☐ PHYSICIAN TO APPEAR

☐ EXAMINATION ☑ ENDORSEMENT

16216
LICENSE NUMBER

3/29/18
ISSUE DATE

Sarah A. Traxler
PHYSICIANS NAME

APPLICATION RECEIVED 2/2/18 DATE FEE RECEIVED 2/2/18 DATE

NATIONAL PRACTITIONER DATA BANK SELF-QUERY ☑

06G
SPECIALTY CODE

STATE LICENSURE VERIFIED MN ND PA

FCVS APPLICATION ☐

==========

LICENSING COMMITTEE

HELEN DREW

STEVEN BLAZAR MD

JAMES GRIFFIN DO

CHIEF ADMINISTRATIVE OFFICER

JAMES MCDONALD MD

☑ APPROVED 3/27/18
DATE OF APPROVAL

☐ DENIED
DATE OF DENIAL

==========

☐ EMAILED PHYSICIAN OF OUTSTANDING CREDENTIAL(S) _____

CREATED BY AP

| ***FOR OFFICE USE ONLY*** | |
|---|---|
| | RECEIVED FEB 0 3 2021 PROCESSED |
| Receipt # | 565862 |
| ID # | 565862 |
| Issue Date | |
| License # | |

endorsement

# Rhode Island
# Board of Medical Licensure and Discipline

Room 205
3 Capitol Hill
Providence, RI 02908-5097

## Instructions and License Application for:

- [x] Allopathic Medicine
- [ ] Osteopathic Medicine
- [ ] Academic Faculty (Limited Medical Registration)
- [ ] Temporary Post Graduate – Allopathic Medicine

  PGY 2 _____ PGY 3 _____

- [ ] Temporary Post Graduate – Osteopathic Medicine

  PGY 2 _____ PGY 3 _____

Sarah Ann Traxler, MD

*Applicant – Print/Type Name (First/MI/Last)*

- [ ] I am also applying for a RI Uniform Controlled Substance Registration (CSR) and I have attached the CSR application to this license application.

**Phone: (401) 222-3855** **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

**Rhode Island Board of Medical Licensure and Discipline**
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

**ADDENDUM 2**
**Additional Physician Information**

Complete each section as instructed.

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1. **Specialty of Practice**: Refer to the ABMS Certification Codes List (pages 4 and 5 of this addendum) when completing this section. You must provide a copy of your ABMS certificate(s). You may report "None", "Other", or "Unknown" if necessary.

ObG
Primary Specialty Code — Board Certified? ☑ Yes ☐ No
If Yes, Year Certified/Recertified: _____

_____
Secondary Specialty Code — Board Certified? ☐ Yes ☐ No
If Yes, Year Certified/Recertified: _____

_____
Secondary Specialty Code — Board Certified? ☐ Yes ☐ No
If Yes, Year Certified/Recertified: _____

_____
Secondary Specialty Code — Board Certified? ☐ Yes ☐ No
If Yes, Year Certified/Recertified: _____

2. **Practice Information**: Specify where in this State do you intend to practice, and list type of practice using the codes below. (If additional space is needed, attach a separate sheet)

ACD = Academia
ADM = Administration
FTY = Faculty
FEL = Fellowship
GRP = Group
HSP = Hospital
HMO = HMO
OFC = Office
RES = Research
OTH = Other

Location #1: Planned Parenthood 671 Vandalia Street
City: Saint Paul, Minnesota 55114 Practice Type (See Code): OFC

Location #2: _____
City: _____ Practice Type (See Code): _____

Location #3: _____
City: _____ Practice Type (See Code): _____

Identify any translational services that may be available at your primary practice location: _____

3. **Medical School Faculty Appointments**: Identify any appointments to medical school faculties and indicate as to whether you have had responsibility for graduate medical education within the most recent ten (10) years.
Adjunct Assistant Professor, Univ of MN Medical School – current
Instructor in OB/GYN, Univ of PA School of Medicine – 2014-2015
I had the responsibility for graduate medical education @ both institutions.

4. **Medical Licensure**: List all countries (other than the U.S. and Canada) in which you are now, or ever have been licensed to practice medicine, or any other profession.

South Dakota — ☑ Active ☐ Inactive
Country
Minnesota — ☑ Active ☐ Inactive
Country
North Dakota — ☑ Active ☐ Inactive
Country

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

September 21, 2016

Sarah Ann Traxler, M.D.
[redacted]

Dear Doctor:

Congratulations! I am pleased to inform you that you have satisfactorily completed the 2016 Maintenance of Certification assignments.

As of this date, you have earned 25 AMA Category 1 CME credits for completion of the 2016 Part II MOC requirements. These will be awarded by the American College of Obstetricians and Gynecologists.

You should have received a 2016 MOC label insert from Jim Henry, Inc. within 60 days from the time of your MOC application.

Your certification in Obstetrics and Gynecology is valid through 12/31/2017. The ABOG MOC program is a continuous certification process, and you must participate each year. The application for the 2017 program will be available through your ABOG Member Login page beginning January 7, 2017.

Please use this letter to provide documentation of your certification for your hospital(s).

Sincerely yours,

[redacted]

George D. Wendel, Jr. M.D.
Director of Maintenance of Certification

GDW

ABOG ID: 9030498



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A founding member of The American Board of Medical Specialties
www.abog.org

5. **Board Discipline**: List any disciplinary actions by licensing boards in other states. Please describe any prior or pending Board action or investigation. Please attach any relevant supplemental materials. If necessary, you may continue on a separate sheet.

☒ Check here if not applicable

| Licensing Board (abbreviate) and Nature of Action (e.g. TX – Professional Misconduct): | Month/Year | Type of Discipline: |
|---|---|---|
| | ___/___ | |
| | ___/___ | |
| | ___/___ | |
| | ___/___ | |
| | ___/___ | |

6. **Hospital Discipline**: Please explain any disciplinary actions and attach any relevant supplements materials. List any revocation of hospital privileges for reasons related to competence or quality of patient care that have been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded. Also, report resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course or threat of investigation. If necessary, you may continue on a separate sheet.

