolis, Minnesota, UNITED STATES
Year of Grad:	2008
Degree Type:	MD

BOARD ACTIONS

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

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Reported
PENNSYLVANIA	MD445822	5/16/2012	12/31/2014	4/1/2014

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

the DataBank

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

http://www.npdb.hrsa.gov

5500000089286620
Process Date: 05/16/2014
Page: 1 of 1

To: BORAAS, CHIRSTY MARIE

[redacted]

From: National Practitioner Data Bank
Re: Response to Your Self-Query

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended; Section 1921 of the Social Security Act; and Section 1128E of the Social Security Act.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners.

Section 1921 of the Social Security Act expanded the scope of the NPDB. Section 1921 was enacted to protect program beneficiaries from unfit health care practitioners, and to improve the anti-fraud provisions of federal and state health care programs. Section 1921 authorizes the NPDB to collect certain adverse actions taken by state licensing and certification authorities, peer review organizations, and private accreditation organizations, as well as final adverse actions taken by state law or fraud enforcement agencies (including, but not limited to, state law enforcement agencies, state Medicaid Fraud Control Units, and state agencies administering or supervising the administration of a state health care program), against health care practitioners, health care entities, providers and suppliers.

Section 1128E of the Social Security Act was added by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996. The statute established a national data collection program (formerly known as the Healthcare Integrity and Protection Data Bank) to combat fraud and abuse in health care delivery and to improve the quality of patient care. Section 1128E information is now collected and disclosed by the NPDB as a result of amendments made by Section 6403 of the Affordable Care Act of 2010, Public Law 111-148. Section 1128E information includes certain final adverse actions taken by federal agencies and health plans against health care practitioners, providers, and suppliers.

Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), and HRSA, Division of Practitioner Data Banks.

Reports from the NPDB contain limited summary information and should be used in conjunction with information from other sources in granting privileges, or in making employment, affiliation, contracting or licensure decisions. NPDB responses may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an exclusion from a federal or state health care program and an adverse licensure action). The NPDB is a flagging system, and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB is considered confidential and must be used solely for the purpose for which it was disclosed. Further, ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

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

the DataBank

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

http://www.npdb.hrsa.gov

5500000089286620
Process Date: 05/16/2014
Page: 1 of 1

BORAAS, CHIRSTY MARIE - SELF-QUERY RESPONSE

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

Practitioner Name: BORAAS, CHIRSTY MARIE
Date of Birth: [redacted]/1978 **Gender:** FEMALE
Other Name(s) Used: BORAAS ALSLEBEN, CHRISTY MARIE
Work Address: 7210 WHIPPLE ST, PITTSBURGH, PA 15218-2010
Social Security Number: [redacted]4 **DEA:** FB3217711, FB3398888

NPI: 1750544581
License: PHYSICIAN (MD), MD445822, PA, OBSTETRICS & GYNECOLOGY
Professional School(s): UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW (2008)

B. PAYMENT INFORMATION

Credit Card Information: [redacted]
NPDB Charge: $8.00* **NPDB Bill Reference Number:** N33950546
* Each charge will appear separately on your credit card statement.
Transaction Date: 05/16/2014 **Additional Paper Copies Requested:** 0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 05/16/2014

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are enclosed for restricted/limited use as prescribed by statutes listed on the preceeding cover page.

---------- **No Reports Found** ----------

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

Address Correction Requested

Hasler
05/19/2014
US POSTAGE $00.48º
ZIP 22033
011D11630697

National practitioner
Data Bank
Self-Query for:

Boraas, Christy Marie

MN BOARD OF
MAY 27 2014

05/21

152182010 C087

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-324
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MN Relay Service for Hearing Impaired (800) 627-3529

MALPRACTICE HISTORY REPORT

Minnesota Statute 147.035 requires that applicants previously practicing medicine in another state submit the following information for the last five years of active practice. For each malpractice suit in which you have been named, you must include a detailed clinical explanation of the situation and insurance papers or other formal documentation of the outcome/status.

