Susan Pfleger, MD

Licensed Physician #MD2014-0148

Issue Date	Expiration Date
03/07/2014	07/01/2014

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Susan Pfleger, MD

License Number: MD2014-0148

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 03/07/2014 Date Expires: 07/01/2014*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

1 3470 $400.00

New Mexico Medical Board
2055 S. Pacheco Street, Building 400
Santa Fe, NM 87505
505-476-7220
Fax: 505-476-7233

RECEIVED
FEB 03 2014
NM MEDICAL BOAR

R# 1565460

Susana Martinez
Governor

Steven Weiner, MD
Chair

ADDITIONAL PHYSICIAN INFORMATION

Physician Name: PFLEGER (Last) SUSAN (First) LYNN (Middle)

An asterisk (*) indicates that this information will be kept confidential.

Exam

Will you be applying by endorsement? Yes ☑ No ☐	**Citizenship:** USA
Immigration Status:	**INS Certification #:** N/A ☑
***Fed Tax ID#:** Pending ☐ N/A ☑	***NM Tax ID#:** Pending ☐ N/A ☑
***Fed. Drug Enforcement Admin. (DEA) Registration #:** [redacted] **Exp. Date:** 3/14	Pending ☐ N/A ☐
***State Controlled Substance Registration (CSR)#** **State:** **Exp. Date:**	Pending ☐ N/A ☑
***Medicare Unique Physician Identification Number (UPIN):** 1407963804	Pending ☐ N/A ☐
***State Medicaid Provider Number:** 3178340D **State:** W,	Pending ☐ N/A ☐

PRACTICE INFORMATION – Please list all applicable practice information below.

Current Practice Name: COMPHEALTH LOCUM TENANS	
Street Address: [redacted]	
City: SALT LAKE CITY **State:** UT **Zip Code:** 84171	
Telephone Number: 800-338-3541	**Facsimile Number:**
***Office Manager or Contact Person:** JODY MASSE	**Practice Limited to (clinical specialty):** OB-GYN
Foreign Languages (spoken fluently by practitioner): ENGLISH	
Foreign Languages (spoken fluently at Practice):	
What are your immediate or future Practice Plans in New Mexico? LOCUM TENANS	
Practice Associates in NM (if applicable): N/A	
Call Coverage in NM (if applicable):	
Other Practice Locations (if applicable):	
Other Practice Name:	
Street Address:	
City: **State:** **Zip Code:**	
Telephone Number:	**Facsimile Number:**
Answering Service:	**Effective Date:**

Applicant Name: SUSAN PFLEGER

PROFESSIONAL REFERENCES – Please list three professional peers familiar with your professional performance in the past 5 years (not including current or impending partners or associates in practice).

(1) Name and Title: FRITS BAOEKHUIZEN, MD			
Street Address: MCOW 9000 W WISCONSIN AVE			
City: MILWAUKEE	**State:** WI	**Zip Code:** 53226	
Telephone Number: 414-805-7666	**Facsimile Number:**		

(2) Name and Title: DANIEL GILMAN, DO			
Street Address: 10101 S 27th ST			
City: FRANKLIN	**State:** WI	**Zip Code:** 53132	
Telephone Number: 414-327-4910	**Facsimile Number:**		

(3) Name and Title: LOUIS JENO, MD			
Street Address: 12203 N CORPORATE PKWY			
City: MEQUON	**State:** WI	**Zip Code:** 53097	
Telephone Number: 262-387-8200	**Facsimile Number:**		

SPECIALTY BOARD CERTIFICATIONS ☐ N/A **Are you Board Certified?** ☑ Yes ☐ No

Note: If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the: ABOG		
Date Certified: 12/1994	**Date Last Recertified:** 12/2013	**Exp. Date:** 12/31/2014
Certified/Recertified by the:		
Date Certified:	**Date Last Recertified:**	**Exp. Date:**
Accepted for Examination by the:		
Until (expiration date):	**If not accepted, have you made application?** ☐ Yes ☐ No	