☒ Check here if not applicable

(1) Name of Hospital

___/___/___ Month Day Year — Type of Action

(2) Name of Hospital

___/___/___ Month Day Year — Type of Action

(3) Name of Hospital

___/___/___ Month Day Year — Type of Action

(4) Name of Hospital

___/___/___ Month Day Year — Type of Action

7. **Criminal Convictions**: Respond to the questions below, then list any criminal convictions(s) in the space provided. If necessary, you may continue on a separate sheet.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, or ordinance, or are any formal charges pending; including use of illicit substances or operating a motor vehicle while intoxicated (Please include any offenses which have been expunged from your record)? ☐ Yes ☒ No

| Abbreviation of State and Conviction* (e.g.CA – Illegal possession of a controlled substance) | Month/Year |
|---|---|
| | ___/___ |
| | ___/___ |
| | ___/___ |
| | ___/___ |

*For purposes of this section, a person shall be deemed to be convicted of a crime if he/she please guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

8. **Questions**: Check either "Yes" or "No" for each question below. **Note: if you answer "Yes" to any question**, you are required to furnish complete details, including date, place, reason and disposition of the matter on a separate sheet.

| | | YES | NO |
|---|---|---|---|
| 1. | During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? | ☐ | ☒ |
| 2. | During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training? | ☐ | ☒ |
| 3. | During any Post Graduate Training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons? | ☐ | ☒ |
| 4. | During any post graduate training, were you ever requested to leave or did you leave temporarily or permanently, prior to completion of training? (excluding maternity leave) | ☐ | ☒ |
| 5. | Are there any charges or investigations pending, in any state, against you? | ☐ | ☒ |
| 6. | Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? | ☐ | ☒ |
| 7. | Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state? | ☐ | ☒ |
| 8. | Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation? | ☐ | ☒ |
| 9. | Have you ever failed to pass an examination for medical licensure (including National Boards, FLEX, USMLE)? If you have failed to pass any segment of the USMLE within three (3) attempts you do not meet the requirements for licensure. Please contact us at (401) 222-3855 to discuss. | ☐ | ☒ |

9. **Physician Honors and Peer-Reviewed Publications (Optional)**: List any information regarding professional or community service awards and/or information regarding publication in peer-reviewed medical literature within the last ten (10) years. Do **not** submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

Awards, Honors:

_____

_____

_____

Publications:

_____

_____

_____

10. **Professional and Community Memberships (Optional):** List any professional and community memberships. Do **not** submit your curriculum vitae to satisfy the requirements of this section. If necessary, you may continue on a separate sheet.

_____

_____

_____

PLANNED PARENTHOOD MINNESOTA, NORTH DAKOTA, SOUTH DAKOTA
Curriculum Vitae

Date: 11/01/2017

Sarah Ann Traxler, MD, MS, FACOG

Address: Planned Parenthood Minnesota, North Dakota, South Dakota
[redacted]

If you are not a U.S. citizen or holder of a permanent visa, please indicate the type of visa you have:
none (U.S. citizen)

Education:

| | | |
|---|---|---|
| 2015 | M.S.H.P. | University of Pennsylvania, Perelman School of Medicine Philadelphia, Pennsylvania (Health Policy Research) |
| 2009 | M.D. | Oregon Health and Science University, Portland, Oregon |
| 1997 | B.A. | Newcomb College, Tulane University, New Orleans, Louisiana (Spanish and Latin American Studies – *cum laude*) |
| 1995 | | Universidad de Madrid, Madrid, Spain (Spanish) |

Postgraduate Training and Fellowship Appointments:

| | |
|---|---|
| 2013-2015 | Fellow, Contraceptive Research and Family Planning University of Pennsylvania, Department of Obstetrics and Gynecology, Philadelphia, Pennsylvania |
| 2009-2013 | Resident, Obstetrics and Gynecology, University of Minnesota, Minneapolis, Minnesota |

Institutional Appointments:

| | |
|---|---|
| 5/2017-present | Medical Director<br>Planned Parenthood Minnesota, North Dakota, South Dakota, Saint Paul, MN |
| 8/2015-5/2017 | Associate Medical Director<br>Director of Family Planning Services<br>Planned Parenthood Minnesota, North Dakota, South Dakota, Saint Paul, MN |
| 2015-present | Adjunct Assistant Professor<br>University of Minnesota Medical School |

| | |
|---|---|
| 2014-2015 | Instructor in Obstetrics and Gynecology, University of Pennsylvania School of Medicine, Philadelphia, PA, University of Pennsylvania |

Hospital and/or Administrative Appointments:

| | |
|---|---|
| 2016-present | Medical Staff<br>Obstetrics, Gynecology, and Women's Health<br>University of Minnesota Medical Center, Minneapolis, MN |
| 2014-2015 | Attending in Obstetrics and Gynecology, Hospital of the University of Pennsylvania, Department of Obstetrics and Gynecology, Philadelphia, PA |

Specialty Certification:

| | |
|---|---|
| 2015, current | Diplomate, American Board of Obstetrics and Gynecology |

Licensure:

| | |
|---|---|
| 2015-present | Minnesota Medical Licensure |
| 2015-present | South Dakota Medical Licensure |
| 2016-present | North Dakota Medical Licensure |

Awards, Honors and Membership in Honorary Societies:

| | |
|---|---|
| 2008 | The Robert H. Kaplan Resident Award for outstanding diagnostic and technical skills in obstetrics and gynecology |
| 2009 | The Laura Edwards Resident Award for excellence in obstetrics and gynecology |
| 2016-present | Disparities Leadership Program |

Memberships in Professional and Scientific Societies and Other Professional Activities:

| | |
|---|---|
| 2004-2009 | Medical Students for Choice (Student Leader) |
| 2004-2012 | American Medical Association |
| 2006-present | American Congress of Obstetricians and Gynecologists<br>(Physician Member, Junior Fellow (2006-2015), Fellow (2015-present) |
| 2014-present | Society of Family Planning |
| 2014-present | Physicians for Reproductive Health |

| | |
|---|---|
| 2014- present | Association of Reproductive Health Professionals |
| 2014-present | National Abortion Federation |
| 2014-present | Leonard David Institute of Health Economics (fellow) |
| 2015-present | Minnesota Medical Association |
| 2015-present | Twin Cities Medical Society |

Academic and Institutional Committees:

| | |
|---|---|
| 2016-present | Transgender Health Services Leadership Team<br>Medical Lead, Executive Sponsor |
| 2017-present | PrEP Leadership Team<br>Executive Sponsor |
| 2015-present | Outpatient Miscarriage Management Project<br>MD Lead and Clinician Trainer |
| 2015-present | LGBTQ Clinical Services Committee |
| 2015-present | Clinical Research Committee |

