Physician and Surgeon Application Summary

Wenzel, Luke Richard
1900 South Ave
La Crosse, WI 54601

Application #: 137817
Application Rec'd: 01/19/2021
Board Date: 03/14/2022
Basis: COMLEX
Legal:

PY DOM

Deposit # : H7B-22164
Amt Paid : 425.25

Birthdate: [redacted]1986
Birthplace: Viroqua, WI USA

Received:	Completed:	
Exam		
02/22/2022	02/16/2022	COMLEX1 611 07/15/2014;COMLEX2 629 07/20/2015;COMLEX3 668 04/10/2017;
Competency		
Medical School		
02/14/2022	02/14/2022	DES MOINES U COLLEGE OF OSTEO MED Des Moines IA USA - D.O. 05/28/2016
01/19/2022	01/19/2022	Diploma
Medical Training		
02/18/2022	02/10/2022	University of Nebraska Medical Center College of M 07/01/2016-06/30/2020 Omaha NE USA OB & GY- Obstetrics & Gynecology AMA FREIDA Packet
01/19/2022	01/19/2022	Certificate
Licenses		
02/16/2022	02/16/2022	WI, USA 10/31/2023
02/25/2022	02/25/2022	NE, USA 10/31/2021
02/25/2022	02/25/2022	NE, USA 07/01/2020
Hospital Privileges		
Recommendations		
02/18/2022	02/11/2022	Deborah Simon
03/04/2022	02/16/2022	Heather riese
Databank Searches		
01/31/2022	01/31/2022	AMA
01/31/2022	01/31/2022	Federation

03/07/2022	01/19/2022	the DataBank - NPDB

Miscellaneous

12/21/2021	12/21/2021	Accounting of time
01/19/2022	01/11/2022	Photo
01/19/2022	01/11/2022	Release
01/19/2022	01/11/2022	Malpractice history report None
01/19/2022	01/11/2022	Facilities list
		Military papers Branch -
01/19/2022	01/11/2022	Addendum To Application Click Profile to update, if any
01/19/2022	01/19/2022	Driver's License
01/19/2022	01/19/2022	Treating Physician Statement N/A
03/14/2022	03/14/2022	CBC Fingerprint Results Received, Reviewed and Returned

MINNESOTA
BOARD OF MEDICAL PRACTICE

335 Randolph Avenue, Suite 140
St. Paul, MN 55102
612.617.2130 (phone) | 612.617.2166 (fax)
medical.board@state.mn.us | mn.gov/boards/medical-practice

MN BOARD OF MEDICAL PRACTICE
JAN 19 2022

Addendum to Application Cover Sheet

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 Board)
- ☐ United States Medical Licensing Exam (USMLE)
- ☐ Combination of FLEX, NBME, USMLE (must be completed by year 2000)

For Board Use Only

Application #: 137817
Check/Receipt #: 164,15
Amount Paid: $425.25
License #:

Account Code	Amount
635009 lic	
635010 app	
635064 cbc	

Instructions

Complete each section of the Addendum as instructed. Please type or print your responses and your identifying info at the bottom of the addendum pages.

If additional space is necessary, attach a separate sheet referencing the question number to which you are responding.

If the answer to any question is "yes", please explain in detail on the addendum, using a separate sheet if necessary. Additional documents may be required.

Return the completed addendum along with this cover page, application fee of $425.25, forms, and other required documents to the Minnesota Board. Use the checklists to ensure you send all required items.

IMPORTANT NOTICE: Minnesota Statute, section 214.074 requires that all new applicants for licensure must complete a fingerprint – based criminal background check. Applications received on and after January 1st, 2019 must include the $33.25 criminal background check fee or they will be returned. For more information please visit: https://mn.gov/boards/medical-practice/.

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Addendum to Application

1. Business Address

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

Facility name: Gundersen Health System

Street Address: 1900 South Avenue

City / State or Province / Zip: La Crosse, WI 54601

☐ 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? ☒ No ☐ Yes - me. ☐ Yes - spouse. If discharged, provide discharge date: _____

☒ I certify that I have not served any military duty.

☐ I certify that I have served military duty in the following branch of service: _____

Rank at Discharge: _____ Type of Discharge: _____

Entry Date (mm/dd/yyyy): _____ Release Date (mm/dd/yyyy): _____

3. Criminal Conviction(s)

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

If you have more than two items to report, attach additional sheets as needed.

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

☐ I certify that I have had the following felony or gross misdemeanor on or after July 1, 2013:

1. Conviction Date (mm/dd/yyyy): _____ Conviction Type: ☐ Felony ☐ Gross misdemeanor

Crime Description: _____

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

Sentence: _____

2. Conviction Date (mm/dd/yyyy): _____ Conviction Type: ☐ Felony ☐ Gross misdemeanor

Crime Description: _____

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

Sentence: _____

_____

4. Malpractice Liability Claims Information

The Board requires all applicants to complete the Malpractice Liability Claims Information page within the online Uniform Application unless there have been no claims. Report all claims that are pending or have been dismissed. If you have had no claims, check the box below certifying that you have not had any claims against you and leave the online UA page blank.