Certified/Recertified by the Subspecialty Board of:		
Date Certified:	**Date Last Recertified:**	**Exp. Date:**
Certified/Recertified by the Subspecialty Board of:		
Date Certified:	**Date Last Recertified:**	**Exp. Date:**
Accepted for Examination by the Subspecialty Board of:		
Until (expiration date):	**If not accepted, have you made application?** ☐ Yes ☐ No	

PROFESSIONAL LIABILITY INSURANCE*

Do you have current liability insurance? ☑ Yes ☐ No ☐ Pending		**Current Carrier:** CONTINENTAL CASUALTY
Complete address: PO 713100 SLC, UT 84171		
Dates Insured From: 6/2012 **To:** PRESENT	[redacted]	**Coverage Limits:**

Applicant Name: SUSAN PFLEGER

Uniform Application for Physician Licensure

UA Username spfleger
FCVS Status Applicant has an FCVS Packet

Date Submitted 1/25/2014

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

1. Full Name (use no initials)

Last Name	Pfleger
First Name	Susan
Middle Name	Lynn
Suffix	
Maiden Name	

M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

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

2. Address/Phone

Business

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

Street [redacted]
City MILWAUKEE **State/Province** WI **Zip Code** 53217-3523
Country USA
Telephone [redacted]
Fax [redacted]
Email [redacted]
Alternate Phone

Home

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

Street [redacted]
City MILWAUKEE **State/Province** WI **Zip Code** 53217-3523
Country USA
Telephone [redacted]
Fax
Email [redacted]
Alternate Phone

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

3. Identification

[redacted]	Milwaukee	Wisconsin	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

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

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

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

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

4. Medical School

1 **School Name** Vanderbilt University School of Medicine
Address 21st Avenue South at Garland Avenue

City Nashville
State/Province TN
ZIP Code 37232
Country USA
Attendance Dates **From (mm/yyyy)** 07/1977 **To (mm/yyyy)** 05/1981
Graduation Date 5/15/1981
Degree MD

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

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			

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

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

6. Postgraduate Training

1 **Hospital Name** Aurora Sinai Medical Center
Hospital Address 945 N 12th Street

City Milwaukee
State/Province Wisconsin
ZIP Code 53233
Country USA

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

Department/Specialty Obstetrics and Gynecology

From: 01 /1989 **To:** 02 /1992 **Successfully Completed?** [X] Yes [ ] No **In Progress** [ ]
Month Year Month Year

2 **Hospital Name** Oregon Health Sciences University
Hospital Address 3181 SW Sam Jackson Park Road

City Portland
State/Province Oregon
ZIP Code 97201-3098
Country USA

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

Department/Specialty Surgery-General

From: 06 /1981 **To:** 07 /1984 **Successfully Completed?** [ ] Yes [X] No **In Progress** [ ]
Month Year Month Year

3 **Hospital Name** University of Miami School of Medicine
Hospital Address 1611 NW 12th Ave, South Wing Bldg. Office 303
R-370

City Miami
State/Province Florida
ZIP Code 33136
Country USA

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

Department/Specialty Anesthesiology

From: 07 /1984 **To:** 07 /1985 **Successfully Completed?** [ ] Yes [X] No **In Progress** [ ]
Month Year Month Year

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

7. Examination History

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

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
NBME Part III			☒ P	☐ F	1

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

8. ECFMG (If applicable)

Certificate Number	Issue Date	Valid Through Date

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

9. State Licensure

1	**State/Province**	WI	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)	
	License Number	29977	**Status**	Active	**Issue Date**	1/1/1989

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

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 08 Year: 1985 To: Month: 12 Year: 1988 In Progress ☐	**Practice/Employment Name** community Health of South Dade (or list non-working time as indicated above) **Practice/Employment Address** 10300 sw 216th St **City** Culter Bay **State/Province** Florida **ZIP Code** 33190 **Country** USA **Position and Department** **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