Lectures by Invitation:

| | |
|---|---|
| Feb, 2014 | Penn Nursing Students for Choice, Speaker, "Abortion 101: Procedural Basics" |
| Feb, 2014 | Hospital of The University of Pennsylvania Department of Obstetrics and Gynecology Grand Rounds: "Is Depo-Provera a safe contraceptive for adolescents: a debate regarding bone health" |
| Mar, 2014 | Penn Nursing Students for Choice, Speaker, Trainer: "Manual Vacuum Aspiration and IUD Placement" |
| Apr, 2014 | Speaker, Medicine-Pediatrics Residency Didactic, Philadelphia, PA: "Issues in Reproductive Healthcare: Women with Intellectual and Developmental Disabilities" |
| May, 2014 | Speaker, Mid-Atlantic Cystic Fibrosis Research Consortium, Villanova, PA: "Contraceptive Hormones and Women with Cystic Fibrosis" |
| June, 2014 | Family Planning Council Annual Meeting Breakout Session, Philadelphia, PA: "Providing Long-Acting Reversible Contraception to Young Women" |
| Oct, 2014 | Grand Rounds Speaker, University of Nebraska, Omaha, NE: "Contraception in the Adult Cystic Fibrosis Population" |

| | |
|---|---|
| Dec, 2014 | Division of Pulmonology, Children's Hospital of Pennsylvania: "Contraception, Abortion and Early Pregnancy Failure" |
| Mar, 2015 | Temple University Law Students for Reproductive Justice, panel speaker: "Provider Perspectives" |
| Mar, 2015 | Penn Nursing Students for Choice, Speaker, Trainer: "Manual Vacuum Aspiration and IUD Placement" |
| Apr, 2015 | Medical Students for Choice Annual Meeting Philadelphia, PA: "Products of Conception and Post Procedure Care" |
| Apr, 2015 | Hospital of The University of Pennsylvania Department of Obstetrics and Gynecology Resident Didactic: "Abortion Complications" |
| Apr, 2015 | Hospital of the University of Pennsylvania Department of Obstetrics and Gynecology Resident Didactic: "Cancer and Contraceptive Hormones" |
| May, 2015 | Fellowship in Family Planning, National Meeting: "Family Planning in the Adult Cystic Fibrosis Population: Utilization, Preferences and Impact on Contraception Use" |
| Apr, 2016 | Women's Health OB/GYN Update, HealthPartners: "The Right Contraception: How to choose and how to start" |
| May, 2016 | Teen Pregnancy Prevention Month, Planned Parenthood: "Teen Pregnancy in the US: What it looks like and how to prevent it" |
| Sept, 2017 | Minnesota Reproductive and Sexual Health Update: "What's New in Contraception" & "Focusing on Contraception in Medically Complicated Women" |

Bibliography:

Research Publications, peer reviewed (print or other media):

1. O'Rourke RW, Kay T, Lyle EA, Traxler SA, Deveney CW, Jobe BA, Roberts CT Jr, Marks D, Rosenbaum JT. "Alterations in peripheral blood lymphocyte cytokine expression in obesity." *Clinical and Experimental Immunology*. 2006 Oct;146(1): 39-46.

2. Stanczyk M, Deveney CW, Traxler SA, McConnell DB, Jobe BA, and O'Rourke R. "Gastro-gastric Fistula in the Era of Divided Roux-en-Y Gastric Bypass: Strategies for Prevention, Diagnosis, and Management." *Obesity Surgery*. 2006 Mar;16(3): 359-364.

Research Publications, peer-reviewed reviews:

1. Roe A, Traxler S, Schreiber CA. "Contraception in Women with Cystic Fibrosis: A Systematic Review of the Literature," *Contraception.* 2016 Jan;93(1):3-10.

Abstracts:

1. Traxler S, Hadjiliadis D, Schreiber CA, Mollen C. "Understanding how women with cystic fibrosis make decisions about family planning." Poster presentation, American Society for Reproductive Medicine Annual Meeting. Baltimore, MD. October 2015.
2. Roe A, Traxler S Hadjiliadis D, Schreiber CA. "Contraceptive Needs and Preferences in a Cohort of Women with Cystic Fibrosis" Poster presentation, American College of Obstetrics and Gynecology Annual Meeting. San Francisco, CA. May 2015.

Editorials, Reviews, Chapters, including participation in committee reports (print or other media):

1. Schreiber, CA; Traxler SA: The State of Family Planning. *Clinical Obstetrics & Gynecology.* Rebekah Gee (eds.). Lippincott Williams & Wilkins, 2015.

UA | UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

# Affidavit and Authorization for Release of Information

Mail this completed notarized form to:

Rhode Island Board of Medical Licensure and Discipline
Room 205, 3 Capitol Hill; Providence, RI 02908-5097

**Applicant:**

Sign this form with attached photo in the presence of a notary public. Send this notarized form with any other required materials to the Board at the address listed above.

If you are using FCVS for credentials verification, you must also send the separate FCVS affidavit form to FCVS if you have not already done so.

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]

[redacted]

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

Traxler

Applicant's printed last name

Sarah A

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

12/29/2017

Date of signature (must correspond to date of notarization)

-fold up- -fold up-

*To fit this form in a standard envelope, fold the bottom portion under the photograph toward the top, and then fold the top edge to the new bottom edge.*

## Notary

State of Minnesota, County of Ramsey

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 29 day of December, 2017.

Notary Public Signature [redacted]

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: 1/31/2021

Elizbeth J K Janssen
NOTARY PUBLIC
MINNESOTA
My Commission Expires 1/31/2021

# Rhode Island Board of Medical Licensure and Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

MA

## ADDENDUM 4

**Rhode Island Uniform Controlled Substances Act Registration (CSR)**

IF Applying for CSR, this Application **MUST BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION.** Substitute forms are not acceptable.

---

I am applying for a Rhode Island Uniform Controlled Substance Act Registration (CSR). **I understand that this application MUST be submitted along with my Board Application. I also understand that there is an additional $200.00 fee for this Registration and that the check or money order for $1,290.00 (Non-Refundable Board Application fee ($1,090.00) PLUS CSR Application fee ($200.00) must be made out to the "RI General Treasurer." Note: To be issued a RI Controlled Substance Registration you must have a Rhode Island Business Address.**

Print/Type Full Name _____ Business Name _____

Signature _____ Business Address _____

Date _____ Business Telephone _____ Business Fax _____

Complete this application for registration to prescribe controlled substances in the State of Rhode Island.

A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.

The CSR is renewed at the same time that the professional license is renewed.

Note: Read important information on the bottom of this application.