☒ I certify that I have never had a malpractice claim, award, judgment, or settlement against me.

☐ I certify that I have listed all malpractice claims information within the online Uniform Application.

5. Additional Physician Information

Alien Registration Number (if applicable): Number _____

Driver's License*: State WI Number [redacted]

Identifying Characteristics (if you are using FCVS, you do not need to complete this question):

Height (ft/in.) 05/06 Weight (lbs) 155 Hair Color Brown Eye Color Blue

Identifying marks _____

Your intended street address (if known): _____

City / State or Province / Zip / Country: _____

Effective Date: _____

Proposed practice plans in Minnesota (if any): Gundersen Winona Clinic/Telemedicine

**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.*

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

Country: _____ License Number: _____ Date Issued: _____

Country: _____ License Number: _____ Date Issued: _____

Country: _____ License Number: _____ Date Issued: _____

Country: _____ License Number: _____ Date Issued: _____

7. Membership in Professional Societies and Organizations

Organization: ACOG From (mm/yy): 07/16 To (mm/yy): 01/22

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

Organization: _____ From (mm/yy): _____ To (mm/yy): _____

8. Attestation Questions

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons.

If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable question(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s).

For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders/conditions, or chemical dependency or chemical abuse.

The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your license is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling.

If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is necessary, use the end of page 7. Attach a separate sheet if needed.

RIGHTS OF SUBJECTS OF DATA

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

		YES
1.	Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.	☐
1a.	If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe.	☐
1b.	If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.	☐
2.	Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety? Please describe.	☐

		YES	NO
3.	Are you engaged in any illegal use of controlled substances including the use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe.	☐	
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.	☐	
3b.	If yes, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe.	☐	
4.	Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? If you answer this question "yes", please answer the following:	☐	
4a.	With regard to any condition referenced above, are you being treated so that such impairment is avoided?	☐	
4b.	With regard to any condition referenced above, are you in compliance with the recommended treatment?	☐	
4c.	With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?	☐	
4d.	Please explain.		
4e.	Identify your treating physician.	☐	
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.	[redacted]	
6.	Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.		

YES NO

7. 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.

8. 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.

9. 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.

10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, complete section 4 of this Addendum and 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).

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

12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, complete section 3 in this Addendum and submit a personal statement below 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.

	YES	NO
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 below 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.		[redacted]

Use this space for additional information. Be sure to list the question number you are answering.

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Certificate of Ethical and Moral Character

This certificate must be signed by **two** licensed physicians who are personally acquainted with the applicant.

1. I certify that the photograph attached is a recent one and likeness of Dr. Wenzel and that he/she is a person of good ethical and moral character.

Signature

Heather Riese
Print or type name

1/11/22
Date

69120-20
License Number

WI
State of Issue

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

State Wisconsin County La Crosse

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 with the signature on his/her identifying document.

Sworn to before me by the applicant on this 11th day of Jan 2022.

Notary Public Signature Lynn A Albrecht

Expiration Date 11/19/23

SEAL
The impression of the seal must be partly upon the photo
NOTARY PUBLIC
STATE OF WISCONSIN

Applicant's Signature

2. I certify that the photograph attached is a recent one and likeness of Dr. Wenzel and that he/she is a person of good ethical and moral character.

Signature

Deborah Simon
Print or type name

1/11/22
Date

67331
License Number

MN
State of Issue

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials. A directory of state medical and osteopathic boards is available at http://www.fsmb.org/policy/contacts.

Please send this form to: Minnesota Board of Medical Practice
335 Randolph Avenue, Suite 140
St. Paul, MN 55102

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]

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

WENZEL, LUKE, R

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

1/17/2022

Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

State of Wisconsin, County of La Crosse,

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.

NOTARY PUBLIC STATE OF WISCONSIN

The statements on this document are subscribed and sworn to before me by the applicant on this 17th day of Jan, 2022.