HOSPITAL & ASC AFFILIATIONS: *NEW APPLICATIONS: List all hospitals, ambulatory surgery centers and med where you have ever had an affiliation or where you have an application in process. Indicate affiliation status (Active, Courtesy, Provi Temporary, etc.) Begin with current affiliations and then list past affiliations. Enter additional affiliations on a separate sheet of paper to the application. Do not include Residency or Internship information in this area. REAPPOINTMENT: List hospitals where you ha affiliation at any time in the past two years. Include current affiliation status.*

Name		Start and End Dates (Month & Year)
FRONTIER HEALTH		1/2014 – CURRENT
Street Address: 9200 W WISCONSIN AVE		City, State and Zip Code: MILWAUKEE, WI 53226
Phone Number (Include Area Code): 414-805-3913	Fax Number (Include Area Code): 414-805-3999	Affiliation Status: ACTIVE
Name: AURORA SINAI		Start and End Dates (Month & Year): 4/1992 – 2013, REAPPLYING
Street Address: 945 N 12th ST		City, State and Zip Code: MILWAUKEE, WI 53233
Phone Number (Include Area Code): 414-219-2000	Fax Number (Include Area Code):	Affiliation Status: ACTIVE
Name: MERCY WALWORTH		Start and End Dates (Month & Year): 6/2012 – 6/2013
Street Address: N 2950 STATE RD 67		City, State and Zip Code: LAKE GENEVA, WI 53147
Phone Number (Include Area Code): 262-245-0535	Fax Number (Include Area Code):	Affiliation Status: COURTESY
Name: RIVERVIEW MEDICAL CENTER		Start and End Dates (Month & Year): 7/2013 – 10/2013
Street Address: 410 DEWEY ST		City, State and Zip Code: WI RAPIDS WI 54494
Phone Number (Include Area Code): 715-423-6060	Fax Number (Include Area Code):	Affiliation Status: TEMPORARY
Name		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status
Name		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status
Name		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status

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

11. Malpractice Liability Claims Information

Name of patient involved:

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

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

Current status of claim:

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

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

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

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

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

Federation of STATE MEDICAL BOARDS

Federation of State Medical Boards

UA Summary of Reported Board Actions

Physician Identification

Name: **Susan Lynn Pfleger**
Alternate Names: **Pfleger, Susan L**
DOB: [redacted]
Medical School: **Vanderbilt University School of Medicine**

Year of Graduation: 1981

Summary of Reported Board Actions

No Reportable Board Actions Found

Reportable Actions as of UA Submission Date : 01/25/2014
UA Submission ID : 66,665
UA User Name : spfleger

Federation of STATE MEDICAL BOARDS

Federation of State Medical Boards
UA Licensure History

Physician Identification

Name:	Susan Lynn Pfleger
Alternate Names:	Pfleger, Susan L
DOB:	[redacted]
Medical School:	Vanderbilt University School of Medicine
Year of Graduation:	1981

Licensure History

State Board/Licensing Entity	License Number	Issue Date	Expiration Date
Wisconsin Medical Examining Board	29977-20	01/18/1989	10/31/2013
Oregon Board of Medical Examiners	MD13213	07/10/1982	01/01/1996

Licensure History as of UA Submission Date: 01/25/2014
UA Submission ID: 66665
UA User Name: spfleger