The Rhode Island Uniform Controlled Substances Act can be accessed at the following web site:
http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm

**Drug Schedule (Check all that apply)**

☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V

**A Copy of the DEA Registration must be provided to the Medical Board within 60 Days of its issuance by the DEA.** The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See the bottom of this form for information on how to contact the DEA. *

All Applicants MUST answer the following:

A. Has the applicant been convicted of, or entered a plea of nolo contedere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? ☐ Yes ☐ No

B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United State or of any state relating to drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island, or is such action pending? ☐ Yes ☐ No

**If you answered "Yes" to question "A" or "B" attach an explanation to this form.**

**Important Information**

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "VOID." Licensed drug facilities and licensed practitioners with prescriptive privileges cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice." "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island CSR must be obtained prior to applying for DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospitals/Clinics, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following website: www.deadiversion.usdoj.gov./drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Bldg., 15 new Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV, and V cannot be written for more than one hundred (100) dosage units and not more than one hundred(100) dosage units may be dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet, or suppository, or not more that one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

**Rhode Island Board of Medical Licensure and Discipline**
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

**ADDENDUM 3**
**Mandatory Addendum to Licensure Application**
**Verification of Social Security Number**
**Tax Payer Status Affidavit / Identity Verification**

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

---

**Licensee Declaration**

☒ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case # _____)

☐ I am in state receivership. (Case # _____)

☐ I have been discharged from bankruptcy. (Case # _____)

Allopathic Medicine
Type of Professional License for which you are applying.

Sarah Traxler
Full Name (Please Print or Type)

[redacted]
Social Security Number

[redacted]
Signature

[redacted]
Phone Number

12/5/17
Date

This form must be completed, signed and attached to your license application for processing.

Applicant Name: Sarah Ann Traxler
Rhode Island Board of Medical Licensure and Discipline

Date: 1/16/18

**Rhode Island Board of Medical Licensure and Discipline**
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

## ADDENDUM 5
**Voluntary Race/Ethnicity Questions**

This information is completely voluntary and will NOT affect your Application in any way.

---

Note: This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.

For purposes of the above questions kindly use the "Federal Minimum Data Collection" explanations listed below:

1. **Ethnic Categories:**

   **Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish Origin" can be used in addition to "Hispanic or Latino."

   **Not Hispanic or Latino** – A person who is not Hispanic or Latino.

2. **Racial Categories:**

   **American Indian or Alaska Native** – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

   **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

   **Black or African American** – A person having origins in any of the Black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

   **Native Hawaiian or other Pacific Islanders** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

   **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

* This information is being collected in accordance with the Department of Health's policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.

Complete if necessary

# *Malpractice Litigation and Professional Complaints Addendum*

Confidential Information

If you answered yes to disclosure question #12 on Current Disclosure question page, please complete the following form. For each lawsuit or complaint, please furnish the following and attach a copy of the complaint including your response to the complaint and level of participation. It is your responsibility to provide external verification (i.e., statement from an attorney, court records, etc.) of your response. You may choose to have your attorney complete this form. Please make additional copies of this form if needed.

[redacted]

STAT MedCare Solutions, LLC

1/24/2018

Rhode Island Department of Health
Board of Medical Licensure & Discipline
Room 205
Three Capitol Hill
Providence, RI 02908-5097

RE: Sarah Traxler, MD

To whom it may concern:

Please find enclosed an application for a Medical License for Sarah Ann Traxler, MD along with the $1090 application fee.

Dr. Traxler has given me the authorization to handle all communications directly with the Rhode Island Medical Licensing Board. I have enclosed the authorization form.

All other supporting documents/verifications will be sent to you directly from the designated authorities.

Please contact me with any discrepancies or questions you might have.

Sincerely,

[redacted]

Sonja Deckelman-Klinke, CPCS, CPMSM
Provider Enrollment Specialist III
Cell: 706-414-9706
Fax: 706-432-1020
Email: sdeckelman-klinke@statmedcaresolutions.com

# AUTHORIZATION FOR THIRD PARTY CONTACT

Provider Name: SARAH TRAXLER

Phone Number: [redacted]

SSN: [redacted] Date of Birth: [redacted]

Email: [redacted]

I, Sarah Traxler, hereby authorize the following person/business to communicate with the licensing board regarding my application for initial licensure. I understand that information received from the person or business listed below shall be binding and that I will be responsible for the accuracy of all information and documents received as part of my application for initial licensure. This authorization shall expire upon issuance of the license, referral to enforcement or expiration of the application.

Name of authorized representative: Sonja Deckelman-Klinke
Phone: 706-414-9706
Email: sdeckelman-klinke@statmedcaresolutions.com

[redacted]
Applicant Signature

11/22/17
Date

# Uniform Application for Licensure

**Application ID:** 237781
**FID:** 215185042
**License Requested:** MD
**Submitted to:** Rhode Island Board of Medical Licensure and Discipline
**Submission Date:** 12/07/2017

## Practitioner Name

**Traxler, Sarah Ann**

## Contact Information

Address

| Public Access | Board Contact | Type | Address |
|---|---|---|---|
| Yes | Yes | Business | [redacted]<br>UNITED STATES |

Phone

| Public Access | Board Contact | Type | Phone Number | Phone Extension |
|---|---|---|---|---|
| Yes | Yes | Business | [redacted] | |

Email

| Public Access | Board Contact | Email |
|---|---|---|
| Yes | Yes | [redacted] |

## Identification

| USMLE Number | SSN | Birth Date | Birth Place | Gender | NPI | Practitioner Type | US Citizen |
|---|---|---|---|---|---|---|---|
| 51691764 | [redacted] | [redacted] | [redacted] | [redacted] | 1538301650 | MD | Yes |

## Medical School

| Medical School Name | Address | Start Date | End Date | Graduation Date | Degree Code |
|---|---|---|---|---|---|
| Oregon Health and Science University School of Medicine | 3181 S.W. Sam Jackson Park Road<br>Portland, OR 97239<br>UNITED STATES | 08/01/2004 | 06/04/2009 | 06/04/2009 | MD |

## Fifth Pathway

None Reported

## ECFMG

| Certificate Number | Issue Date |
|---|---|
| None Reported | |


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## Postgraduate Training

| | | | |
|---|---|---|---|
| **Hospital Name:** | **University of Minnesota Program**<br>Minneapolis, MN UNITED STATES | **Program Code:** | ACGME 2202621149 |
| | | **Attendance Dates:** | |
| **Institution:** | University of Minnesota Medical School | **Start Date:** | 06/07/2009 |
| **Training Specialty:** | Obstetrics & Gynecology | **End Date:** | 06/07/2013 |
| | | **Program Type:** | Residency |
| **Training Status:** | Completed | | |

| | | | |
|---|---|---|---|
| **Hospital Name:** | **University of Pennsylvania**<br>Philadelphia, PA UNITED STATES | **Program Code:** | |
| | | **Attendance Dates:** | |
| **Institution:** | Perelman School of Medicine | **Start Date:** | 07/01/2013 |
| **Training Specialty:** | Family Planning | **End Date:** | 06/30/2015 |
| | | **Program Type:** | Fellowship/Research |
| **Training Status:** | Completed | | |