Notary Public Signature Lynn A Albrecht My Notary Commission Expires 11/19/23

Uniform Application for Licensure

pplication ID: 342094
FID: 301885463

License Requested: DO
License Type: Permanent Medical License
Submitted to: Minnesota Board of Medical Practice
Submission Date: 12/21/2021 12:01 PM

Practitioner Name

Wenzel, Luke Richard

Contact Information

Address

Public Access	Board Contact	Type	Address
Yes	Yes	Business	1900 South Avenue WI La Crosse, WI 54601 UNITED STATES

Phone

Public Access	Board Contact	Type	Phone Number	Phone Extension
Yes	Yes	Business	(608) 782-7300	

Email

Public Access	Board Contact	Email
Yes	Yes	lrwenzel@gundersenhealth.org

Identification

USMLE Number	SSN	Birth Date	Birth Place	Gender	NPI	Practitioner Type	US Citizen
	[redacted]	/1986	Viroqua, Wisconsin UNITED STATES	M	1669823571	DO	Yes

Medical School

Medical School Name	Address	Start Date	End Date	Graduation Date	Degree Code
Des Moines University Osteopathic Medical Center	3200 Grand Avenue Des Moines, IA 503124198 UNITED STATES	08/08/2012	05/28/2016	05/28/2016	DO

Fifth Pathway

None Reported

ECFMG

Certificate Number	Issue Date
None Reported	

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Postgraduate Training

Hospital Name: **University of Nebraska Medical Center College of Medicine Program**
Omaha, NE UNITED STATES

Program Code: ACGME 2203021161

Attendance Dates:

Institution: University of Nebraska Medical Center College of Medicine

Start Date: 07/01/2016

Training Specialty: Obstetrics & Gynecology

End Date: 06/30/2020

Program Type: Residency

Training Status: Completed

Clinical %: 0

Administrative %: 100

Examination History

Exam	State	Last Attempt	Pass/Fail	Number Of Attempts
None Reported				

State Licensure History

MD, DO, PA License History

License Entity	Licensing State	License Number	Issue Date	Expiration Date	License Type	License Status
Nebraska Board of Medicine and Surgery	NE	2049	06/11/2019	10/31/2021	Full	Expired
Wisconsin Medical Examining Board	WI	73741-21	07/20/2020	10/31/2023		Active
Nebraska Board of Medicine and Surgery	NE	7717	07/01/2016	07/01/2020	Training	

Physician Reported License History

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

Chronology of Activity Type

Practice/Emp/ Desc: **Kickapoo High School**

Chronology Type: PGT/Education

Address: S6520 State Highway 131
Viola, WI 54664
US

Attendance Dates:

Position/Dept: Student - High School - High School

From: 09/01/2001 to 06/01/2004

Clinical %: 0

Admin %: 100

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

Practice/Emp/ Desc: **Winona State University**

Chronology Type: PGT/Education

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Address: 175 West Mark Street
Winona, MN 55987
US

Attendance Dates:

Position/Dept: Student - Undergrad - Undergrad Studies

From: 06/15/2004 to 05/15/2008

Clinical %: 0

Admin %: 100

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

Practice/Emp/ Desc: **Peace Corps**

Chronology Type: Work

Address: 1275 First Street NE
Washington, DC, DC 20526
US

Attendance Dates:

Position/Dept: Employment - Mozambique Public Health Program

From: 06/01/2008 to 12/01/2010

Clinical %: 100

Admin %: 0

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

Practice/Emp/ Desc: **Mayo Clinic**

Chronology Type: Work

Address: 200 First Street SW
Rochester, MN 55905
US

Attendance Dates:

Position/Dept: Laboratory Assistant - Lab Technician

From: 01/02/2011 to 08/01/2012

Clinical %: 90

Admin %: 10

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

Practice/Emp/ Desc: **Des Moines University Osteopathic Medical Center**

Chronology Type: Medical Education

Address: Des Moines, IA
US

Attendance Dates:

Position/Dept:

From: 08/08/2012 to 05/28/2016

Clinical %:

Admin %:

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

Practice/Emp/ Desc: **Waiting for Classes to begin**

Chronology Type: Vacation

Address:

Attendance Dates:

Position/Dept:

From: 06/01/2016 to 07/01/2016

Clinical %: 0

Admin %: 0

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

Practice/Emp/ Desc: **University of Nebraska Medical Center College of Medicine Program**

Chronology Type: Accredited Training

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	Address:	Omaha, NE US	**Attendance Dates:**		
	Position/Dept:		**From:**	07/01/2016	to 06/30/2020
	Clinical %:	0			
	Admin %:	100			
	Employment:	**Staff Privileges:**	**Affiliation:**		

Practice/Emp/ Desc:	**Bellevue Health Clinic**		**Chronology Type:**	Work	
	Address:	1002 W Mission Ave Bellevue, NE 68005 US	**Attendance Dates:**		
	Position/Dept:	Contracted Physician - Clinic Staff	**From:**	07/01/2019	to 06/01/2020
	Clinical %:	90			
	Admin %:	10			
	Employment:	**Staff Privileges:**	**Affiliation:**		

Practice/Emp/ Desc:	**Applying for Employment/Credentialing**		**Chronology Type:**	Seeking Employment	
	Address:		**Attendance Dates:**		
	Position/Dept:		**From:**	07/01/2020	to 08/01/2020
	Clinical %:	0			
	Admin %:	0			
	Employment:	**Staff Privileges:**	**Affiliation:**		