PROFESSIONAL PRACTICE QUESTIONS – Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1.	Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐ No ☑
2.	Have you ever been denied professional liability insurance coverage?	Yes ☐ No ☑
3.	Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐ No ☑
4.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐ No ☑
5.	Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐ No ☑
6.	Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐ No ☑
7.	Have you ever been named as a defendant in any criminal proceedings?	Yes ☐ No ☑
8.	Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐ No ☑
9.	Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐ No ☑
10.	**a.** Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency? **b.** Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes ☐ No ☑ Yes ☐ No ☑
11.	Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐ No ☑
12.	**a.** Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied? **b.** Are any currently held licenses pending investigation or being challenged?	Yes ☐ No ☑ Yes ☐ No ☑
13.	Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐ No ☑
14.	Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	[redacted]
15.	Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, complete the Malpractice Liability Claims Information page in the online UA. Include the following information in the specifics area:** • Name, age, sex of patient/claimant. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Name of defense attorney.	Yes ☐ No ☑

Applicant Name: SUSAN PFLEGER

16.	Have you ever been reported to the National Practitioner Data Bank?	Yes ☐ No ☑
17.	Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	[redacted]
18.	In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**	[redacted]
19.	Have you ever, for any reason:	
	a) Resigned from a medical school or postgraduate training (PGT) program?	Yes ☐ No ☑
	b) Withdrawn from a medical school or postgraduate training program?	Yes ☐ No ☑
	c) Been suspended, dismissed, or expelled from a medical school or PGT program?	Yes ☐ No ☑
	d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?	Yes ☐ No ☑
	e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	Yes ☐ No ☑

If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Applicant Name: SUSAN PFLEGER

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Diplomate Verification Search

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Susan L. Pfleger, M.D.
Status as of 2/17/2014

Below are all certifications held by this physician with ABOG.

ABOG ID: 929458
Milwaukee, WI

Obstetrics and Gynecology Certification		
Original Certification Date	Certification Status	Meeting Requirements of Maintenance of Certification
12/9/1994	Valid through: 12/31/2014	YES

Search Again

To purchase a copy of this status information sent from ABOG
Purchase Status Letter
The letter will contain the information above and be sent directly to an address of your choosing

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

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

Applicant:

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

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

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

DO NOT SEND THIS FORM TO FSMB.

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

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

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

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

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

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

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

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

PFLEGER

Applicant's printed last name

SUSAN L

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

1/28/2014

Date of signature (must correspond to date of notarization)

RECEIVED FEB 03 2014 NM MEDICAL BOARD

Notary

State of Wisconsin County of Milwaukee.

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 28TH day of January, 2014.

Notary Public Signature:

My Notary Commission Expires: 9-4-2016

(NOTARY PUBLIC SEAL) NOTARY PUBLIC JOHN A. ADAMAITIS STATE OF WISCONSIN

AMA Physician Profile

Name and Mailing Address
SUSAN LYNN PFLEGER MD
[redacted]
MILWAUKEE WI 53217-3523

Primary Office Address

STE 302
1218 W KILBOURN AVE
MILWAUKEE WI 53233-1325

Phone [redacted]

Birth date [redacted]

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)

GENERAL SURGERY (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 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
1407963804	08/23/2006	NOT RPTD	NOT RPTD	NOT RPTD	01/27/2014

Current and/or historical medical school

VANDERBILT UNIV SCH OF MED, NASHVILLE TN 37232

Degree Awarded: Yes

Degree Year: 1981

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

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

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

Sponsoring Institution: SINAI SAMARITAN MED CTR
Sponsoring State: WISCONSIN
Specialty: OBSTETRICS & GYNECOLOGY
Dates: 01/1989 - 12/1991 (Verified)

Sponsoring Institution: JACKSON MEM HOSP/JACKSON HLTH SYS
Sponsoring State: FLORIDA
Specialty: ANESTHESIOLOGY
Dates: 07/1984 - 06/1985 (Not Yet Verified)

Sponsoring Institution: OR HLTH SCI UNIV HOSP
Sponsoring State: OREGON
Specialty: GENERAL SURGERY
Dates: 07/1982 - 06/1984 (Verified)

Sponsoring Institution: OR HLTH SCI UNIV HOSP
Sponsoring State: OREGON
Specialty: GENERAL SURGERY
Dates: 07/1981 - 06/1982 (Verified)