## Examination History

| Exam | State | Last Attempt | Pass/Fail | Number Of Attempts |
|---|---|---|---|---|
| USMLE Step 1 Examination | | 06/15/2006 | Pass | 1 |
| USMLE Step 2 CK Examination | | 06/18/2007 | Pass | 1 |
| USMLE Step 2 CS Examination | | 01/24/2009 | Pass | 1 |
| USMLE Step 3 Examination | | 10/18/2010 | Pass | 1 |

## State Licensure History

MD, DO, PA License History

| License Entity | Licensing State | License Number | Issue Date | Expiration Date | License Type | License Status |
|---|---|---|---|---|---|---|
| South Dakota Board of Medical & Osteopathic Examiners | SD | | | 03/01/2018 | Full | Active |
| North Dakota Board of Medicine | ND | 14130 | 07/22/2016 | 05/10/2018 | Full | Active |
| Minnesota Board of Medical Practice | MN | 59828 | 09/12/2015 | 05/31/2018 | Full | Active |
| Pennsylvania State Board of Medicine | PA | MD447970 | 02/27/2013 | 12/31/2016 | Full | Expired |

Physician Reported License History

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


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## Chronology of Activity Type

**Practice/Emp/ Desc:** Planned Parenthood MN, ND, SD
**Chronology Type:** Work

**Address:** 671 Vandalia Street
Saint Paul, MN 55114
US

**Attendance Dates:**

**Position/Dept:** Medical Director - Clinical Operations

**Start Date:** 05/15/2017

**End Date:** In Progress

**Clinical %:** 60

**Admin %:** 40

**Employment:** **Staff Privileges:** **Affiliation:**

---

**Practice/Emp/ Desc:** Planned Parenthood MN, ND, SD
**Chronology Type:** Work

**Address:** 671 Vandalia Street
Saint Paul, MN 55114
US

**Attendance Dates:**

**Position/Dept:** Associated Medical Director - Clinical Operations

**Start Date:** 08/15/2015

**End Date:** 05/14/2017

**Clinical %:** 80

**Admin %:** 20

**Employment:** **Staff Privileges:** **Affiliation:**

---

**Practice/Emp/ Desc:** N/A
**Chronology Type:** Vacation

**Address:**

**Attendance Dates:**

**Position/Dept:**

**Start Date:** 07/01/2015

**End Date:** 08/14/2015

**Clinical %:** 0

**Admin %:** 0

**Employment:** **Staff Privileges:** **Affiliation:**

---

**Practice/Emp/ Desc:** University of Pennsylvania
**Chronology Type:** Other Training

**Address:** Philadelphia, PA
US

**Attendance Dates:**

**Position/Dept:**

**Start Date:** 07/01/2013

**End Date:** 06/30/2015

**Clinical %:**

**Admin %:**

**Employment:** **Staff Privileges:** **Affiliation:**

---

**Practice/Emp/ Desc:** University of Minnesota Program
**Chronology Type:** Accredited Training


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**Address:** Minneapolis, MN
US

**Attendance Dates:**

**Position/Dept:**

**Start Date:** 06/07/2009

**End Date:** 06/07/2013

**Clinical %:**

**Admin %:**

**Employment:** **Staff Privileges:** **Affiliation:**

---

**Practice/Emp/ Desc:** **Oregon Health and Science University School of Medicine**

**Chronology Type:** Medical Education

**Address:** Portland, OR
US

**Attendance Dates:**

**Position/Dept:**

**Start Date:** 08/01/2004

**End Date:** 06/04/2009

**Clinical %:**

**Admin %:**

**Employment:** **Staff Privileges:** **Affiliation:**

[redacted]


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PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

## PRACTITIONER PROFILE

| | | |
|---|---|---|
| Prepared for: | Uniform Application for Physician State Licensure | As of Date:12/7/2017 |

### PRACTITIONER INFORMATION

| | |
|---|---|
| Name: | Traxler, Sarah Ann |
| DOB: | [redacted] |
| Medical School: | Oregon Health and Science University School of Medicine Portland, Oregon, UNITED STATES |
| Year of Grad: | 2009 |
| Degree Type: | MD |
| NPI: | 1538301650 |

### BOARD ACTIONS

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

### LICENSE HISTORY

| Jurisdiction | License Number | Issue Date | Expiration Date | Last Updated |
|---|---|---|---|---|
| MINNESOTA | 59828 | 9/12/2015 | 5/31/2018 | 12/6/2017 |
| NORTH DAKOTA | 14130 | 7/22/2016 | 5/10/2018 | 11/16/2017 |
| PENNSYLVANIA | MD447970 | 2/27/2013 | 12/31/2016 | 5/15/2017 |
| SOUTH DAKOTA | | | 3/1/2018 | 10/27/2017 |



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PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

## PRACTITIONER PROFILE

Prepared for: Uniform Application for Physiciah State Licensure

As of Date:12/7/2017

Practitioner Name: Traxler, Sarah Ann

**ABMS® CERTIFICATION HISTORY**

Certifying Board: American Board of Obstetrics and Gynecology
Certificate: Obstetrics and Gynecology
Certification Type: General
Certification Status: Certified
Participating in MOC: Yes

| Status | Duration | Effective Date | Expiration Date | Reverification Date | Occurrence | Last Reported |
|---|---|---|---|---|---|---|
| Active | Time Limited | 12/31/2017 | 12/31/2018 | | Recertification | 12/6/2017 |
| Active | Time Limited | 12/31/2016 | 12/31/2017 | | Recertification | 12/6/2017 |
| Expired | Time Limited | 12/11/2015 | 12/31/2016 | | Initial | 12/6/2017 |

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NATIONAL PRACTITIONER DATA BANK

# NPDB

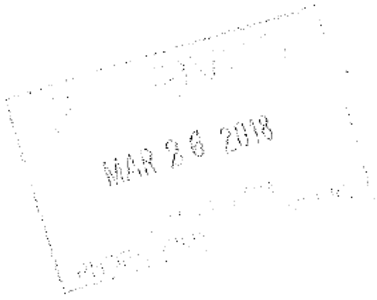
P.O. Box 10832
Chantilly, VA 20153-0832

https://www.npdb.hrsa.gov

5500000131951408
Process Date: 03/26/2018
Page: 1 of 1

**To:** TRAXLER, SARAH ANN

[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.