NAME AND ADDRESS OF PROFESSIONAL LIABILITY INSURER IN OTHER STATE:

1. Tri-Century Insurance 600 Grant Street, UST015901
2. Pittsburgh, PA 15219
3. phone: (412) 432-7697 fax: (412) 432-7709

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

Number	Date	Disposition
NONE		

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

Print Name Boraas, Christy M.

Signature [redacted] Date 5/28/14

*If there has been no settlement or award, write **NONE**.

01/02

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

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

Federation of STATE MEDICAL BOARDS

Federation of State Medical Boards

UA Summary of Reported Board Actions

Physician Identification

Name: **Christy Marie Boraas Alsleben**

Alternate Names:

DOB: [redacted]**1978**

Medical School: **University of Minnesota Medical School - Minneapolis**

Year of Graduation: 2008

Summary of Reported Board Actions

No Reportable Board Actions Found

Reportable Actions as of UA Submission Date : 05/14/2014

UA Submission ID : 72,726

UA User Name : cboraas

Federation of STATE MEDICAL BOARDS

Federation of State Medical Boards
UA Licensure History

Physician Identification

Name:	Christy Marie Boraas Alsleben
Alternate Names:	
DOB:	[redacted]1978
Medical School:	University of Minnesota Medical School - Minneapolis
Year of Graduation:	2008

Licensure History

State Board/Licensing Entity	License Number	Issue Date	Expiration Date
Pennsylvania State Board of Medicine	MD445822	05/16/2012	12/31/2014

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Addendum 3a

Hospital Privileges Verification Form

(This form may be duplicated)

As part of the medical license application process, the Minnesota Board of Medical Practice requires that this form be completed by each hospital where the applicant has held formal privileges within the last ten years. This form must be completed by each hospital listed on the Facilities List and mailed directly by each 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 Boraas, Christy M SSN (last 4 digits only) [redacted]

Signature [redacted] Date 5/13/2014

The hospital completes the following information:

It is hereby certified that: (Name of Physician) _____

Had hospital privileges at: (Name of Hospital) _____

Located at: (Address) _____

_____

From: (Month/Day/Year) _____ To: (Month/Day/Year) _____

Type of Privilege: _____

Any disciplinary action? Yes* ___ No ___ Any derogatory information on file? Yes* ___ No ___

*Please attach letter of explanation

SEAL**

Print Name _____

Signature _____

Title _____

Date _____

Phone _____

Fax _____

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

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Addendum 6

Verification of Specialty Board Certification

This form is for verification of specialty board certification for applicants who have not taken a licensing exam for 10 years. Applicants are required to pass the SPEX exam if it has been more than 10 years since taking the USMLE, National Board, FLEX, LMCC, or state exam unless the applicant is currently certified by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. The form must be mailed directly by the specialty board (e.g. American Board of Internal Medicine, **not** American Board of Medical Specialties) to the **Minnesota Board of Medical Practice**. Any fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name _____ SSN (last 4 digits only) _____

Signature _____ Date _____

The Specialty Board completes the following:

It is hereby certified that: (print name of physician) _____

Was issued a certificate on: (month, day, year) _____

By: (name of specialty board) _____

A **Specialty Board of** (check only one):

Not applicable

___ **The American Board of Medical Specialties**
___ **The American Osteopathic Association/Bureau of Osteopathic Specialists**
___ **The Royal College of Physician and Surgeons of Canada**
___ **The College of Family Physicians of Canada**

Expiration date is: (month, day, year) _____

SEAL*

Print Name _____
Signature _____
Title _____
Date _____
Phone _____

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

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Addendum 8

Treating Physician Statement

Applicant: Applicants who have had a medical condition within the last five years which, if untreated, would be likely to impair their ability to practice with reasonable skill and safety must have their treating physician complete this form. A treating physician is the physician who diagnosed and provides or provided treatment for the condition and includes the current treating physician.