Practice/Emp/ Desc:	**Gundersen Health System**		**Chronology Type:**	Work	
	Address:	1900 South Avenue La Crosse, WI 54601 US	**Attendance Dates:**		
	Position/Dept:	Physician - Obstetrics/Gynecology Department	**From:**	08/13/2020	to In Progress
	Clinical %:	90			
	Admin %:	10			
	Employment:	**Staff Privileges:**	**Affiliation:**		

Malpractice

None Reported

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COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION - USA

Official Transcript

MN BOARD OF
FEB 2 2 2022
MEDICAL PRACTICE

Minnesota Board of Medical Practice
335 Randolph Avenue
Suite 140
St. Paul, MN 55102

Examinee: Wenzel, Luke Richard
NBOME ID: 410102 **Date of Birth:** [redacted]1986

EXAMINATION	DATE COMPLETED	PASS / FAIL	3 - DIGIT STANDARD SCORE	3 - DIGIT MINIMUM PASSING	2 - DIGIT STANDARD SCORE	2 - DIGIT MINIMUM PASSING	NOTE
Level 1							
	15-Jul-2014	Pass	611	400	--		
Level 2 Cognitive Evaluation (CE)							
	20-Jul-2015	Pass	629	400	--		
Level 2 Performance Evaluation (PE)							
	07-Jul-2015	Pass	Not Applicable		Not Applicable		
Level 3							
	10-Apr-2017	Pass	668	350	--		

The National Board of Osteopathic Medical Examiners, Inc., does hereby certify the above to be a true report of the examinee.

Date Prepared: February 16, 2022

-- please see reverse for information and description of notes -- v3.0

National Board of Osteopathic Medical Examiners, Inc.
8765 West Higgins Road Suite 200 Chicago IL 60631-4174
Phone: 866/479-6828 Fax: 773/714-0606

UA UNIFORM APPLICATION FOR LICENSURE

For State Board Use Only

Medical or Osteopathic School Verification Form (Form #2)

Applicant: DO NOT COMPLETE THIS FORM IF YOU ARE USING FCVS. FCVS verifies this data for you. If you are not using FCVS, complete Section 1 below. Send this form and a copy of your medical school diploma to the current dean of your medical or osteopathic school. Copy this form for multiple schools.

Dean or Designated Official: Complete Section 2 of this two-page form and certify the enclosed copy of the diploma by placing your school seal on it. Mail the sealed diploma, an official copy of the physician's transcripts, this completed form, and any other documentation needed to the board at the address listed in Section 1. If transcripts are not in English, an original, certified, and official English translation is required.

Section 1: Applicant Information

First name Luke Last name Wenzel Practitioner Type ☐ MD ☑ DO ☐ ____

Middle name Richard Suffix _____ SSN* _____ Birth date (mm/dd/yyyy) [redacted]1986

Name if different when diploma awarded: N/A

Name of school Des Moines University

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

Waiver for Release of Information: I am applying for a license to practice medicine. I authorize the medical/osteopathic school listed above to provide any and all information pertaining to my medical/osteopathic education at that institution to the board at the address listed below. I request that the dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached) as described in the instructions above, then mail this completed form, the sealed diploma copy, and a copy of my official transcripts to the board listed below at the given address:

Board name Minnesota Board of Medicine

Mailing address 335 Randolph Ave,

City/State/Zip St Paul, MN 55102

Applicant signature [redacted] Date 01/11/2022

Section 2: Medical or Osteopathic School Verification

School name Des Moines University

Complete address w/country 3200 Grand Ave., Des Moines, Iowa 50312

School name if different when applicant attended _____

Hours of undergraduate education required for admission n/a Total weeks of education applicant attended 168

Attendance (mm/yyyy) from 08/13/2012 to 05/28/2016 Graduation date 05/28/2016 Degree awarded DO

Unusual Circumstances

The following questions apply to unusual circumstances that occurred during any part of the individual's medical or osteopathic education. Check the appropriate responses and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation attached to this form.

1. Do the official records for this individual reflect interruptions or extensions in his/her medical/osteopathic education? **If yes,** indicate the reasons for each interruption or extension, the dates of each interruption or extension, and whether each interruption or extension was approved or unapproved. Yes ☐ No ☒

☐ Personal or family	From _____ to	☐ Approved	☐ Unapproved
☐ Academic remediation	From _____ to	☐ Approved	☐ Unapproved
☐ Health	From _____ to	☐ Approved	☐ Unapproved
☐ Financial	From _____ to	☐ Approved	☐ Unapproved
☐ Participation in a joint degree program	From _____ to	☐ Approved	☐ Unapproved
☐ Participation in a non-research special study (e.g., fellowship, intl. experience)	From _____ to _____	☐ Approved	☐ Unapproved
☐ Other _____	From _____ to _____	☐ Approved	☐ Unapproved