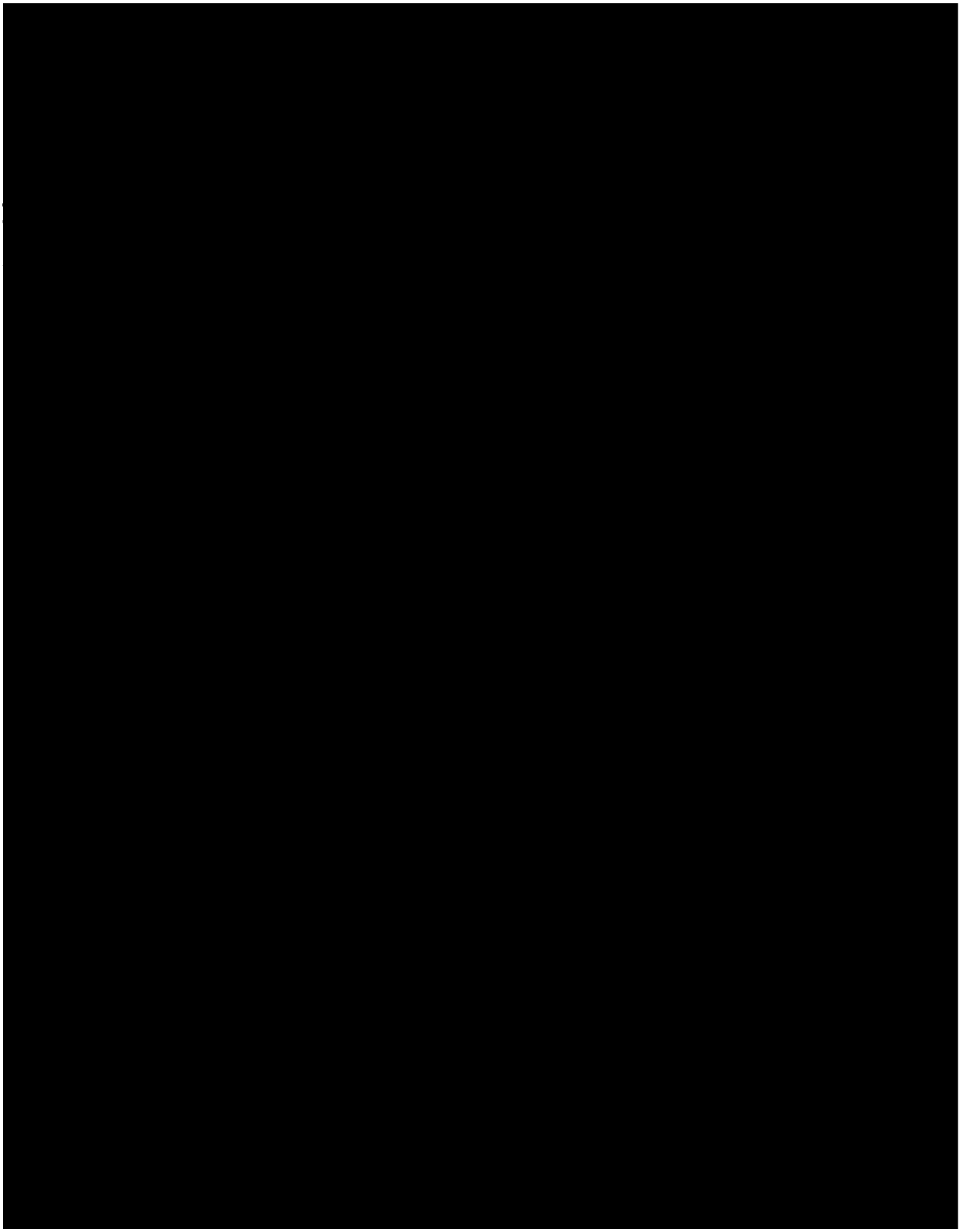
Section 1128E of the Social Security Act was added by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996. The statute established a national data collection program (formerly known as the Healthcare Integrity and Protection Data Bank) to combat fraud 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 (https://www.npdb.hrsa.gov) or contact the NPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB Customer Service Center is closed on all Federal holidays.



CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

# NORTH DAKOTA
# BOARD OF MEDICINE

Established 1890

418 E Broadway Ave, Suite 12 - Bismarck, ND 58501-4086
Phone (701) 328-6500 - Fax (701) 328-6505
www.ndbom.org

Bonnie Storbakken
Executive Secretary

Lynette McDonald
Deputy Executive Secretary


December 20, 2017

This is to certify that a standard search of the available records of the North Dakota Board of Medicine indicates the following:

| | |
|---|---|
| **PHYSICIAN:** | Sarah Ann Traxler, MD |
| **DATE OF BIRTH:** | [redacted] |
| **LICENSE NUMBER:** | 14130 |
| **DATE ISSUED:** | 07/22/2016 |
| **EXPIRATION DATE:** | 05/10/2018 |
| **STATUS:** | Active - Unconditioned |
| **BASIS OF ISSUANCE:** | USMLE - Step 1, 2, 3 |
| **DISCIPLINARY ACTION:** | No |

This license information was last updated on: 12/18/2017

If our records above show that the license has been disciplined, photocopies from the public file are available upon written request.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this board.

Sincerely,

[redacted]

Bonnie Storbakken
Executive Secretary

# 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*


January 24, 2018

Rhode Island Board of Medical Licensure and Discipline
Cannon Building
Three Capitol Hill, Room 205
Providence, RI 02908-5097

This is to certify that a standard search of the available records of the Minnesota Board of Medical Practice indicates the following:

| | |
|---|---|
| **Physician:** | Sarah Ann Traxler |
| **Date of birth:** | [redacted] |
| **Was issued license number:** | 59828 |
| **On:** | September 12, 2015 |
| **Expiration date is:** | May 31, 2018 |
| **Status:** | Active |
| **Issued on the basis of:** | USMLE - United States Med Lic Exam |
| **Corrective action:** | None |
| **Disciplinary action:** | None |

This license information was last updated on: 1/19/2018 3:13:49PM

The above format is the standard format prepared for all physicians regulated by this board.

Please be advised that the Board does not release information as to whether there has been a complaint filed or an investigation conducted on individual verifications. All physicians are considered in good standing unless noted otherwise.

Further public records including disciplinary and corrective actions may be available from the Board's website at www.bmp.state.mn.us under professional profile. If other information is needed, please contact the Minnesota Board of Medical Practice at 612-617-2130.