Treating Physician: Complete and mail this form directly to the **Minnesota Board of Medical Practice**. This form is also available on our website.

Applicant's Printed Name _____

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

I hereby authorize you, my treating physician, to disclose my medical records to the Minnesota Board of Medical Practice. I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing oral information or documents, records, or other information to the Board.

Signed _____ Date _____

The treating physician completes the following:

Nature of medical condition including diagnosis and significant symptoms _____

_____

_____ not applicable

Date first saw patient: _____ Date last saw patient: _____

Has the applicant been compliant with treatment? (If no, please explain) ___ Yes ___ No

_____

_____

What medication is the applicant taking for this condition? _____

_____

If this medical condition was untreated, would it be likely to impair the applicant's ability to practice with reasonable skill and safety? (If yes, please explain) ___ Yes ___ No

_____

_____

Should the condition be monitored? (If yes, please explain) ___ Yes ___ No

_____

_____

Treating Physician (print name) _____

Signature _____ Date _____

Phone _____ Fax _____

CONFIDENTIAL

MID MICHIGAN VASCULAR SURGERY, P.C.

Ronald A. Bays, M.D., F.A.C.S.

4701 Towne Centre Rd., Suite 202
Medical Arts Bldg II
Saginaw, MI 48604
Phone: 989-790-2600
Fax: 989-790-3311

DATE: 06/24/14

This is Page 1 of 5 Pages (including this cover sheet)

TO: Pat Hayes

Fax Number: 1-612-617-2166

Delivery Instructions: Urgent ✓ Routine

Comment:

CONFIDENTIAL INFO
The information contained in this transmission is c
designated recipient. If you receive this in error, pl
destroy this fax. Thank you for your cooperation.

Not for
OH

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Addendum 7

Temporary Permit Application

A temporary permit is available for physicians who have applied for permanent licensure and have complied with all requirements and wish to practice prior to the next regularly scheduled Board meeting. Upon request, a temporary permit will be issued after eligibility for licensure has been established and the credentialing and verification process has been completed. This process may take several weeks. The Board may, at its discretion, issue a temporary permit under the above conditions. A temporary permit is valid only until the next Board meeting at which your application would be considered.

Applicants requesting a temporary permit must complete this form and submit a non-refundable $60 fee in U.S. currency. Please make checks payable to the **Minnesota Board of Medical Practice**.

Name (please print) _____

Temporary Permit will be used at the following proposed practice location:

_____
(Hospital/Clinic)

_____
(Address)

_____
(City, State, Zip Code)

Professional telephone number (including area code) _____

Anticipated date of commencing practice at proposed location: _____

Mailing address for temporary permit:

_____

_____

_____

_____

UPMC

Practice/ Office Name

Department of OBGYN, Magee Womens Hospital
300 Halket Street, Pittsburgh, PA 15213
Fax: 412-641-1133 Phone:

Fax

To: pat &/or paul **From:** C Boraas

Fax: 612 617 2166 **Pages:** 5 **including cover sheet**

Phone: **Date:** 6/24/14

Re: MD license application **CC:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

verification of OH training license

• IF YOU DO NOT RECEIVE ALL PAGES AS INDICATED ABOVE, PLEASE CONTACT US IMMEDIATELY.

"THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY PENNSYLVANIA LAW AND FOR DRUG AND/OR ALCOHOL INFORMATION, IS ALSO PROTECTED BY 4 PA. CODE 255.5(b) AND FEDERAL LAW (42 CFR PART 2). PENNSYLVANIA AND FEDERAL LAWS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR IS AUTHORIZED BY THE CONFIDENTIALITY OF HIV-RELATED INFORMATION ACT OR BY 4 PA. CODE 255.5 (b) AND 42 CFR PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF DRUG AND/OR ALCOHOL INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE"