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical/osteopathic education? **If yes,** indicate below the reasons for each time of probation and the dates of placement on and removal from probation. Also attach documentation or information of each circumstance and outcome. Yes ☐ No ☒

☐ Academic	From _____ to	☐ Documentation attached
☐ Unprofessional conduct	From _____ to	☐ Documentation attached
☐ Behavioral reasons	From _____ to	☐ Documentation attached
☐ Other _____	From _____ to _____	☐ Documentation attached

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☒

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical/osteopathic school or parent university? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☒

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **If yes,** explain below and/or attach documentation or information of each circumstance and outcome. Yes ☐ No ☒

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 Melinda J. Miller
Print name Melinda Miller
Title Registrar Date 02/14/2022
Phone number 515.271.1460 Fax number 515.271.7025
Email registrar@dmu.edu

AFFIX INST RE
(If no seal is ust be notarized.)

Please ma n and any other items to the board at the address listed in Section 1. Thank you.

Received 05-29-2020 kmrugrod

Des Moines University
Osteopathic Medical Center

upon recommendation of the faculty of the

College of Osteopathic Medicine

and by the authority of the State of Iowa
hereby confers upon

Luke R. Wenzel

the degree of

Doctor of Osteopathic Medicine

with all the honors, rights and privileges thereunto appertaining,
in recognition of the satisfactory completion of the requirements for this degree.
In witness whereof the Board of Trustees has caused the seal of the University
to be affixed at Des Moines, Iowa, this twenty-eighth day of May, 2016.

Angela L. Franklin
President of the University

Dean of the College

DES MOINES UNIVERSITY 1898

Chairman of the Board

Secretary of the Board

UA UNIFORM APPLICATION FOR LICENSURE

Postgraduate Training Verification Form (Form #3)

MN BOARD OF MEDICAL PRACTICE FEB 16 2022 RECEIVED

Institution Name: UNMC

Institution Address: 983255 Nebraska Med Center Omaha, NE 68198

Affiliated School: NA

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: Luke Richard Wenzel **Suffix** ____ **Practitioner type:** M.D. ☐ D.O. ☑

Date of birth [redacted]986 (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: N/A

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: Minnesota Board of Medical Practice

Mailing address: 335 R[redacted] Avenue, Suite 140. St. Paul, MN 55102

Applicant Please Sign Here → **Applicant Signature** [redacted] **Date** 01/11/2022

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 completion date in the "To" field.

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

Report Internships, Residencies and Fellowships separately.

Training Level: 1 (e.g., 1, 2, 3, etc.)
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: OBGYN
From: 7/1/2016 **To:** 6/30/2017
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: OBGYN
From: 7/1/2017 **To:** 6/30/2019
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: OBGYN
From: 7/1/2019 **To:** 6/30/2020
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). **(Signature by personnel other than an M.D. or D.O. must attach an authorization letter. Applicable only for Nevada State Board of Medical Examiners.)**

Signature:
Print name: Laura Cudzilo
Title: Program Director
Email address: L.Cudzilokelsey@unmc.edu
Phone Number: 402-559-6160 **Date:** 2-10-22

The University of Nebraska

COLLEGE OF MEDICINE

THIS CERTIFICATE MAKES KNOWN THAT THE BOARD OF REGENTS OF THE UNIVERSITY OF NEBRASKA UPON THE RECOMMENDATION OF THE FACULTY AND BY AUTHORITY OF THE STATUTES OF THE STATE OF NEBRASKA, BY ITS OFFICERS SPECIALLY AUTHORIZED, GRANTS THIS TESTIMONIAL OF SERVICE AS

RESIDENT IN OBSTETRICS AND GYNECOLOGY

AT THE UNIVERSITY OF NEBRASKA AND AFFILIATED HOSPITALS

JULY 1, 2016 - JUNE 30, 2020

TO

LUKE RICHARD WENZEL, D.O.

IN TESTIMONY WHEREOF WE HAVE HEREUNTO SET OUR HANDS AT LINCOLN THIS THIRTIETH DAY OF JUNE, TWO THOUSAND AND TWENTY.