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

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1982

AMA
AMERICAN MEDICAL ASSOCIATION

Current and/or historical medical licensure

Jurisdiction	MD/ DO	Date granted	Expiration date	Status	License type	Last reported
WISCONSIN	MD	01/18/1989	10/31/2015	ACTIVE	UNLIMITED	01/07/2014
FLORIDA	MD	10/02/1984	01/31/1998	INACTIVE	UNLIMITED	01/08/2014

ECFMG Certfication

Applicant Number:

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

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration date	Last Reported date	Address:
XXXXXX679	22N 33N 4 5	03/31/2015	01/07/2014	302 N Jackson St, Milwaukee, WI 53202-5904
XXXXXX312	22N 33N 4 5	03/31/2014	01/07/2014	Mercy Walworth Medical Center, N 950 State Road 50 & 67, Lake Geneva, WI 53147-

Only the last three characters of active DEA numbers are displayed

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

AMA
AMERICAN MEDICAL ASSOCIATION

Specialty Board Certification

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

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

Certifying board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate type: GENERAL

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date
TIME LIMITED	12/31/2013	12/31/2014		RE-CERT	01/10/2014
TIME LIMITED	12/31/2012	12/31/2013		RE-CERT(**)	01/10/2014
TIME LIMITED	12/31/2011	12/31/2012		RE-CERT(**)	01/10/2014
TIME LIMITED	12/31/2010	12/31/2011		RE-CERT(**)	01/10/2014
TIME LIMITED	12/31/2009	12/31/2010		RE-CERT(**)	01/10/2014
TIME LIMITED	12/31/2008	12/31/2009		RE-CERT(**)	01/10/2014
TIME LIMITED	12/31/2007	12/31/2008		RE-CERT(**)	01/10/2014
TIME LIMITED	12/31/2006	12/31/2007		RE-CERT(**)	01/10/2014
TIME LIMITED	12/31/2005	12/31/2006		RE-CERT(**)	01/10/2014
TIME LIMITED	12/31/2004	04/30/2006		RE-CERT(**)	01/10/2014
TIME LIMITED	12/09/1994	12/31/2004		INITIAL(**)	01/10/2014

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.

AMA
AMERICAN
MEDICAL
ASSOCIATION

Action notifications

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

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

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

Additional Information

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

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

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

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

Fax: (312) 464-5900

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

The Federation of State Medical Boards
of the United States, Inc.
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
FAX (817) 868-4099

BOARD ACTION CLEARANCE REPORT

February 5, 2014

New Mexico Medical Board
Attn: Lynn S. Hart, Executive Director
2055 S. Pacheco St, Ste 400
Santa Fe, NM 87505-0503

Re: Board Action Query Dated: February 5, 2014
Your Reference Number:
FSMB Batch Number: BQ2395184

The following is a report of the search results from the Board Action Data Bank as of February 5, 2014
for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of February 5, 2014

Item	Name	DOB	School	Yr/Grad	Request ID
3	Abdelerahman, Kader	05/28/1982	422010	2009	27152955
		LICENSE HISTORY State Board DELAWARE NEW MEXICO			
4	Asandra, Christopher	05/08/1979	026030	2003	27152957
		LICENSE HISTORY State Board ILLINOIS WISCONSIN			
7	Garcia-Rivera, Ricardo	05/15/1956	665010	1981	27152966
		LICENSE HISTORY State Board ARKANSAS CALIFORNIA CONNECTICUT FLORIDA HAWAII IOWA KANSAS MAINE			

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

The following is a report of the search results from the Board Action Data Bank as of February 5, 2014
for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of February 5, 2014