OHIO License CENTER

Identification Information	[back]
Name	Dr. Christy Marie Boraas Alsleben Birth Date [redacted]978 Birth Place: Willmar, MN Birth Country:
Practice	No address information on file.
Residence	Columbus, OH 43204 County: Franklin
Professional Education	School: 024030-University of Minnesota Medical School - Minneapolis Graduated: 5/3/2008

License and Registration Information

Credential	License Type	Initial Licensure Date	Expiration Date	Status
35	Doctor of Medicine			Fee Not Received
57.014608	MD Training Certificate	07/28/2008	06/29/2012	INACTIVE

Specialties

OBSTETRICS & GYNECOLOGY

Specialty listings are voluntarily provided by the physician. They are not verified by the State Medical Board and do not confirm that the physician is Board certified by a professional specialty organization. To find out if a physician is certified by a specialty board, you should contact that board. Information and links to specialty boards can be found by clicking this green box.

Formal Action Information

No formal action exists.

The above is an accurate representation of information currently maintained by the State Medical Board of Ohio as of 6/24/2014. The JCAHO and the NCQA have informed the Board that they consider this on-line license status

information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards. This information is otherwise provided as a public service and no user may claim detrimental reliance thereon.

The State Medical Board utilizes the Federation Credentials Verification Service (FCVS) as an agent and partner in licensing physicians in Ohio. Physicians initially licensed in Ohio after February 1st, 1997 have had their medical education, post-graduate training and examination history primary source verified by FCVS. Therefore, the use of this website for documentation of primary source verification (PSV) of education and training meets current NCQA guidelines for those licensed after February 1, 1997. This statement, affirming that primary source verification of medical education and post-graduate training has been performed as part of the licensure process, should be printed out and retained in your files. Prior to February 1, 1997, the State Medical Board prime source verified the post-graduate training and examination history.

OHIO License CENTER

Task List
- Start Instructions
- Name
- License Number
- Verification Destination
- Completion Instructions
- Review
- Payment

- **Comments?**

Once your credit card has cleared, you will be notified of your registration with the OHDAS.

Please print a copy for your records.

Record of Receipt

Medical Board - VER.Verification of license

Authorization succeeded

You will be charged a registration fee of $50.00.

Please print a copy for your records.

Contact Information:

Name:	Christy Boraas Alsleben
Address:	7210 Whipple St
City, State, Zip:	Pittsburgh, PA, 15218
Phone:	(555) 555-5555
Email:	cboraas@gmail.com

Order Information:

Order Number: 286319

Item	Desc	Amount
286319.1	Application Fee for VER.Verification of license	50.00
286319.2	Surcharge Fee for VER.Verification of license	0.00
	Total	50.00

Credit Information:

Card Number:	
Expiration Date:	/
Transaction Amount:	50.00
Approval Code:	745184

We welcome your comments
Was this site helpful? Please let us know. **Click here to leave a comment**

Print Receipt | Complete Application

Once your credit card has cleared, you will be notified of your registration with the OHDAS.

Please print a copy for your records.

Record of Receipt

Medical Board - VER.Verification of license

Authorization succeeded

You will be charged a registration fee of $50.00.

Please print a copy for your records.

Contact Information:

Name:	Christy Boraas Alsleben
Address:	7210 Whipple St
City, State, Zip:	Pittsburgh, PA, 15218
Phone:	(555) 555-5555
Email:	cboraas@gmail.com

Order Information:

Order Number: 286319

Item	Desc	Amount
286319.1	Application Fee for VER.Verification of license	50.00
286319.2	Surcharge Fee for VER.Verification of license	0.00
	Total	50.00

Credit Information:

Card Number:	
Expiration Date:	/
Transaction Amount:	50.00
Approval Code:	745184

Print Receipt

MINNESOTA BOARD OF MEDICAL PRACTICE

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May 21, 2014

Christy Marie Boraas, M.D.
7210 Whipple Street
Pittsburgh, PA 15218

Dear Dr. Boraas:

This letter acknowledges receipt of your application to practice medicine in Minnesota. The Board meeting at which your application may be considered for permanent licensure is September 13, 2014. The following item(s) are needed to complete your file:

- Direct verification of USMLE exam scores, medical school, all medical training and OH and PA state medical licenses/permits
- Copy of medical school diploma and first year medical training certificate
- Notarized NPDB self-query disclosure report
- Completed malpractice history report form (enclosed)

Your file must be complete at least three weeks prior to the Board meeting date.