CORPORATION SECRETARY OF THE BOARD

CHAIRMAN OF THE DEPARTMENT

CHANCELLOR OF THE UNIVERSITY MEDICAL CENTER

CHAIRMAN OF THE BOARD

PRESIDENT OF THE UNIVERSITY

DEAN OF THE COLLEGE OF MEDICINE

STATE OF WISCONSIN
Department of Safety and Professional Services
4822 Madison Yards Way
Madison WI 53708-8935

Governor Tony Evers **Secretary Dawn B. Crim**

Mail to:
PO Box 8935
Madison WI 53708-8935

Email: dsps@wisconsin.gov
Web: http://dsps.wi.gov
Phone: 608-266-2112

CERTIFICATION

DATE: 02/16/2022

I, Aloysius F. Rohmeyer, do hereby certify that I am the Record Custodian in the Department of Safety and Professional Services, a department of the government of the State of Wisconsin; that I am the custodian of the records relating to Medicine and Surgery, DO and its seal; that a standard search of the available records of this office indicates the following:

THIS IS TO CERTIFY THAT:	WENZEL, LUKE R
CREDENTIAL TYPE:	MEDICINE AND SURGERY, DO
WAS ISSUED LICENSE NO:	73741-21
STATUS:	CREDENTIAL LICENSE IS CURRENT (ACTIVE)
ISSUE DATE:	07/20/2020
EXPIRATION DATE:	10/31/2023

Credential Holder History

Date	Code	Description
06/30/2020	ENDORSED FROM	Endorsed from NBOME

According to our records, this credential holder has not been disciplined.

The information above is the only certification information provided by this Department. **We strongly encourage you to verify the license status of this individual by checking the DSPS online license look-up at http://app.wi.gov/licensesearch.** To expedite the certification process, the above format is the standard format for all professions regulated by this Department.

Aloysius F. Rohmeyer

Aloysius F. Rohmeyer
Record Custodian
Department of Safety and Professional Services

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Public Health Licensure Unit
Certification of Licensure

This certificate serves as primary source verification of licensure in the State of Nebraska as of the close of the business day before 2/25/2022.

Name:	Luke Richard Wenzel DO
Type:	Temporary Educational Permit
Number:	7717
Status:	Null and Void
Issued:	07/01/2016
Expiration:	07/01/2020
Education:	05/28/2016 DES MOINES UNIV-OSTEOPATHIC MEDICAL CTR

Disciplinary/Non-Disciplinary Information:

No disciplinary/non-disciplinary actions taken against this license.

If you have questions about this information, please contact the Licensure Unit at (402) 471-2115 or DHHS.LicensureUnit@nebraska.gov.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Public Health Licensure Unit
Certification of Licensure

This certificate serves as primary source verification of licensure in the State of Nebraska as of the close of the business day before 2/25/2022.

Name:	Luke Richard Wenzel DO
Type:	Osteopathic Physician & Surgeon
Number:	2049
Status:	Expired
Issued:	06/11/2019
Expiration:	10/31/2021
Education:	05/28/2016 DES MOINES UNIV-OSTEOPATHIC MEDICAL CTR

Disciplinary/Non-Disciplinary Information:

No disciplinary/non-disciplinary actions taken against this license.

If you have questions about this information, please contact the Licensure Unit at (402) 471-2115 or DHHS.LicensureUnit@nebraska.gov.

MINNESOTA
BOARD OF MEDICAL PRACTICE

335 Randolph Avenue, Suite 140
St. Paul, MN 55102
612.617.2130 (phone) | 612.617.2166 (fax)
medical.board@state.mn.us | mn.gov/boards/medical-practice

BOARD OF MEDICAL PRACTICE
MAR 0 4 2022

PHYSICIAN RECOMMENDATION FORM (2)

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

Applicant Print Name Luke Richard Wenzel

Applicant Signature [redacted] Date 01/11/2022

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant) Luke Wenzel

1. How long have you known the applicant? 2 years
2. What has been the nature of your relationship with the applicant? colleague
3. How would you characterize the moral and professional conduct of the applicant? Excellent, caring and 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.

A. Clinical skills	Marginal*	(Fully Meets Standards)
B. Any indication of chemical dependency?	Yes*	(No)
C. Any indication of malprescribing?	Yes*	(No)

*Please attach letter of explanation.

Completed By:

Printed Name Heather Briese, MD Signed [signature]

Health Profession ObGyn License # 69120-20 State WI

Date 12/16/22 Phone# (608) 775-2704 Fax

Email hbriese@gundersenhealth.org

8/21

MINNESOTA
BOARD OF MEDICAL PRACTICE

335 Randolph Avenue, Suite 140
St. Paul, MN 55102
612.617.2130 (phone) | 612.617.2166 (fax)
medical.board@state.mn.us | mn.gov/boards/medical-practice

MN BOARD OF MEDICAL PRACTICE
FEB 18 2022

PHYSICIAN RECOMMENDATION FORM (1)

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

Applicant Print Name Luke Richard Wenzel

Applicant Signature [redacted] Date 01/11/2022

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant) Luke Wenzel

1. How long have you known the applicant? 2 years
2. What has been the nature of your relationship with the applicant? co-worker
3. How would you characterize the moral and professional conduct of the applicant? excellent
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.