Item	Name	DOB	School	Yr/Grad	Request ID
		MASSACHUSETTS MICHIGAN MINNESOTA MISSOURI MONTANA NEBRASKA NEW HAMPSHIRE NEW JERSEY NEW YORK OKLAHOMA PENNSYLVANIA RHODE ISLAND TEXAS UTAH VERMONT VIRGINIA WISCONSIN			
1	Lee, Bryan	05/04/1981	099570	2008	27152950
		LICENSE HISTORY State Board No License Information Available			
8	Mednick, Adam	11/24/1959	033070	1990	27152969
		LICENSE HISTORY State Board CONNECTICUT FLORIDA ILLINOIS KANSAS MASSACHUSETTS NEW YORK OHIO OKLAHOMA PENNSYLVANIA WISCONSIN			
9	Pfleger, Susan	[redacted]	043040	1981	27152974
		LICENSE HISTORY State Board OREGON WISCONSIN			
5	Shen, Jason	10/17/1969	044020	1999	27152961
		LICENSE HISTORY State Board CALIFORNIA CONNECTICUT			

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

The following is a report of the search results from the Board Action Data Bank as of February 5, 2014
for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of February 5, 2014

Item	Name	DOB	School	Yr/Grad	Request ID
		KANSAS MISSOURI OKLAHOMA TEXAS UTAH			
2	Stewart, Janelle	03/15/1976	099840	2012	27152952
		LICENSE HISTORY State Board No License Information Available			
6	Yu, Edward	02/20/1976	014020	2004	27152962
		LICENSE HISTORY State Board FLORIDA KANSAS NEW YORK			

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

Wisconsin Department of Safety and Professional Services
Wisconsin Medical Examining Board

Electronic Licensure Verification

This real-time Licensure Verification page is electronically certified proof of licensure, as requested, and as it appears in the files of the Wisconsin Medical Examining Board as of Monday, January 27, 2014 10:11:32 AM - Central Standard Time

License Information

Name	PFLEGER, SUSAN L
Credential Type	Medicine and Surgery, MD
Credential Number	29977-20
Location	MILWAUKEE, WI
Status	credential license is current (active)
Issue Date	01/18/1989
Expiration Date	10/31/2015
Disciplinary Order(s)	No
Licensee	SUSAN L PFLEGER

History

Description	Code	Date
ENDORSED NATIONAL BOARD	ENDORSED FROM	01/18/1989
GRADUATED FROM 04705 VANDERBILT U-NASHVILLE TN	GRADUATED FROM	05/15/1981

AIM
Association of State Medical Board Executive Directors

Oregon Medical Board Search Results

License Number	MD13213
License Type	MD License
Dispensing	No
License Status	Expired
License Expiration Date	01/01/1996
Name	Dr. Susan Lynn Pfleger MD
Gender	Female
Address	[redacted]
City	Milwaukee
State	WI 53217
Country	United States
Issue Date	07/10/1982
Year of Birth	[redacted]
School	VANDERBILT UNIV SCH/MED
School Location	NASHVILLE, TN, United States
School Graduation Date	05/15/1981
Basis of Licensure	NBME
License Status2	Unrestricted
Additional Information	Click for more information on this licensee

Please read the OMB Disclaimer
Oregon Medical Board Homepage
Direct questions and comments about these results via
E-Mail or you may call us at 971-673-2700 from 1:00 p.m. to 4:30p.m. Pacific Time
This Board's data has been searched 11172023 times since 02/04/1999

Please read the AIM Disclaimer

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

RECEIVED
FEB 10 2014
NM MEDICAL BOAR

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**.

Applicant Name: SUSAN DELEGER [redacted]

Applicant Signature

Address: MILWAUKEE, WI 53217

City/State/Zip

*Dates of Privilege/Employment mm/yy to mm/yy (must be provided): 4/1992 - 2/2014

Telephone Number: 414-351-5004

The section below should be completed by the chief of staff or facility's administrative staff. Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Type or Print Name of person completing this form: DANISH SIDDIQUI

Title: MD

Name of Institution: AURORA SINAI MEDICAL CT.