[redacted]

Ruth M. Martinez
Executive Director

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

P. O. Box 2649

Harrisburg, PA 17105-2649

03/26/2018

## License Information

SARAH ANN TRAXLER

Philadelphia, Pennsylvania 19107

| | | | |
|---|---|---|---|
| Board/Commission: | State Board of Medicine | Status Effective Date: | 01/04/2017 |
| LicenseType: | Medical Physician and Surgeon | Issue Date: | 02/27/2013 |
| Specialty Type: | | Expiration Date: | 12/31/2016 |
| License Number: | MD447970 | Last Renewal: | 11/25/2014 |
| Status: | Expired | | |

## Disciplinary Action Details

No disciplinary actions were found for this license.

This site is considered a primary source for verification of license credentials provided by the Pennsylvania Department of State.

SARAH ANN TRAXLER
[redacted]

BIRTHDATE: [redacted]

AT THE GRADUATE LEVEL

## ACADEMIC PROGRAM

School: PERELMAN SCHOOL OF MEDICINE
Division: BIO MEDICAL PHD
Degree Program: MASTER OF SCIENCE IN HLTH POL RSRCH
Graduate Group: HEALTH POLICY RESEARCH

## DEGREES AWARDED

05-18-15 MASTER OF SCIENCE IN HLTH POL RSRCH

## UNIVERSITY OF PENNSYLVANIA COURSE WORK

**Summer 2013** BIO MEDICAL PHD

| | | | | | |
|---|---|---|---|---|---|
| HPR | 501 | Economics of Health Care Delivery | 1.00 | CU | |
| HPR | 600 | Introduction to Health Policy and Health Services Research | 1.00 | CU | |
| | | Term Statistics: | 2.00 | CU | GPA |
| | | Cumulative: | 2.00 | CU | GPA |

**Fall 2013** BIO MEDICAL PHD

| | | | | | |
|---|---|---|---|---|---|
| HPR | 603 | Health Services and Policy Research Methods I | 1.00 | CU | |
| HPR | 604 | Introduction to Statistics for Health Policy | 1.00 | CU | |
| PUBH | 529 | Public Health Perspectives in Family Planning | 1.00 | CU | |
| | | Term Statistics: | 3.00 | CU | GPA |
| | | Cumulative: | 5.00 | CU | GPA |

**Spring 2014** BIO MEDICAL PHD

| | | | | | |
|---|---|---|---|---|---|
| HPR | 607 | Health Services and Policy Research Methods II | 1.00 | CU | |
| HPR | 608 | Applied Regression Analysis for Health Policy Research | 1.00 | CU | |
| | | Term Statistics: | 2.00 | CU | GPA |
| | | Cumulative: | 7.00 | CU | GPA |

**Summer 2014** BIO MEDICAL PHD

| | | | | | |
|---|---|---|---|---|---|
| HPR | 951 | HPR THESIS I: C Schreiber | 1.00 | CU | |
| PUBH | 505 | Public Health Policy and Administration | 1.00 | CU | |
| | | Term Statistics: | 2.00 | CU | GPA |
| | | Cumulative: | 9.00 | CU | GPA |

*(No further entries this column)*

## UNIVERSITY OF PENNSYLVANIA COURSE WORK

*(Continued from previous column)*

**Fall 2014** BIO MEDICAL PHD

| | | | | | |
|---|---|---|---|---|---|
| HPR | 606 | Fundamentals of Health Policy | 1.00 | CU | |
| NURS | 588 | THE POLITICS OF WOMEN'S HEALTH CARE | 1.00 | CU | |
| | | Term Statistics: | 2.00 | CU | GPA |
| | | Cumulative: | 11.00 | CU | GPA |

**Spring 2015** BIO MEDICAL PHD

| | | | | | |
|---|---|---|---|---|---|
| HPR | 611 | IMP SCI IN HLTH CARE: Implementation Science in Health and Health Care | 1.00 | CU | |
| HPR | 952 | HPR THESIS II: C SCHREIBER | 1.00 | CU | |
| | | Term Statistics: | 2.00 | CU | GPA |
| | | Cumulative: | 13.00 | CU | GPA |

*** * * * * NO OFFICIAL ENTRIES BEYOND THIS POINT * * * * * ***

THE REGISTRAR

UNIVERSITY OF PENNSYLVANIA PHILADELPHIA

OFFICIAL TRANSCRIPT OF ACADEMIC RECORD

**Record of : Sarah Ann Traxler**
**SSN:** [redacted] **Student No:U00028880**

**Date Issued: 22-DEC-2017 OFFICIAL**

**Course Level : Medical**

Matriculated: Fall 2004

RECEIVED
JAN 03 2017

**Current Program**
College : School of Medicine
**Major:** Medicine

**Degree Information:**
Degree Awarded: Doctor of Medicine 04-JUN-2009
**Major:** Medicine

| Subj | No. | Title | Cred | Grade | Pts | R |
|---|---|---|---|---|---|---|
| **INSTITUTION CREDIT:** | | | | | | |
| **Fall 2004** | | | | | | |
| MSCI | 611 | Gross Anat/Imag/Emb | 12.00 | [redacted] | 36.00 | |
| MSCI | 612 | Cell Structure & Function | 8.00 | | 24.00 | |
| MSCI | 711 | Principles of Clinical Med I | 4.00 | | 12.00 | |
| **Earned Hrs:** 24.00 | | | | | | |
| **Winter 2005** | | | | | | |
| GMED | 705G | History of Medicine II | 0.50 | [redacted] | 0.00 | |
| MSCI | 613 | System Processes & Homeostasys | 9.00 | | 18.00 | |
| MSCI | 712 | Principles of Clinical Med II | 4.00 | | 12.00 | |
| **Earned Hrs:** 13.50 | | | | | | |
| **Spring 2005** | | | | | | |
| GMED | 705H | History of Medicine III | 0.50 | [redacted] | 0.00 | |
| MSCI | 614 | Biological Basis of Disease | 9.00 | | 27.00 | |
| MSCI | 713 | Principles of Clinical Med III | 4.00 | | 12.00 | |
| **Earned Hrs:** 13.50 | | | | | | |
| **Fall 2005** | | | | | | |
| GMED | 705I | History of Medicine IV | 0.50 | [redacted] | 0.00 | |
| MSCI | 622 | Circulation | 8.00 | | 24.00 | |
| MSCI | 624 | Metabolism | 5.00 | | 15.00 | |
| MSCI | 714 | Principles of Clinical Med IV | 4.00 | | 0.00 | |
| **Earned Hrs:** 13.50 | | | | | | |
| **Winter 2006** | | | | | | |
| GMED | 705J | History of Medicine V | 0.50 | [redacted] | 0.00 | |
| GMED | 705M | Clinical Skills Workshop | 1.00 | | 0.00 | |
| MSCI | 621 | Neuroscience & Behavior | 8.00 | | 24.00 | |
| MSCI | 623 | Blood | 4.00 | | 12.00 | |
| MSCI | 715 | Principles of Clinical Med V | 4.00 | | 0.00 | |
| **Earned Hrs:** 13.50 | | | | | | |