A. Clinical skills	Marginal*	(Fully Meets Standards)
B. Any indication of chemical dependency?	Yes*	(No)
C. Any indication of malprescribing?	Yes*	(No)

*Please attach letter of explanation.

Completed By:

Printed Name Deborah Simon Signed [signature]

Health Profession OB-GYN License # 67331 State MN

Date 2/11/22 Phone# 608 775-6930 Fax 608 775-6611

Email ~~dasimon22@gmail.com~~ dasimon@gundersenhealth.org

8/21

AMA Physician Profile

PREPARED FOR

Minnesota Board of Medical Practice, Minneapolis, MN

Name and Mailing Address

LUKE RICHARD WENZEL
455 COUNTRY CLUB LN
ONALASKA, WI 54650-8793

Primary Office Address

LIMITED TO OFFICIAL GOVERNMENT DUTIES
ON
UNIVERSITY OF NEBRASKA MEDICAL CENTER
1836 SOUTH AVE
LA CROSSE, WI 54601-5429
Phone (608) 783-7300

Birth date 05/01/1986

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
1669823571	06/22/2016	NOT RPTD	NOT RPTD	NOT RPTD	01/21/2022

Current and/or historical medical school

DES MOINES UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE

Degree Awarded: YES

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Degree Year: 2016

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

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

Beginning with the 2016/2017 cycle of the National GME Census post-graduate training segments will include a training type of specialty (residency) or subspecialty (fellowship). Training types for programs reported prior to 2016 will not include this designation.

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

If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.

Sponsoring Institution:	UNIVERSITY OF NEBRASKA MEDICAL CENTER COLLEGE OF MEDICINE
Sponsoring State:	NEBRASKA
Program name:	UNIVERSITY OF NEBRASKA MEDICAL CENTER COLLEGE OF MEDICINE PROGRAM
Specialty:	OBSTETRICS & GYNECOLOGY
Training Type:	SPECIALTY
Dates:	7/2016 - 6/2020 (Verified)

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 0

Specialty Board Certification

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

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-

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approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

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

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC

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

This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties (ABMS). Copyright 2022 American Board of Medical Specialties. All right reserved.

Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
73741	DO	WI	07/20/2020	10/31/2023	10/31/2023	ACT	UNL	01/06/2022	Wenzel, Luke, R
2049	DO	NE	06/11/2019	10/31/2021		INA	UNL	11/01/2021	Luke Richard Wenzel
7717	DO	NE	07/01/2016	07/01/2019		INA	RES	06/04/2019	NRT

Abbreviation key: ACT = Active, DEN = Denied, INA = Inactive, LIM = Limited, NRT = Not reported, RES = Resident, TEM = Temporary, UNK = Unknown, UNL = Unlimited

Action Notifications

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

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

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Department of Justice.

U.S. Drug Enforcement Administration (DEA)

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DEA Number*	Business Activity†	Drug Schedule	Activity	Expiration Date	Payment Indicator	Last Reported	Address
------827	C-0	22N 33N 4 5	Active	05/31/2022	Exempt	01/27/2022	Limited To Official Government Duties On University Of Nebraska Medical Center 983255 Nebraska Medical Ctr Omaha, NE 68198-3255

** Only the last three characters of DEA numbers are displayed*

† The Business Activity code and subcode provide additional detail about the physician. For instance, Business Activity code-subcode combinations C-1, C-4, C-5, C-6, C-9, C-A, C-B, C-C, and C-D indicate the physician holds a DEA DATA waiver. Learn more about Business Activity code-subcode combinations.

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

ECFMG Certification

Applicant Number:

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

Profile Information

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

If any of the data in this Profile is believed to be incorrect, please log in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

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

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PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Minnesota Board of Medicine As of Date:1/31/2022

PRACTITIONER INFORMATION

Name:	Wenzel, Luke Richard
DOB:	5/1/1986
Medical School:	Des Moines University Osteopathic Medical Center Des Moines, Iowa, UNITED STATES
Year of Grad:	2016
Degree Type:	DO
NPI:	1669823571

BOARD ACTIONS

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

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1669823571	Individual			09/16/2020

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
NEBRASKA	7717	07/01/2016	07/01/2020	01/06/2022
		FSMB License Status: N/A		
NEBRASKA	2049	06/11/2019	10/31/2021	01/06/2022
		FSMB License Status: Expired		
WISCONSIN	73741-21	07/20/2020	10/31/2023	01/03/2022
		FSMB License Status: Active		

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

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PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Minnesota Board of Medicine As of Date:1/31/2022

Practitioner Name: Wenzel, Luke Richard

DEA Number	Schedule	Address	Expiration Date	Last Reported
FW6118827	22N 33N 4 5	OMAHA,NE 68198	05/31/2022	01/05/2022
FW9561160	22N 33N 4 5	LA CROSSE,WI 54601	05/31/2023	01/05/2022

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PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	Minnesota Board of Medicine	As of Date:1/31/2022
Practitioner Name:	Wenzel, Luke Richard	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.