Address: 945 N 12th Street

City / State / Zip

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___ Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___ Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___ Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___ Yes ✓ No

If not, please provide correct dates: Beginning 7/22/1992 (Month/Year) Ending 4/18/2013 (Month/Year).

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Printed name of person completing this form

Please affix hospital or notary seal here

Signature of Notary (if applicable) Date

My commission expires:

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above.
Thank you for your cooperation.

MERCY WALWORTH HOSPITAL & MEDICAL CENTER
Mercy Health System
HIGHWAY 50 AND 67
N2950 STATE ROAD 67
LAKE GENEVA, WI 53147
262•245•0535 877•893•5503
A System for Life

January 29, 2014

New Mexico Medical Board
2055 S. Pacheco Street
Building 400
Santa Fe, NM 87505

RE: Susan L. Pfleger, MD

To Whom It May Concern:

Susan L. Pfleger, MD; was a physician in good standing at Mercy Walworth Hospital and Medical Center, N2950 State Rd 67, Lake Geneva, WI 53147.

Appointment:	June 2012 – June 2013 per diem coverage *(Her privileges actually expired December 2013, but her last date of service was June 2013)*
Status:	Courtesy/Locum tenens Staff Privileges
Department:	OB/GYN
Specialty:	OB/GYN

There were no quality issues identified; privileges were not restricted; the practice of her specialty was not impeded by any health issues.

If you have any questions or concerns please give me a call (262) 245-2221.

Best regards,

Deborah L. Madden
Medical Staff Service Coordinator
Hospital/Clinic Coordinator

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505**.

Applicant: SUSAN PEREIRA [redacted]

Applicant Signature

Address: MILWAUKEE, WI 53217

City/State/Zip

*Dates of Privilege/Employment mm/yy to mm/yy (must be provided): 6/2012 - 6/2013

Telephone Number: 414-[redacted]-5004

The section below should be completed by the chief of staff or facility's administrative staff. Letters of Recommendation are ***NOT*** accepted in lieu of this form.

RANDALL NEMEROVSKI, MD
Type or Print Name of person completing this form

PRESIDENT of the MEDICAL STAFF · DIRECTOR of ANESTHESIA
Title

MERCY WALWORTH HOSPITAL · MED CTR
Name of Institution

N2950 STATE RD 67
Address

LAKE GENEVA, WI 53147
City / State / Zip

1. This evaluation is based on: X Observation of applicant ___Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes X No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes X No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes X No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* X Yes ___No

If not, please provide correct dates: Beginning 6/2012 (Month/Year) Ending 6/2013 (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

RANDALL NEMEROVSKI, MD / Randall Nemerovski MD
Printed name of person completing this form / SIGNATURE

Cindy L Shroda 1/31/14
Signature of Notary (if applicable) Date

STATE OF WISCONSIN NOTARY PUBLIC CINDY L. SHRODA
Please affix hospital or notary seal here

My commission expires: 5/22/16

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above.
Thank you for your cooperation.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

RECEIVED
FEB 03 2014
NM MEDICAL BOARD

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

SUSAN DELEGER
App[redacted]

Address
MILWAUKEE, WI 53217
City/State/Zip

Applicant Signature
7/2013 - 10/2013
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)
414-351-5004
Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff. Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Lisa Klein
Type or Print Name of person completing this form

Credentialing Coordinator
Title

Riverview Hospital Association
Name of Institution

410 Dewey Street
Address

Wisconsin Rapids, WI 54495
City / State / Zip

1. This evaluation is based on: ___Observation of applicant X Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes X No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes X No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes X No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* X Yes ___No

If not, please provide correct dates: Beginning 7/13 (Month/Year) Ending 10/13 (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Lisa Klein, B.A. - Lisa Klein 1/30/14
Printed name of person completing this form

Signature of Notary (if applicable) Date

My commission expires:

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above.
Thank you for your cooperation.