Address changes must be made in writing to the Board office. Submit a signed address change request to the above address. A certified package, containing your medial license card, wall certificate, etc. will be mailed to you approximately two weeks after the Board meeting date. The above address will become public information upon issuance of a permanent medical license.

If needed, additional application forms can be found on our website at www.bmp.state.mn.us.

Sincerely,

Pat Hayes
Licensure Specialist

ph

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September 16, 2014

Christy Marie Boraas, M.D.
7210 Whipple Street
Pittsburgh, PA 15218

RE: License to Practice Medicine

Dear Dr. Boraas:

Congratulations!

Your application for medical licensure in Minnesota was approved by the Board of Medical Practice September 13, 2014. You have been issued Minnesota medical license number 58304 effective September 13, 2014.

Your license expires the last day of your birth month unless your birth month is less than 6 months from the first day of the month issued, in which case it expires in your birth month of the following year. The first renewal fee will be prorated to reflect this conversion. Thereafter, the renewals will take place annually based on your birth month.

Enclosed are certificates indicating the effective dates of your Minnesota medical license. It may also be used as identification, as it carries your license number and current address.

We remind you that Minnesota rules require a licensee to submit written notice to the Board within thirty (30) days of an address or name change.

Sincerely,

Ruth M. Martinez
Executive Director

Enclosures

MINNESOTA BOARD OF MEDICAL PRACTICE

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

July 7, 2014

Christy M. Boraas, M.D.
4624 Vallacher Ave
St. Louis Park, MN 55416

Dear Dr. Boraas:

We have received your application for Minnesota medical licensure, required supporting documentation, application fee and an additional remittance with a request for a Temporary Permit. Both fees, under Minnesota Statute, are non-refundable.

The Board will next consider candidates at the September 13, 2014 Board meeting.

Your application and supporting materials have been reviewed. You are hereby granted TEMPORARY PERMIT 107714 on July 3, 2014 to practice medicine in the State of Minnesota. Once approved, your permanent license will become effective September 13, 2014.

Temporary Permits are only issued once and are valid only until the next scheduled Board meeting date.

Sincerely,

Robert A. Leach
Executive Director

RAL: PEL

Temporary Permit Number: 107714

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60

MN BOARD OF MEDICAL PRACTICE
JUN - 2 2014

447-11

Addendum 7

Temporary Permit Application

A temporary permit is available for physicians who have applied for permanent licensure and have complied with all requirements and wish to practice prior to the next regularly scheduled Board meeting. Upon request, a temporary permit will be issued after eligibility for licensure has been established and the credentialing and verification process has been completed. This process may take several weeks. The Board may, at its discretion, issue a temporary permit under the above conditions. A temporary permit is valid only until the next Board meeting at which your application would be considered.

Applicants requesting a temporary permit must complete this form and submit a non-refundable $60 fee in U.S. currency. Please make checks payable to the **Minnesota Board of Medical Practice**.

Name (please print) Boraas, Christy M

Temporary Permit will be used at the following proposed practice location:

Planned parenthood St. Paul Health Center
(Hospital/Clinic)

671 Vandalia Street
(Address)

St. Paul, MN 55114
(City, State, Zip Code)

Professional telephone number (including area code) [redacted]

Anticipated date of commencing practice at proposed location: September 2, 2014

Mailing address for temporary permit:

after July 1, 2014

[redacted]

until July 1, 2014: 7210 Whipple Street
Pittsburgh, PA 15218