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

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National Practitioner Data Bank
Health Resources and Services Administration
U.S. Department of Health and Human Services
P.O. Box 10832
Chantilly, VA 20153-0832
https://www.npdb.hrsa.gov

DCN: 5500000184999868
Process Date: 01/19/2022
Page: 1 of 1
WENZEL, LUKE R
For authorized use by:
GUNDERSEN CLINIC LTD

WENZEL, LUKE R - ONE-TIME QUERY RESPONSE

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

Practitioner Name: WENZEL, LUKE R
Date of Birth: [redacted]1986 **Gender:** MALE
Organization Name: GUNDERSEN LUTHERAN CREDENTIALING SERVICE
Work Address: 1910 SOUTH AVE, LA CROSSE, WI 54601-5467
Home Address: 1900 SOUTH AVE, LA CROSSE, WI 54601-5467
NPI: 1669823571
License: OSTEOPATHIC PHYSICIAN (DO), 73741-21, WI, OBSTETRICS & GYNECOLOGY
Professional School(s): DES MOINES UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE (2016)

MN BOARD OF MEDICAL PRACTICE
MAR 07 2022

B. QUERY INFORMATION

Statutes Queried: Title IV; Section 1921; Section 1128E
Query Type: This is a One-Time query response. Your organization will only receive future reports on this practitioner if another query is submitted.
Entity Name: GUNDERSEN CLINIC LTD (DBID ending in ...31)
Authorized Agent: GUNDERSEN LUTHERAN CREDENTIALING SERVICE
Authorized Submitter: DALE ATTLESON, CREDENTIALING SPECIALIST, (608) 775-8420

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 01/19/2022

The following report types have been searched:

Medical Malpractice Payment Report	No Reports	Health Plan Action(s):	No Reports
State Licensure or Certification Action	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

---------- No Reports Found Based on the Subject Information Submitted ----------

Luke Wenzel DO

Signed or attested before me on 3/2/22
by Luke Wenzel
Lynn A Albrecht
Lynn A. Albrecht, Notary Public
State of Wisconsin, County of La Crosse
My Commission Expires 11/19/2023

Lynn A. Albrecht NOTARY PUBLIC STATE OF WISCONSIN

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MINNESOTA
BOARD OF MEDICAL PRACTICE

335 Randolph Avenue, Suite 140
St. Paul, MN 55102
612.617.2130 (phone) | 612.617.2166 (fax)
medical.board@state.mn.us | mn.gov/boards/medical-practice

FACILITIES LIST

The Board requires a list of all facilities where you have had medical privileges during the last 10 years. List any facility where you are getting (have been) paid outside of a postgraduate training program. If you have had no privileges, write **NONE** and sign and date the form.

CURRENT PRIVILEGES

Facility	City and State	Type of Privilege
Gundersen Lutheran Medical Center	La Crosse, WI	Active

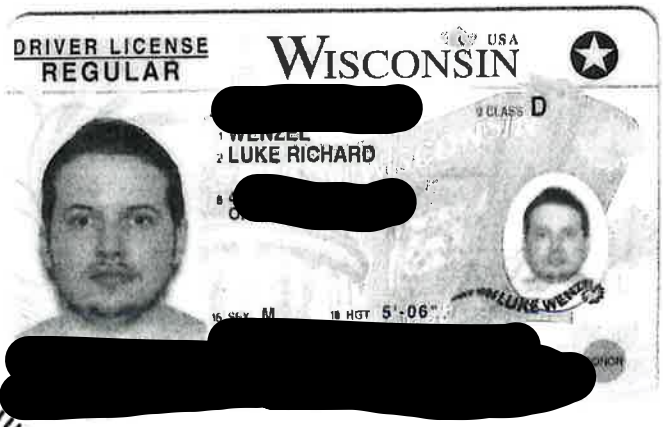
PAST PRIVILEGES (LAST 10 YEARS)

Facility	City and State	Type of Privilege
Bellevue Health Clinic	Bellevue, NE	Inactive

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

Print Name Luke Richard Wenzel

Signature [signature] Date 01/11/2022



Lynn A. Albrecht
NOTARY PUBLIC
STATE OF WISCONSIN

I certify that this is a true copy of the original document

Lynn A. Albrecht

Lynn A. Albrecht, Notary Public
State of Wisconsin, County of La Crosse
My Commission expires 11/19/23

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N/A

Treating Physician Statement

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

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 (Mo/Day/Yr)_____ Health Profession_____

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

Signed_____ Date_____

Nature of medical condition including diagnosis and significant symptoms

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

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

What medications is the applicant taking for this condition?

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

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

Treating Physician (print name)_____

Signature_____ Date_____

Phone_____ Fax_____