| Subj | No. | Title | Cred | Grade | Pts | R |
|---|---|---|---|---|---|---|
| **INSTITUTION CREDIT:** | | | | | | |
| **Spring 2006** | | | | | | |
| MSCI | 626 | Human Development | 6.00 | [redacted] | 18.00 | |
| MSCI | 716 | Principles of Clinical Med VI | 12.00 | | 36.00 | |
| **Earned Hrs:** 18.00 | | | | | | |
| **Summer 2006** | | | | | | |
| JCON | 717A | Transition to Clerkship | 3.00 | [redacted] | 0.00 | |
| JCON | 722 | Primary Care | 9.00 | | 18.00 | |
| PSYC | 720 | Psychiatry | 9.00 | | 27.00 | |
| **Earned Hrs:** 21.00 | | | | | | |
| **Fall 2006** | | | | | | |
| JCON | 705V | MedNet I | 1.00 | [redacted] | 0.00 | |
| JCON | 705X | Spec Elec: Bridging the Gap | 1.00 | | 0.00 | |
| JCON | 709Z | International Medicine Extern | 6.00 | | 0.00 | |
| OBGY | 720 | Obstetrics/Gynecology | 9.00 | | 18.00 | |
| SURG | 720 | Surgery I | 9.00 | | 18.00 | |
| **Earned Hrs:** 26.00 | | | | | | |
| **Winter 2007** | | | | | | |
| FAMP | 720 | Family Medicine | 9.00 | [redacted] | 9.00 | |
| JCON | 720 | Child Health I | 9.00 | | 9.00 | |
| **Earned Hrs:** 18.00 | | | | | | |
| **Spring 2007** | | | | | | |
| IMED | 720 | Internal Medicine I | 18.00 | [redacted] | 36.00 | |
| JCON | 719 | Continuity Curriculum/CPX | 2.00 | | 0.00 | |
| **Earned Hrs:** 20.00 | | | | | | |
| **Summer 2008** | | | | | | |
| JCON | 721 | Pediatrics II | 6.00 | [redacted] | 18.00 | |
| OBGY | 709X | Spec Elec: Oncology | 6.00 | | 18.00 | |
| PATH | 751A | Introduction to Pathology | 6.00 | | 18.00 | |
| **Earned Hrs:** 18.00 | | | | | | |
| **Fall 2008** | | | | | | |
| ANST | 709A | Anesthesiology | 6.00 | [redacted] | 6.00 | |
| OBGY | 709A | Perinatology | 6.00 | | 18.00 | |
| **Earned Hrs:** 12.00 | | | | | | |
| **Winter 2009** | | | | | | |
| ETOX | 709X | Toxicology Poisoning/Overdose | 6.00 | [redacted] | 18.00 | |
| OBGY | 709H | Family Planning | 6.00 | | 18.00 | |
| **Earned Hrs:** 12.00 | | | | | | |



OREGON HEALTH & SCIENCE UNIVERSITY

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env: 1936 page: 2 of 3
CONFIDENTIAL RECORD ISSUED IN ACCORDANCE WITH THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974

OFFICIAL TRANSCRIPT OF ACADEMIC RECORD

**Record of : Sarah Ann Traxler**
**SSN:** [redacted] **Student No:U00028880**

**Date Issued: 22-DEC-2017 OFFICIAL**

| Subj | No. | Title | Cred | Grade | Pts | R |
|---|---|---|---|---|---|---|
| **INSTITUTION CREDIT:** | | | | | | |
| **Spring 2009** | | | | | | |
| CARD | 709B | CCU at OHSU | 6.00 | [redacted] | 6.00 | |
| JCON | 718 | Transition to Residency | 3.00 | | 0.00 | |
| NEUR | 721 | Neurology | 6.00 | | 18.00 | |

**Earned Hrs:** 15.00

| Transcript Totals | Earned Hrs |
|---|---|
| TOTAL INSTITUTION | 238.00 |
| TOTAL TRANSFER | 0.00 |
| OVERALL | 238.00 |

----------END OF TRANSCRIPT----------



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UA UNIFORM APPLICATION FOR LICENSURE

# Postgraduate Training Verification Form (Form #3)

**Institution Name:** University of Minnesota Medical School

**Institution Address:** 420 Delaware St SE, Minneapolis, MN 55455

**Affiliated School:** University of Minnesota

**Applicant:** Do not complete this form for verification of accredited training if you are using FCVS. FCVS does not verify non-accredited training. When using FCVS, use this form only if your licensing board requires verification of non-accredited training.

**Program Director or designated Official:** Please complete Section 2, and mail this form and any other items to the designated state medical board at the address listed in Section 1. Thank you.

**Section 1: To be completed by the Applicant.**

**Name:** Sarah Ann Traxler **Suffix** ____ **Practitioner type:** M.D. ☑ D.O. ☐

**Date of birth:** [redacted] (mm/dd/yyyy) **SSN*** [redacted]

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

**Name if different when diploma awarded:** ____

**Board Information:** To be completed by the applicant.

**Waiver for Release of Information: I request that the program director or a designated official complete Section 2 of this form as outlined below. I authorize the postgraduate training program listed above to provide any all information pertaining to my training there to the board listed below:**

**Board Name:** Rhode Island Department of Health

**Mailing address:** 3 Capitol Hill Providence, RI 02908

Applicant Please Sign Here → **Applicant Signature** [redacted] **Date** 12/5/17

**Section 2: 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 comple ion date in the "To" field.

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

Report Internships, Residencies and Fellowships separately.

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

**Specialty/Subspecialty:** OB/GYN
**From:** 6/8/2009 **To:** 6/7/2013
**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 appropriate responses and explain any "Yes" or omitted response(s) on a separate sheet of paper. Attach pages as needed.

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

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

**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.** This section MUST be signed by the program director (M.D. or D.O. only). **Please Note: The Nevada Board of Medical Examiners requires an authorization letter to be attached if this form is completed by someone other than an M.D. or D.O.**

**Signature:** [redacted]

**Print name:** Phillip N. Rauk, MD

**Title:** Program Director

**Email address:** raukx004@umn.edu

**Phone Number:** 612-301-3415 **Date:** 1/24/2018